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Family support is not a risk factor of negative self-esteem in HIV/AIDS women

Jean Valeria*, Surilena, Yanto Budiman***, Samsuridjal Djauzi****, and Haridana Indah******

ABSTRACT

BACKGROUND

Women with HIV/AIDS (WLWHA) have a complex psychosocial burden and a tendency to negative self-esteem, possibly resulting in mental and emotional problems. They need family support to deal with the HIV/AIDS infection and its psychosocial burden. The purpose of this study was to determine chacteristics of family support, self-esteem, and depression of WLWHA and the relationship between family support and self-esteem and depression.

METHOD

This was a cross-sectional study of 99 WLWHA infected through their husbands/partners, with no history of drug abuse. The data was taken by a consecutive sampling of two proportions test at Dharmais Cancer Hospital from November 2013 – January 2014. The instruments comprised a demographic questionnaire, the Rosenberg Self-Esteem questionnaire, the Hamilton Depression Rating Scale (HDRS), and a family support questionnaire. The data was analyzed by binary logistic regression.

RESULTS

There were 99 respondents with mean age of 36 years, of whom 44.4% were high school graduates, 54.5% unemployed, and 91.9% had HIV/AIDS for more than a year. Binary logistic regression analysis showed no significant relationship between family support and self-esteem (p=0.700) and depression (p=0.396). Good family support has a protective effect of 1.3 times (OR=0.772; 95%CI: 0.138-3.770) towards increasing self-esteem, whereas poor family support increases the risk of depression 1.5 times (OR=1.477; 95%CI: 0.598-3.645) in WLWHA infected with HIV/AIDS from their husband/partner.

CONCLUSIONS

Good family support tend to have a protective effect towards increasing self-esteem, whereas poor family support increases the risk of depression in WLWHA infected with HIV/AIDS from their husband/partner.

Keywords: HIV/AIDS, self-esteem, depression, family support, women

*Medical Profession Program, Faculty of Medicine, Atma Jaya Catholic University of Indonesia, Jakarta
**Department of Psychiatry, Faculty of Medicine, Atma Jaya Catholic University of Indonesia, Jakarta
***Department of Radiology, Faculty of Medicine, Atma Jaya Catholic University of Indonesia, Jakarta
****Dharmais Cancer Hospital, Jakarta

Correspondence
Jean Valeria
Medical Profession Program, Faculty of Medicine,
Atma Jaya Catholic University of Indonesia
Jl. Pluit Raya No.2
Jakarta Utara 14440
Mobile: +6285641332222
Email:
jean.valeria93@hotmail.com

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Dukungan keluarga bukan merupakan faktor resiko terhadap self-esteem *pada perempuan dengan HIV/AIDS*

ABSTRAK

PENDAHULUAN

Perempuan yang terinfeksi HIV/AIDS (ODHA perempuan) memiliki beban psiko-sosial kompleks dan cenderung dengan self-esteem *negatif yang dapat berlanjut dengan gangguan mental emosional. Dalam menghadapi infeksi dan beban psikososial HIV/AIDS, ODHA perempuan membutuhkan dukungan keluarganya. Tujuan dari penelitian ini adalah untuk mengetahui gambaran dukungan keluarga,* self-esteem, *dan depresi pada perempuan dengan HIV/AIDS, serta hubungan antara dukungan keluarga dengan* self-esteem *dan depresi.*

METODE

Desain penelitian ini adalah cross-sectional pada 99 perempuan yang terinfeksi HIV dari suami/pasangannya, tidak ada riwayat penyalahgunaan Napza, secara consecutive sampling dari uji dua proporsi di RS Kanker Dharmais, November 2013 – Januari 2014. Instrumen penelitian adalah kuesioner demografi, Rosenberg Self-Esteem, Hamilton Depression Rating Scale *(HDRS), dan dukungan keluarga (keluarga suami/pasangannya). Data dianalisis dengan* binary logistic regression

HASIL

Terdapat 99 responden dengan rerata usia 36 tahun, 44,4% pendidikan SMA, 54.5% tidak bekerja (ibu rumah tangga), dan 91,9% menderita infeksi HIV/AIDS lebih dari satu tahun. Analisis binary logistic regression *menunjukkan tidak ada hubungan signifikan antara dukungan keluarga dengan* self-esteem *(p=0,700) dan depresi (p=0,396). Dukungan keluarga yang baik memiliki efek protektif sebesar 1,3 kali (OR=0,772; 95%CI: 0,138-3,770) terhadap peningkatan self esteem dan dukungan keluarga yang buruk meningkatkan resiko untuk terjadinya depresi sebesar 1,5 kali (OR=1,477; 95%CI: 0,598-3,645) pada ODHA perempuan yang terinfeksi dari pasangan /suaminya.*

