Perceived Psychosocial Needs, Social Support, Quality of Life and Adjustment in Subjects with HIV/AIDS

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Abstract
The psychosocial needs, amount of and satisfaction with social support, quality of life, lifestyle changes and adjustment of subjects with HIV/AIDS were assessed using a self-report instrument with 40 items and a cronbach’s alpha coefficient of 0.74. Eighteen subjects at varying stages of HIV infection who knew their sero-status served as subjects. Results showed that psychosocial needs (love, trust, acceptance, empathy) were perceived as most important by subjects but these needs were not being met by subjects’ most valued sources of social support. Therefore 83.3% subjects expressed dissatisfaction with the quantity and quality of support received since the diagnosis. About 66.7% subjects reported low social adjustment, 44.4% reported severe lifestyle changes (especially in social aspects) and 61.2% reported a low quality of life/wellbeing (especially social wellbeing). Subjects reported social dysfunction in four areas: fear of stigma and rejection (83.3%), lack of satisfying relationship with family (83.3%), lack of inner motivation (66.7%) and social isolation (66.7%). Extroverted individuals perceived significantly more lifestyle changes, reported a higher fear of rejection, a lower satisfaction with social support and a lower adjustment to the disease than introverted individuals. Subjects with late-stage HIV infection reported a significantly lower social adjustment, lower quality of life and more severe lifestyle changes. Satisfaction with social support correlated significantly with quality of life and with social adjustment. We therefore conclude that the higher the level of satisfaction with social support, the higher the quality of life and the higher the social adjustment to HIV/AIDS. Therefore the health worker must harness and encourage the provision of qualitative social support to clients with HIV/AIDS.

Introduction
The diagnosis and treatment of HIV/AIDS are associated with complex psychosocial effects like stigma and rejection, fear of the unknown, social isolation, impaired quality of life and the need to make remarkable lifestyle changes (Sowell & Opava, 1995). These psychosocial issues can be as devastating to the person living with AIDS as the physical symptoms. There is therefore the need to focus on the psychosocial aspects of HIV/AIDS care as these are critical to the physical and psychosocial wellbeing of the HIV-infected person. Stigma impairs society’s willingness to provide the needed social support to sufferers (Herok & Capitano, 1993). Yet, social support has been found to be vital in ensuring social adjustment in chronic diseases and an improved quality of life. According to Kaplan, Cassel & Gore (1977), coping with illness is facilitated through social support. Such support strengthens the individual’s ability to realistically appraise stressful events and develop effective coping strategies (Kaplan et al, 1977; Hirsch, 1980). It also moderates the effect of stress (Cobb, 1976), enhances wellbeing (Sowell & Opava, 1995) and significantly influences health outcomes and recovery patterns (Zink, 1996). Cohen & Willis (1985) have attributed these influences to the fact that socially supportive relationships provide emotional support, affection and companionship, thereby aiding coping, adjustment and wellbeing.

The purpose of this study was to identify the perceived psychosocial needs, social support, quality of life and adjustment in subjects with HIV/AIDS. Social support is defined in terms of availability of social interaction with others.
people who make the individual feel valued. Quality of life is the measure of the perceived physical, psychosocial and spiritual wellbeing. While social adjustment is the measure of the absence of social dysfunction, and success in reducing tensions associated with the illness.

SUBJECTS AND METHODS
Procedure
This descriptive study, lasting twelve months, was carried out in two hospitals in Calabar (General Hospital and Infectious Diseases Hospital). A convenience sample of 18 patients with HIV/AIDS who knew their diagnosis, served as subjects. The sample, based on availability, comprised 8 patients with early AIDS disease and 10 with late-stage disease with opportunistic infections. Permission to carry out the study was obtained from the co-ordinator of the AIDS-control programme in the State and the Medical Directors of the two hospitals. Written informed consent was obtained from subjects willing to participate in the study. Subjects' confidentiality was assured by using codes rather than subjects' names during data collection.

Instrument
A self-report instrument, with 40 items, on a five-point Likert type scale was developed by the investigators and used to interview subjects and collect data. The items were adapted from three standardized instruments (Quality of Life instrument by Ferrell et al 1992, with a reliability coefficient of 0.71 to 0.85; Sarason's social support questionnaire by Sarason et al 1983, with a test-retest reliability of 0.83 to 0.90 and Linn's social dysfunction rating scale by Linn et al, 1969, which measures social adjustment and has a Kendall's Index of 0.91). High scores on the social dysfunction scale indicate low social adjustment. The self-report instrument had 8 items on social support (4 on amount and 4 on satisfaction with social support), 12 on quality of life, 8 on social adjustment, 7 on lifestyle changes and 5 on psychosocial needs. The instrument was pre-tested on a convenience sample of six subjects at various stages of HIV infection, with a (Cronbach's alpha of 0.74) and from 0.51 to 0.82 (sub-scales). Six items on the personal data section were adapted from Eysenck's Personality Inventory to identify subjects' personality.

