

Psychological Assessment and Management of Death Anxiety, Self-Esteem and Somatisation Among People Living with HIV/AIDS (A Case Study of Apin Clinics, In Some Selected Hospitals Across South Western, Nigeria)

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Abstract

The psychological problems of persons living with HIV/AIDS in Nigerian cities have not been systematically documented. This study is a pre-test and post test experimental study of the assessment and management of death anxiety, self esteem (low) and somatisation among a randomly selected sample of 160 people living with HIV/AIDS and 160 HIV seronegative people. The main objectives of the study were to determine the presence of psychological distress among persons living with HIV/AIDS and to assess the effectiveness of psychological interventions in providing relief from these distressing symptoms. The psychological intervention utilized in the study was client centred group therapy in conjunction with relaxation training. The psychological instruments used were administered to the study participants in the pre-test and post test assessments. The one-way Analysis of variance, the t-independent test and f-scheffe multiple comparison tests were used in analyzing data. The study indicates that there were significantly higher levels of death anxiety, somatisation and low self esteem among persons living with HIV/AIDS compared with HIV seronegative persons. It was observed that client centred group therapy in conjunction with relaxation training could effectively lead to reduction in death anxiety. The most prominent effect of the therapeutic intervention was observed in relation to improvement in self esteem. It was recommended that Governmental Agencies that are saddled with responsibility of giving care to the victims put into consideration the psychological treatment as hallmark to lessen the burden of the disease thus improving well being and quality of life among HIV/AIDS persons.

Keywords: Death anxiety, Self-esteem, Somatisation Psychological intervention, HIV/AIDS.

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1. Introduction

HIV/AIDS is a global pandemic, which is threatening to rid the world of its entire workforce. By far, HIV/AIDS is one of the most deadly diseases of modern man. Hitherto, the attempts at getting a uniformity effective cure or preventive vaccine have eluded the arsenals of modern medicine. As early as 1993, the World Health Organization had stated that about one in forty adults in sub-Saharan Africa was HIV seropositive, and the picture in East Africa was far gloomier with 1 in 3 adults being seropositive [20]. The disease HIV/AIDS is a major cause of hospitalizations, outpatient clinic attendance, excessive health care expenses, lost earnings and productive activity, and leads to major disablement and early death of its victims. Hitherto, most people that develop the full-blown disease die within one or two years of its development. Incidentally, the citizens of the industrially advanced countries who develop the disease can now have their lives somewhat prolonged with the use of a cocktail of drugs, whereas our own nationals cannot have access to the same medication because they are very costly. It is a grave disease with significant economic implications for a developing country like Nigeria. Having no cure, and no preventive vaccine, HIV/AIDS is currently a major cause of premature death and excessive mortality. The disease afflicts mostly people aged 15-50 years who are usually in their most productive years and the major breadwinners of their families. The affliction of these people leads to financial losses, employment problems, declining productivity, increased health expenses, financial hardship for dependent family members, prolonged disability and early death [2]. The death of these parents and bread-winner leaves many orphans in its wake and this accentuates a vicious cycle of poverty within the coming generation. For a disease that is spreading very rapidly very in a complex society like ours where most citizens are ignorant and illiterate, the economic impacts of having a large segment of the work force afflicted by the HIV/AIDS disease portends economic doom In the near future

The HIV/AIDS disease has a number of psychological concomitants. The psychological impacts of the HIV/AIDS disease are exerted from the pre-clinical period and all through the course the disease. These psychological effects of the disease cause untoward suffering, disability, and diminished quality of life for the

victims. Incidentally, attention has always been focused on the medical and drug management of the disease, with little devotion of resources towards the exploration of psychological care interventions. Though, the psychological problems associated with HIV/AIDS are common, very little published material is available on it. The psychological distress that attends this disease is either endured quietly by the victims or is seen as signs of its progression. Estimates of the extent of psychological problems in association with HIV/AIDS have varied widely, depending on the locality, population, and nature of the presenting syndromes. For instance, it has stated that adjustment and stress reactions are observed in as many as 90% of people recently diagnosed as having HIV seropositivity. Although this usually subsides in most people with the passage of time and acceptance of the implications of the diagnosis, in a few people, these may persist for long, and result in serious psychiatric disorders [14]. There may also be other psychological and behavioural problems which may arise in the course of the illness.