KESIMPULAN

Dukungan keluarga yang baik cenderung memiliki efek protektif terhadap peningkatan self esteem *dan dukungan keluarga yang buruk meningkatkan resiko akan terjadinya depresi pada ODHA perempuan yang terinfeksi dari pasangan /suaminya.*

Kata kunci: *HIV/AIDS,* self-esteem*, depresi, dukungan keluarga, perempuan*

INTRODUCTION

Acquired immunodeficiency syndrome (AIDS) is an end stage manifestation of human immunodeficiency virus (HIV) infection which causes opportunistic infection due to immune deficiency.[1] World Health Organization data for 2011 show that 49% of people living with HIV/AIDS (PLWHA) worldwide are women, with the highest mode of transmission being sexual intercourse.[2] In Indonesia, the highest mode of transmission in 2012 was 48.7% through sexual intercouse and 42.4% through injection. In 2012, the Indonesian Health Minister stated that housewifes are threatened with HIV/AIDS infection because the majority of men using the services of sexual workers do not use condoms.[3] The United Nations Programme on HIV/AIDS (UNAIDS) report that 34 million people worldwide are infected with HIV/AIDS, among whom 16.7 million women, while 22% of new cases are women.[4]

According to WHO criteria, HIV/AIDS stages are determined from the severity of the disease. The first stage is asymptomatic, the second shows a decrease in immune system functioning, and clinical manifestations begin to start, such as weight loss (<10%), recurrent pulmonary infection, herpes zoster, oral ulcer, etc. In the third stage, the symptoms grow worse, with weight loss of >10%, persistent diarrhea, persistent fever, persistent oral candidiasis, hairy leukoplakia, tuberculosis, anemia (<8 g/dL), etc. The fourth stage is the final stage, with wasting syndrome, pneumocystis pneumonia, extrapulmonary tuberculosis, chronic herpes simplex, Kaposi's sarcoma, toxoplasmosis, encephalopathy, meningitis, etc.[4]

HIV/AIDS causes physical and psychosocial impacts which vary between individuals. Women living with HIV/AIDS (WLWHA) have a heavier psychosocial burden compared to men. The psychosocial burden faced by WLWHA is complex, comprising changes in self-esteem, care of HIV/AIDS-infected family members, death of family members, and working to financially support the family if their husband dies, losing their custody, infecting their children and guilt. Women living with HIV/AIDS also face the stigma and discrimination from the neighbourhood and family, and other issues regarding social aspects such as social relations with their friends and family.[5,6] The psychosocial burden of WLWHA may cause a negative self-esteem, mental and emotional health problems which could lead to a mental emotional disorder.[7-9] Depression is one of the mental disorders encountered in WLWHA, with an incidence of around 5% - 48%.[10]

Family support has a role in self-esteem development in WLWHA. The family plays a role in giving emotional support in the form of empathy, affection, affording treatment, motivating a healthy life style, and encouraging them to take their medicine regularly.[11] Research shows that family support in WLWHA is needed in several conditions, such as decision making, going through treatment and rehabilitation, facing infection and the psychosocial impact of HIV/AIDS, and facing their future.[12] Li et al.[11] stated that family support gives a positive impact to WLWHA in various forms, the most significant coming from their partner and siblings. The aim of the present research was to determine the relationship between family support and self-esteem and between family support and depression, in women infected with HIV/AIDS from their partner/husband.

METHODS

Research design

The design used in this research was a cross sectional and the research was conducted between November 2013 – January 2014 at Dharmais Cancer Hospital, Jakarta.

Research subjects

The subjects were 99 women infected with HIV/AIDS from their partner/husband, aged 16-60 years, with no history of drug abuse, with family, able to read and write, never having engaged in sexual intercourse with others than their husband/partner. They were excluded if they had a record of serious mental health issues, such as psychosis and mental retardation. The diagnoses had been established previously by a specialist in internal medicine and stated in the medical records. The sample were obtained through consecutive sampling by two proportions test.