Analysis
Data were analyzed using descriptive statistics, t-test for significance of scores and Pearson product moment correlation for the relationship between variables. Data entry and analysis were made using the EPI-INFO-6 programme. On the social adjustment scale, scores of 8 to 19 signified low social dysfunction (high social/adjustment) and 31 to 40 (high dysfunction/low adjustment). On the Social Support Amount and Social Support Satisfaction Sub-scales scores of 4 to 8 indicated low amount/satisfaction 9 to 15 (moderate) and 16 to 20 (high). Scores of 12 to 26 on the Quality of life scale signified low wellbeing, 27 to 47 (moderate) and 48 to 60 (high wellbeing). Scores of 7 to 14 signified mild lifestyle changes, 15 to 25 (moderate) and 26 to 35 (severe changes).

RESULTS
The sample comprised 55.6% males and 44.4% females with age ranging from 26 to 58 years and a mean of 31.7 and standard deviation of 7.3. All subjects knew their sero-status (11.1% for less than 3 months, 33.3% for 3 to 6 months, 27.8% for 7 to 12 months and another 27.8% for over 12 months). Ten subjects (55.6%) were introverts and 5 (44.4%) extroverts. Table 1 shows demographic characteristics.

The most important needs perceived by subjects as necessary for their adjustment to the disease were psychosocial needs (love, trust, acceptance, empathy, esteem, encouragement) for 55.6% subjects, and instrumental needs (finance, drugs, food, tangible practical helping activities) for 33.3% subjects. Only 11.2% subjects identified information as most important. Only three (16.7%) subjects reported that their most important needs were being met. Identified sources of social support for subjects included family (for emotional support and financial needs), close friends and colleagues (financial needs), religious associates (emotional and spiritual needs) and healthcare workers (physical and informational needs). The most valued sources of social support were spouses (44.4% subjects), children (22.2%), and siblings (22.2%) while the most valued networks of support were family/friends (44.4%) family/religious associates (33.3%) and family/neighbours (22.2%). About 83.3% subjects expressed dissatisfaction with the quantity and quality of support they received from these valued sources since the illness. Table 2 shows the degree of psychosocial indices in subjects. About 66.7% of subjects reported low social adjustment to the illness, 27.8% reported moderate adjustment and only 5.6% reported satisfactorily high adjustment. Subjects reported social dysfunction in four areas - lack of inner motivation (66.7%), fear of stigma and rejection (83.3%), lack of satisfying relationship with spouse/partner and/or family (83.3%) and social isolation (66.7%). Reponses were not mutually exclusive. All the subjects reported some degree of lifestyle changes with 16.7% reporting mild changes, 38.9% (moderate) and 44.4% (severe changes). The type of lifestyle changes imposed by the disease were social (in terms of altered relationships, leisure and social activities) for 72.2% subjects and physical (personal care and physical activities) for 27.8% subjects. Subjects generally reported poor adjustment to these lifestyle changes. Out of the 10 subjects who had known their sero-status and diagnosis for over six months, 9 (90%) reported a reduction in the number and duration of social contacts and expressed the need for more social support and contact. The level of Perceived Quality of Life in subjects was low for 61.2% subjects moderate for 27.8% and high for 11.1%. The two subjects who scored high on the Quality of Life index were those who had known their sero-status for less than three months.

The means, standard deviations and t-test values on the psychosocial indices presented on Table 3 show a mean of 32.8, S.D. of 8.0 and t-value of significant at 0.02 level on the social dysfunction scale. A high mean and significant t-value on this index signify low social adjustment. Physical Quality of life/wellbeing and lifestyle changes were also significant at 0.02 and 0.001 levels respectively. All other values were not significant. The personality of subjects correlated significantly with social adjustment (r = 0.49, p = 0.05), satisfaction with social support (r = 0.43, p = 0.05) and lifestyle changes (r = 0.61, p = 0.001) but not statistically significant for amount of social support received and quality of life/wellbeing. Extroverts perceived more lifestyle changes (p = 0.02) reported a lower satisfaction with social support (p = 0.05), lower social adjustment to the illness and to lifestyle changes (p = 0.01) and a higher fear of rejection and stigma (p = 0.001) than introverted individuals. Subjects with late-stage HIV infection expressed significantly lower social adjustment (p = 0.01) experienced a lower feeling of wellbeing (p = 0.05) and more severe lifestyle changes (p = 0.02) than those with early HIV-infection. Satisfaction with social support correlated significantly with the quality of life (r = 0.48, p = 0.02) and with social adjustment (r = 0.43, p = 0.05). This implies that the higher the level of satisfaction with the social support received, the higher the perceived quality of life and the higher the social adjustment to HIV/AIDS.