Death anxiety has been considered as an emotional condition in which there is the fear and uncertainty about death. It is observed that death anxiety appears first of all, as an adolescent experience, then reappears in middle age and finally in later life. Individual differences arise from the operation of variable factors like sex, age, religious inclination, socio-cultural experiences and the environment. Death anxiety could manifest in the form of panic disorder, obsessive-compulsive, generalized anxiety disorder, and post-traumatic stress disorder (PTSD).

So far, Nigerian Government like those of other similarly affected countries in Africa has now accepted the reality of the AIDS challenge, and has started promoting educational messages with a view to combating the spread of the disease, but unable to make accessible the treatments that are available to citizens of other countries and could slow the progression of the disease. However, laudable as the country's approach is, it is not enough. A lot still needs to be done.

AIDS IN NIGERIA

Nigeria is the most populous nation in Africa with population of 160.5 million inhabitants, 45% of these live in the urban areas. Literacy rate is 44% and life expectancy is 51 years with infant mortality rate of 100 deaths in 1,000 births. HIV/AIDS was discovered in Nigeria between 1987 and 1988 according to studies carried out about this time in Ogun, Borno, Calabar and Maiduguri [2]. People infected with HIV in Nigeria belong to the sexually active age group of 18 to 29 years. The male to female ratio for infection is 3:1. Mortality rate from the disease is 88.9%. The urban areas have a greater rate of infection than the rural area. Factors that favour the incidence of HIV in Nigeria are most likely socioeconomic circumstances, cultural practices of circumcision and tribal marking, inheritance of widows; and travel. In addition, certain professions (including prostitution) are high risks for HIV infection. In Nigeria, infection is caused by both HIV1 and 2 types of the virus. The prevalence of HIV/AIDS infection in Nigeria is about 3.5% of the national population.

The broad aim of this study is to assess the presence of psychological distress among persons living with HIV/AIDS and determine the effect of a psychological treatment approach in its management.

The specific objectives of the study are as follows:

- (1) To assess the presence of death anxiety, low self esteem and somatisation among persons living with HIV/AIDS.
- (2) To determine whether a psychological intervention could affect the presence of death anxiety, low self esteem, and somatisation among persons living with HIV/AIDS.
- (3) To determine the psychological variables (death anxiety, low self-esteem and somatisation) impacted upon by the chosen psychological intervention.

REVIEW OF THE PSYCHOLOGICAL CONSTRUCTS THAT ARE THE FOCUS OF THE STUDY

A number of studies have been carried out on the assessment and/ or treatment of death anxiety, self-esteem and somatisation in non-clinical and clinical groups in the general population. These studies are mostly western in focus, with some few Nigerian studies centred around mostly clinical group and people living with HIV/AIDS (PLW HIV/AIDS). Some of these studies have examined each of somatisation, self-esteem and death anxiety individually or in relationship with other psychological variables. Some other studies have focused on the treatment aspects of somatisation, self-esteem, or death anxiety. However, since this present research combines both phases- the assessment and establishment of relation on the one hand, and the treatment of the psychological conditions on the other, relevant past research was looked into.

THE CONCEPT OF DEATH

Death refers to cessation of all consciousness [4]. The three facets of death are: the biological, the social and the psychological.

BIOLOGICAL DEATH

This involves the psychological and medical processes that result in the cessation of life. The occurrence of biological death is identified on the basis of a number of medical criteria such as cessation of breathing, loss of heart beat or disappearance of electrical activity in the brain

PSYCHOLOGICAL DEATH

[4] explained the psychological participation of the dying person in terms of a two-fold burden viz.

INTRAPSYCHIC: preparation of oneself for death

INTERPERSONAL: preparing oneself in relation to final separation from loved ones and simultaneously

preparing loved ones to be effective survivors after departure.

APPLIED STUDIES ON DEATH ANXIETY

The individual experiencing death anxiety may therefore be expected to manifest varying characteristics of abnormal self-concept and general psychopathology, depending on the nature of the precipitating stressors and personal coping/adaptive mechanism of the individual.