Measurements

The instruments used in this research were a demographic questionnaire on age, educational, marital, and occupational status, number of children, and number of children with HIV/AIDS, economic status, duration of illness, HIV/AIDS stage, and CD4+ titer. Self-esteem was measured by the Rosenberg Self-Esteem questionnaire of ten questions with four response options, with a different score on each option, giving one total score; self-esteem was positive if the total score was ≥15 and negative if the

score was <15.[13] The Hamilton Depression Rating Scale (HDRS) of 17 questions was used to measure depression, with each question having a different score. Total scores are interpreted as follows: 0-7 = no depression (normal mental state); 8-13 = mild depression; 14-18 = moderate depression; 19-22 = severe depression; and ≥23 = very severe depressions. A family support questionnaire of 20 questions with five different response options was used to measure family support, stated as supportive if the total score is ≥60, and not supportive if the total score is <60.

Statistical analysis

The data were analyzed using binary logistic regression analysis for the relationship between family support and self-esteem, and between family support and depression. Multiple logistic regression analysis was used to examine the relationship between determinant factors and family support.

Ethical clearance

This research had been approved by Ethical Clearance Committee Faculty of Medicine of Atma Jaya Catholic University of Indonesia at April 29th, 2014.

RESULTS

The results showed that the 99 women infected with HIV/AIDS from their partner/ husband had a mean age of 36 years, 44.4% were graduated from high school, 54.5% were unemployed (housewife), 98% were married, 82.8% had children, and 57.6% had a satifactory economical status with an income of more than Rp 2,200,000 per month. The research also showed that 91.9% respondents had been infected with HIV/AIDS for more than a year, 39.4% were in the third stage, and 92.9% had a $CD4^+$ count of ≤200 cell/mm^3 (Table 1).

The results of this research indicate that as many as 93.9% of respondents have a positive

Table 1. Demographic characteristics, self-esteem, family support, and depression of HIV/AIDS women

Variable	n (%)
Age (years)	36.03 ± 13.03
16-30	26 (26.3)
31-45	61 (61.6)
46-60	12 (12.1)
Level of education	
Low (elementary school)	7 (7.1)
Middle (junior high school / high school)	55 (55.5)
High (D3/S1/S2/S3)	37 (37.4)
Occupational status	
Unemployed	54 (54.5)
Employed	45 (45.5)
Marital status	
Unmarried	2 (2.0)
Married	97 (98.0)
Number of children	
0	17 (17.2)
> 1	82 (82.8)
Number of children infected with HIV/AIDS	
0	95 (96.0)
> 1	4 (4.0)
Economic status	
Less than satisfactory	42 (42.4)
Satisfactory	57 (57.6)
Duration of illness	
≤ 1 year	8 (8.1)
> 1 year	91 (91.9)
Stage	
Asymptomatic (I)	28 (28.3)
Mild (II)	28 (28.3)
Moderate (III)	39 (39.4)
Severe (IV)	4 (4.0)
$CD4^+$ Titer	
≤ 200	7 (7.1)
> 200	92 (92.9)
Self-esteem	
Negative	6 (6.1)
Positive	93 (93.9)
Family support	
Unsupportive	42 (42.4)
Supportive	57 (57.6)
Depression	
Normal	28 (28.3)
Depression	71 (71.7)
Mild depression	31 (31.3)
Moderate depression	17 (17.2)
Severe depression	13 (13.1)
Very severe depression	10 (10.1)

Table 2. Relationship between family support and self-esteem and between family support and depression in WLWHA

Variable	B	Sig.	Exp (B)	95% C.I. for Exp (B)	
				Lower	Upper
Self-esteem	-0.325	0.700	0.772	0.138	3.770
Depression	0.390	0.398	1.477	0.598	3.645

self-esteem. The depression status showed that 72.7% had depression, with 32.3% having mild depression, 17.2% moderate depression, 13.1% severe depression, and 10.1% very severe depression The family support data showed that 57.6% of respondents had a supportive family. The results of the binary logistic test showed no significant relationship (p=0.700) between family support and self-esteem and between family support and depression (p=0.396) in WLWHA. Good family support has a protective effect of 1.3 times (OR=0.772; 95%CI, 0.138-3.770) towards an increase in self-esteem and poor family support increases the risk of depression 1.5 times (OR=1.477; 95%CI, 0.598-3.645) in WLWHA infected with HIV/AIDS from their husband/partner (Table 2).