DISCUSSION
Subjects need for love, acceptance, encouragement (psychosocial needs) were basically unmet probably because of the stigma associated with HIV/AIDS. Various social support networks were available to meet subjects' needs. How-
ever, subjects' most valued sources of social support did not give satisfactory social support to subjects since the diagnosis was known. Subjects reported some degree of alienation by family (identified as the most valued source of social support). According to Herek and Capitano (1993) there is usually an initial feeling of blame, rejection and fear of contagion which may lead to alienation (social isolation), hinder social support and disrupt satisfying social relationships. Coyne and Delongis (1986) stated that these may cause poor adjustment of the person with HIV/AIDS to the disease and may have been the case in this study. When a person's network of social relationships is deficient quantitatively (number, structure/composition of people in the network) and qualitatively (level of satisfaction with the social support received) depression, loneliness and social isolation result (Keele-Card, Foxall & Barron 1993). However, Keele-Card et al opined that the quality of social support is more important for coping and social adjustment than the quantity of support, and that the composition of the support network is more vital than the number of people in the network. Cohen (1990) agrees with this and added that for social support to result in effective coping and adjustment to illness, the sick person must be satisfied with both the amount, structure and duration of the social support received. Subjects in this study reported a general dissatisfaction with the quality and quantity of support received from their most valued source of support. This may have been responsible for the lack of inner motivation and other psychosocial dysfunctions reported by subjects. According to Zink (1996), culture plays a vital role in the availability of strong social networks necessary for social adjustment to chronic illnesses. But despite the fact that the African culture encourages family cohesion and support, the stigma and fear of contagion associated with HIV/AIDS hinder strong family bonding with the infected person (Somogy, Watson-Abady & Mandell (990). This may have been responsible for the lack of satisfying relationships, and social isolation (evidenced by reduction in the number and duration of social contact) expressed by subjects. These social lifestyle changes imposed by the disease may have led to the social dysfunction, low social adjustment and low social wellbeing found in this study.

CONCLUSION

HIV/AIDS creates some psychosocial needs and imposes lifestyle changes on infected persons and these may hinder effective adjustment to the disease. There is therefore need to harness and provide qualitative social support to the person with HIV infection as this would enhance coping and social adjustment. However, qualitative social support is difficult to get for these infected persons because of the stigma and fear of contagion associated with HIV/AIDS. The higher the level of satisfaction with the social support received by subjects the higher the perceived quality of life and the higher the social adjustment to HIV/AIDS.

ACKNOWLEDGEMENT

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REFERENCES


Table 1

Demographic Characteristics (n = 18)

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>n</th>
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<tr>
<td>AGE</td>
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</tr>
<tr>
<td>26 to 36</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>36 to 45</td>
<td>7</td>
<td>38.9</td>
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<tr>
<td>45 to 58</td>
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<td>38.9</td>
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<td>Mean:</td>
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<tr>
<td>S.D.:</td>
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<td>MARITAL STATUS</td>
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<td>Single</td>
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<td>Married</td>
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<td>Divorced/Separated</td>
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<tr>
<td>Widowed</td>
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<td>GENDER</td>
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<td>Male</td>
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<td>Female</td>
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<td>44.4</td>
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<td>WORK STATUS (current)</td>
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<tr>
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<td>Employed</td>
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<td>Student</td>
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<td>11.1</td>
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<td>DURATION OF KNOWLEDGE OF DIAGNOSIS</td>
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<td>Less than 3 months</td>
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<td>11.1</td>
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<td>3 to 6 months</td>
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<td>7 to 12 months</td>
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<tr>
<td>Over 12 months</td>
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<td>27.8</td>
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<tr>
<td>PERSONALITY</td>
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<tr>
<td>Introvert</td>
<td>10</td>
<td>55.6</td>
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<tr>
<td>Extrovert</td>
<td>8</td>
<td>44.4</td>
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Africa Journal of Nursing and Midwifery, June 2002 - Vol 4 No 1
Table 2
Degree of Psychosocial Indices in Subjects
(n = 18)

<table>
<thead>
<tr>
<th>Psychosocial Indices</th>
<th>X</th>
<th>SD</th>
<th>t</th>
<th>P</th>
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<tr>
<td>SOCIAL DYSFUNCTION (MEASURES ADJUSTMENT)</td>
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<tr>
<td>Maximum 40</td>
<td>32.88</td>
<td>8.0</td>
<td>2.51</td>
<td>.02</td>
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<tr>
<td>QUALITY OF LIFE (Maximum 60)</td>
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<td></td>
<td></td>
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<tr>
<td>Physical (Maximum 15)</td>
<td>13.1</td>
<td>4.1</td>
<td>2.43</td>
<td>.02</td>
</tr>
<tr>
<td>Psychological (Maximum 25)</td>
<td>9.9</td>
<td>3.2</td>
<td>1.65</td>
<td>.10</td>
</tr>
<tr>
<td>Social (Maximum 20)</td>
<td>8.1</td>
<td>2.4</td>
<td>1.62</td>
<td>.10</td>
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<tr>
<td>SATISFACTION WITH SOCIAL SUPPORT (Maximum 20)</td>
<td>5.6</td>
<td>2.2</td>
<td>1.70</td>
<td>.10</td>
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<tr>
<td>LIFESTYLE CHANGES (Maximum 35)</td>
<td>23.4</td>
<td>7.3</td>
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<tr>
<td>ADJUSTMENT TO LIFESTYLE CHANGES (Maximum 15)</td>
<td>3.8</td>
<td>1.6</td>
<td>1.17</td>
<td>.02</td>
</tr>
</tbody>
</table>

* A high mean indicates high social dysfunction and low social adjustment.

Key words: Perceived psychosocial needs; Quality of life; Lifestyle changes; Social adjustment.

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