[19] carried out a study of death anxiety among nurses. They had three groups of nurses (n=24) undergo treatment in systematic desensitization, relaxation training, and no intervention, with pre-and post-test measures of death anxiety administered. Results showed that systematic desensitization and relaxation training were significantly more effective in death anxiety reduction. The effectiveness of this finding was flawed by the non-inclusion of a placebo group that would have explained the source of differential effects.

Lattaner and Hayship (1985) examined the validity of the sentence completion method in the measurement of death anxiety. They administered ten items from five sentence completion in the measurement of death anxiety. They administered ten items from five sentences from five completion test to 80 employees in death related and non-death related occupations. The findings indicated high significant conscious concerns for death of others and covert expressions of death anxiety for death related occupation subjects. This study is however limited in size and scope as a result of its narrow focus on confirmation of the validity of a specific anxiety assessment technique.

Dranchak and Smith (1989) administered the Templer death anxiety and mood scales to 52 college students. The subjects were shown a neutral videotape, death scene videotape and neutral videotape again. The subjects completed the mood scales before and after showing each videotape. The results showed that the initial level of death anxiety is a significant predictor of changes in the overall levels of depression and general anxiety.

Frazier and Foss – Goodman (1989) investigated the relationship between death anxiety and personality. They administered two death anxiety measures and personality questionnaires to 161 undergraduate students. The findings suggested that death anxiety was significantly related to neuroticism and type A behavior patterns in a manner that indicated that high death anxiety correlated with greater emotionality and aggressiveness. They concluded that neuroticism, type A personality extraversion and anticipated life stressors significantly influence the variability in death anxiety pattern.

(1) investigated the incidence of death anxiety among orthopaedic patients, as well as the effectiveness of relaxation techniques in reducing it. A total 90 subjects (m=61, f=29), consisting of one group of 40 in-patients in orthopedic hospital and randomly selected non-patients (n=50) participated in the study. Two death anxiety measures and an illness behavioral checklist were administered to the two groups at the assessment phase of the study. The 40 in-patient were further randomly assigned to 3 treatment groups of 10 subjects each for the treatment phase of the study. The death anxiety measures were then obtained at the end of the treatment programme. The results showed significantly higher scores on measures of general anxiety, death anxiety, death attribution and general attitude to illness among orthopedic patients than the non-patient group. The results also indicated a significant difference in post-treatment scores in death anxiety measures between the treatment group, placebo group, and the non-treatment control group; which implied the effectiveness of the relaxation techniques in reducing death anxiety.

Dimale (1992) carried out a study to assess and manage death anxiety among Nigerian mobile policemen (n=120). He administered the Awaritife personality inventory (API), the ISE, and the DAS to 40 regular policemen, 40 mobile policemen and 40 non-uniformed persons. He further selected 30 subjects from the study population and assigned randomly to each of three groups viz. the experimental group (mobile policemen, n=10), placebo (regular policemen, n=10) and a control group (non-uniformed men, n=10). He undertook management by applying Albert Ellis's rational emotive therapy in a group of therapy setting of ten sessions. The result showed an insignificant relationship between death anxiety, self-concept and general psychopathology.

SELF ESTEEM

This can be described as the degree to which one values oneself. Self esteem, which is the evaluative component of the self-concept, is such an important construct in psychology that it constitutes the focal principle of certain therapies. For instance humanistic psychologists like client centred therapists believe that empowering clients to accept and appreciate themselves is essential for achieving therapeutic gains. Self esteem is the value an individual places on himself and reasoned that the value depends upon past success and failure experiences of the individual. Self esteem is also the evaluation, which an individual makes and customarily maintains with regard to him or herself.