DISCUSSION

The results of this study indicate that as many as 93.9% of respondents have a positive self-esteem. These results differ from other studies, which showed that 84.62% injecting drug users (IDU) with HIV/AIDS had a negative self-esteem.[14,15] A study on 48 HIV/AIDS in-patients (30 males and 18 females) in Brazil showed that both genders had depression and anxiety.[16] Another study was conducted in Thailand on 409 people living with HIV, consisting of 112 (27.4%) men and 297 (72.6%) women, among whom there were 207 couples (married or living together) with on average 1.4 children aged 6 to 17 years. The study confirmed the importance of family support for people living with HIV in Thailand.[17]

The present study showed that 72.7% of the respondents had depression, with 32.3% having mild depression, 17.2% having moderate depression, 13.1% having severe depression, and 10.1% very severe depression. Another study stated that HIV/AIDS poses a complex problem, comprising physical, social, and emotional problems. A weak physical condition, threats of death, and the psychosocial burden of people living with HIV are likely to cause mental emotional or psychosocial problems.[18] The psychosocial burden of WLWHA is greater than that of men. Douaihy stated that one of the greatest emotional issues experienced by WLWHA was depression. Their number was higher than the general population prevalence of depression, which was about 5-10%.[19] Mascolini [20] stated that 17.9% of women and 14.3% of men living with HIV/AIDS suffered from depression. WLWHA must be a care giver for their husband or children infected with HIV/AIDS, become the “head of the family”, and face social stigma and discrimination. Another research showed that 54% of WLWHA had a psychopathological disorder, 20% had major depression, 18% had a maladaptive behavior, and 74% had drug abuse.[21] Holmes et al.[22] showed that depression affects patient self care. Depression can contribute to a decrease in physical and mental health, causes a reluctance to perform daily self-care routines and to undergo treatment, lack of appetite, lack of excercise, and insomnia that may cause complications aggravating the disorders. Li et al.[11] stated that depression can lead to reluctance to seek help in the form of treatment, care, and to look for information about the disease, which in turn could exacerbate the degree of health.

The results of our research showed that 57.6% of respondents had good family support.

These results are consistent with those of a previous research in 2012 which showed that PLWHA had good family support.[16,19] Jones and Weissmam [21] stated that family support is necessary for PLWHA as a major support system so that they may develop adaptive responses in dealing with stressors and/or infection-related impacts in facing HIV/AIDS. Li et al,[11] reported that family support can have a positive impact on the quality of life of PLWHA.

Our results are consistent with other research showing that there was no significant relationship between family support and self-esteem in WLWHA.[13]

This might be because 93.9% of the respondents of the present research had a positive self-esteem and 57.6% had good family support. These results are consistent with Unnikrishnan et al.[23] study showing that there was no significant relationship between family support and depression. Li et al.[11] suggested that PLWHA experiencing life situations where they often face their own condition without the support of friends or family, could suffer from anxiety, depression, guilt, and suicidal behavior or thoughts. Li et al.[11] also stated that significant HIV/AIDS -related stigma and discrimination had a negative impact on psychological well-being, and that social support was shown to lower the level of depression in PLWHA after controlling for gender, age, economic status, and level of education. Family support had a positive influence toward the psychosocial aspect as a whole.[24]

A limitation of this study was the short time for interview with each respondent, since most of them could give only a little of their time for the interview, so in-depth interviews were not possible. In addition, there was no private room for the interviews, so that some of them had to be done in open space where people passed by. This uncomfortable situation made the respondents feel insecure to give information about their health status and related problems.

This study hopes for the comprehensive treatment of WLWHA, on either physical or emotional aspects. WLWHA need support from their family, partner, friends, and social relations to deal with HIV/AIDS infection, medication, and psychosocial impact. Family support of WLWHA today is still low. This condition can lead to mental emotional problems among WLWHA, such as depression and anxiety, and can reduce their treatment adherence and quality of life. [25,26]

Further studies should be done on WLWHA infected for less than a year and on the assessment of support from the women's family, so increasing the probability of determining the true relationship between family support, self-esteem, and depression.

CONCLUSION

Family support is an important factor needed by WLWHA in their recovery process. Good family support has a protective effect towards increasing self-esteem, whereas poor family support increases the risk of depression in WLWHA infected with HIV/AIDS from their husband/partner.

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