SOMATISATION

Somatization as a tendency to experience and communicate somatic sensations for which there is no known pathological explanation. Since the term was coined in the early half of this century, researchers have speculated about the psychobiological origins of this disorder, which is the expression of personal and social distress in an idiom of bodily complaints with medical help seeking. It is also seen as the presentation of physical symptoms in the absence of organic pathology or the amplification of physical complaints accompanying organic disease beyond what can be accounted for by physiological processes. These somatic symptoms can be viewed as a form

of defence mechanism, based on either individual psychobiology or supported by a social group as a culturally constituted defence mechanism. Africans view illness as coming from an external source and this leads to the development of anxiety related symptoms.[6] He further avers that somatisation represents a defence mechanism whereby psychological distress is channeled into somatic complaints thereby preventing the development of full-blown mental breakdown[5]. If the subjective bodily complaints of distress are not understood and relieved through an intervention, the underlying problem may lead to psychotic breakdown or can attack the part of the body involved in the expression of discomfort, thereby causing psychosomatic illness like peptic ulcer, rheumatoid arthritis or cancer. The physical symptoms observed in states of somatisation are hypothesised to be socially sanctioned expressions of personal and social distress in cultures or situations where overt complaints of misery would be frowned upon. In spite of the appeal of formulations like this, there is little hard data to substantiate the presumed connection between stressful experiences and the onset of the somatisation process. However, there is a more persuasive evidence in the association between live-event and the onset of a variety of functional illness complaints.

The study is construed as an attempt towards unraveling some of the major psychological problems encountered among persons living with HIV/AIDS, with a view to testing the effectiveness of a psychological intervention in the relief of the problems. It is hoped that the outcome of the interventional aspect of the study could have implication for the psychological care of HIV/AIDS clients in Nigeria. As a working tool, the following hypotheses were formulated and tested.

1. There will be no significant difference in respect of death anxiety, self-esteem, and somatisation among people living with HIV/AIDS.
2. There will be significant difference in respect of death anxiety, self-esteem and somatisation among people living with HIV/AIDS.
3. There would be significant difference in respect of death anxiety, self-esteem, and somatisation among people living with HIV/AIDS after psychological intervention.
4. There would be no significant difference in respect of death anxiety, somatisation and self-esteem among people living with HIV/AIDS after psychological intervention.
5. There would be no significant effect on death anxiety and self-esteem among people living with HIV/AIDS after psychological intervention.
6. There would be no significant effect on death anxiety and somatisation among people living with HIV/AIDS after psychological intervention.
7. There would be no significant effect on self-esteem and somatisation among people living with HIV/AIDS after psychological intervention.
8. There would be a significant effect on death anxiety and somatisation in people living HIV/AIDS after psychological intervention.
9. There would be a significant effect on death anxiety and self esteem in people living with HIV/AIDS after psychological intervention.
10. There would be a significant effect on somatisation and self-esteem in people living with HIV/AIDS after psychological intervention.

2. METHODOLOGY

The intervention study adopted experimental approach to assess the required data. 320 participants took part in the study which consisted two main groups of equal number of subjects viz; people who are seropositive and living with HIV/AIDS and people who are seronegative and are not living with HIV/AIDS. The instruments (questionnaire) adopted for the study were standardized ones already valid to Nigerian culture. It consisted of Death Anxiety Scale (DAS), a true-false instrument developed by [16] to measure death anxiety which covers a wide range of items and concerns about death which has been reported reliable with Kuder-Richardson reliability co-efficient of .74 and a 3-week test-retest correlation of .83. Also, Index of Self Esteem scale a 25 –item Likert-type test instrument designed by [8] to measure the degree, severity or magnitude of problems of self esteem and Symptoms Distress Checklist (SCL-90) a 90-item inventory developed by [8], designed to measure several manifestations of psychological distress among psychiatric outpatients and the experience of anguish arising from problems of living among people in the general population. The SCL-90 has alpha coefficients, which range from .77 on psychoticism to .90 for phobic anxiety. It has a concurrent validity with the Retirement Stress Inventory [10], which range from .26 on scale F (hostility) to .47 on scale (neuroticism). After instrumentation, experimental design was employed. A randomized two-group ANOVA was designed for the assessment phase of the study. The independent variable was seropositivity to HIV/AIDS, while the dependent variables were death anxiety self esteem and somatisation. The second phase of the study, the treatment phase utilized the pretest and post-test control group designs with repeated measures; the experimental, placebo and control groups where group therapy represented the independent variable while dependent measures were the DAS, ISE and SCL-90 Scales. In the pre-treatment phase, all the 320 subjects including equal numbers of seronegative and seropositive subjects

were tested individually in the hospitals and clinics using DAS and ISE Scales while ensuring subjects understanding fully the test instructions before the administration of the tests. In the treatment phase, 20 subjects among the seropositives were randomly selected and assigned to either of two group (experimental group= 10, control= 10) and 20 subjects among the seronegatives were also assigned to placebo group with members having 10 sessions of Client Centred Therapy (CCT) as a group therapy intervention technique. In the control group, no treatment was administered. The Facilitator only discussed with the group about the assessment scales on two occasions: initial and final assessments. The Placebo group also met with the Facilitator on days alternating with the meeting-days of treatment. A total of ten group therapy sessions, each lasting for fifty minutes, were observed with members of the placebo group. The sessions with members of the placebo group followed essentially the same pattern with that of the treatment group. Some selected hospitals with APIN Clinics across South West Nigeria represented study areas.

3. RESULTS

Findings from this study are shown below:

This study undertook an assessment and interventional management of death anxiety, low self esteem, and somatisation among 320 subjects that included 160 HIV seropositive and 160 HIV seronegative participants of both sexes.

The data obtained in the pre-assessment phase of the study were analyzed by, first calculating the analysis of variance (ANOVA) for the psychological variables that were the Dependent Variables (DV) viz. Death Anxiety Scale (DAS), the Index of Self Esteem (ISE) and the Symptoms Distress Checklists-90 (SCL-90) for each of the 2 groups' viz.-the seropositives and the seronegatives. The results of the ANOVA data are shown in the Table

TABLE I: PRE-ASSESSMENT ANOVA TABLE FOR SEROPOSITIVES

Source	SS	Df	MSS	F	P
SSB	85505.817	10	42752.909	64.212	.05 two tailed
SSW	24634.775	152	665.085		
Total SS	110140.592	156			

Interpretation: The critical F at $df = (2 \text{ \& } 37)$ $P < .05$ is 5.18 while the calculated $F = 64.212$ suggests a significant difference in the psychological variables, DAS, ISE, and SCL-90 amongst the seropositive group. This implies that there is a within group variance for the dependent variables. This finding is in consonance with hypothesis 2, which states that there will be a significant difference among people living with HIV/AIDS (PLWHA) and the presence of death anxiety, low self esteem and somatisation. Thus, there is substantial evidence to reject hypothesis 1 which states that there will be no significant difference among people living with HIV/AIDS and the presence of death anxiety, low self esteem and somatisation. This means that people who are seropositive are likely to suffer from death anxiety, low self esteem experience somatised symptoms compared with seronegatives.

TABLE II: PRE-ASSESSMENT ANOVA TABLE FOR SERONEGATIVES

Source	SS	Df	MSS	F	P
SSB	6500.000	10	3250.00	2.17	0.05 two tailed
SSW	55409.325	152	1497.549		
Total SS	61909.325	156			

In Table II, the critical F at $df (2 \text{ \& } 37)$ $P < .05$ two-tailed = 5.18 and the calculated F is 2.17.

This suggests that there is no significant difference in the dependent variables among the seronegatives. This implies that people who are seronegative are not at increased risks of developing death anxiety, low self esteem, and somatisation.

POST TREATMENT ANALYSIS OF RESULTS

The post treatment analysis of the results in the three study groups, viz. the experimental group, the placebo group and the control was undertaken and multiple comparisons of the treatment effects were made. The results of this operation are shown in the Table III.

TABLE III: ANOVA TABLE FOR THE REDUCTION SCORES IN THE POST-TEST EXPERIMENTAL GROUP GROUP

Source	SS	Df	P
SSW	308.9	3.35	p.05 two tailed
DFW	27		
VW	11.44		

The critical F at $dfw (27)$ $P < .05$ two tailed = 3.35 while the calculated $F = 11.44$. This shows that there is a significant difference (post-test) in the Dependent Variables viz., ISE, DAS and SCL-90 in the experimental group. This agrees with hypothesis 3 which states that there will be a significant difference in the incidence of death anxiety, low self esteem, and somatisation among people living with HIV/AIDS after psychological intervention. Thus, there is substantial evidence to reject hypothesis 4 which states that there will be no significance difference

in the presence of death anxiety, somatisation and low self esteem among PLWHA

TABLE IV: ANOVA TABLE FOR REDUCTION SCORES IN THE POST TEST PLACEBO GROUP

Source	SS	F	P
SSW	1316.6	3.35	<.05 two tailed
Dfw	27		
Vw	48.76		

In Table IV, the critical F at dfw (27) $P < .05$ two tailed = 3.35, is significantly lower than the calculated F at 48.76. This implies that the Dependent Variables death anxiety, low self esteem and somatisation are significantly different in placebo group. This is however quite an unexpected finding considering the assessment phase results which showed no significant difference in these parameters.

TABLE IV: ANOVA TABLE FOR REDUCTION SCORES IN THE POST TEST PLACEBO GROUP

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Dfw	27		
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TABLE V: ANOVA TABLE FOR THE REDUCTION SCORES IN THE POST TEST CONTROL GROUP

Source	SS	F	P
SSW	10.2	3.35	<.05 two tailed
Dfw	27		
Vw	0.37		

In Table V, the critical F at dfw (27) $p < .05$ two-tailed = 3.35 is significantly higher than calculated F at 0.37. This shows that there is no significant difference in the performance of the control group, pre- and post-test. This could be attributed to the fact that there was no psychological intervention administered on members of this group. This finding is in agreement with hypothesis 3 which states that there would only be a significant difference in death anxiety, low self esteem and somatisation after psychological intervention.

MULTIPLE HYPOTHESES TESTING

In view of the significant results obtained in the preceding section, it is imperative that specific pair-wise comparisons between the dependent variables be made. To find out if there were differences in the mean scores between the pre-post-treatment results and the implications and/or significance of such, a **t-dependent test** was applied to the three sets of data. The results are presented in Table VI.

TABLE VI: T-DEPENDENT TEST OF DIFFERENCES IN THE DEPENDENT VARIABLES (PRE- AND POST-TREATMENT): SCORES FOR ALL THREE GROUPS

Measures	Experimental Group (n=10)	Placebo Group (n=10)	Control Group (n=10)	Critical t
DAS	2.12	14.341	0	0.688
ISE	-2.90	-5.725	1.41	0.688
SCL-90	4.085	1.965	1.41	0.688

The critical t at df (19) $P < .05$ two-tailed = 0.688 On the DAS. The calculated t for the experimental group = 2.12; 14.341 for the placebo group, and 0 for the control group, show a significant difference in the pre- and post-treatment scores of the DAS. This implies that the experimental and placebo groups who had psychological interventions benefited from the treatment. This result partially supports hypothesis 3 of the study, which states that there will be a significant difference in the levels of death anxiety, low self esteem and somatisation among PLWHA after psychological intervention. This result inevitably leads to the partial rejection of hypothesis 4, which states that there will be no significant difference in the levels of death anxiety, somatisation and low self esteem in PLWHA after psychological intervention.

1. Discussion of findings

The findings of this study indicate that people living with HIV/AIDS are more likely to experience death anxiety, low self esteem and somatisation of psychological distress than HIV seronegative people. This is in agreement with prior findings in similar population groups. [12] observed high levels of psychological distress in their population manifested as anxiety, depression, adjustment disorders, insomnia and interpersonal problems. A similar pattern was observed among HIV seropositive adolescents [11] and young children of HIV seropositive mothers [7]. However, [13] have cautioned that the use of self-report measures to identify HIV seropositive persons suffering psychological distress may overestimate the extent of distress present.

The psychological distress and low self esteem observed among persons living with HIV/AIDS probably results from the impact of a deadly disease which so far has no easily available cure on a personality, who is then expected to make adjustments to the reality of the disease and its implications. The afflicted individual in this situation feels devalued and inferior to other people. Moreover, such a person is carrying a social burden of stigmatization as well as the existential burden of imminent possibility of death. These generate intense psychological distress manifesting as death anxiety, low self esteem and somatised symptoms of psychic distress. The inevitability and imminence of death among persons living with HIV/AIDS is not a remote possibility, rather its poignancy is heralded by the presence of symptoms indicative of the progression of the disease in some of them. This scenario possibly accentuates the anxiety, self-devaluation, and demoralization experienced by these persons. There is support for this view in the published literature. The self concept of an individual, though essentially stable over time, becomes threatened and could change in the presence of serious disease or injury, adverse social and interpersonal experiences [3]. The change in self-concept may be transient or more enduring, depending on the nature and persistence of exposure to the provoking circumstances. [6] had observed that Africans generally express their psychological distress in the form of bodily complaints (somatisation), whereas [4] asserted that severe life threatening events could cause the onset of somatisation, without any organic basis. It is noted that negative self evaluation following a serious illness results from the nature of the disability accompanying the disease, the individual's interpretation of the disability and the value the society places on the disability. All these factors probably interacted to produce high levels of death anxiety, low self esteem and somatisation among persons living with HIV/AIDS.

The finding that psychological interventions resulted in the reduction of death anxiety, somatic symptoms of distress and improvement in perceived self esteem among persons living with HIV/AIDS underscores the importance of detecting and managing the psychological problems of this group of people. This is in keeping with the findings of previous research work in this sphere. [16] had observed that identification and management of psychological distress among persons living with HIV/AIDS may lead to improved quality of life and reduced unnecessary utilization of health services. [15] noted that the psychological distress which accompanies testing positive to a deadly disease whether HIV/AIDS or another, usually improves following appropriate psychological interventions. The use of medical therapy for relief of psychological distress in HIV/AIDS patients would give inadequate responses unless the necessary psychological interventions are instituted. Moreover, early intervention has been advocated in view of the negative effects of long-standing psychological distress on the immune system of persons living with HIV/AIDS, which on the whole worsens the disease and accentuates its progression [3].

The psychological interventions that produced relief of psychological distress among the study group were client-centred therapy and deep muscle relaxation training. This was applied in the group setting. However, it is unclear whether it was the dynamics of the group or the specific therapeutic methodology utilized that produced the observed benefits. This is an issue because previous studies had reported benefits from varied approaches ranging from counseling and relaxation training to structured psychotherapeutic interventions. For instance, [1] had reported finding relaxation training an effective intervention for relief of death anxiety among orthopaedic patients. [3] noted that the comprehensive management of the HIV/AIDS syndrome requires the ready availability of psychological interventions, including counseling, and this usually improves the quality of life of the affected persons. Essentially, the same point had been noted by [12] who explored the utility of psychological interventions in the home care of persons living with HIV/AIDS. The necessity of understanding the mechanisms responsible for the overall effectiveness of the chosen intervention strategies has been underscored by the observed improvement in the levels of psychological distress (death anxiety, low self esteem and somatisation) among the members of the placebo group who were all HIV seronegative and received merely group support and interpersonal exchange of information.

The observed significant changes in psychological indices among members of the placebo group may be explained on the basis of the proposition that there is a high level of existential anxiety in the Nigerian society which caused demoralization, worry, and somatic accompaniments of anxiety. This existential anxiety is fostered by widespread general poverty and suspicion, insecurity and protracted economic hardships. The religious and political turmoil in the society, the rising crime wave and the frequent reports of unexpected and untimely deaths and assassinations appear to have prepared the grounds for the pervasive fear, anxiety and apprehension among the citizens. For people living in such a context, it appears that any attempt at reinvigorating hope, order, support, and friendship may lead to improved wellbeing and relief of anxiety. This may have accounted for the observed improvements in the psychological parameters of the placebo group members. There appears to be an established validation for this view point. For instance, it is said that in states of anomie and uncontrolled social change, levels of anxiety, and other forms of psychological distress increase in the population, because of increased demands on individuals to make continual adjustments. However, there is need for the conduct of further studies to explore the validity of this proposition.

Among the psychological variables studied, changes in self esteem and somatic complaints appear to account for most of the effects attributable to the psychological interventions among the persons living with HIV/AIDS.

This is probably a reflection of the interrelatedness of the variables and the fact that demoralization and low self-esteem are pervasive effects of the HIV/AIDS disease. It is possible that the somatic symptoms may be truer representation of anxiety among HIV/AIDS victims than the distressing psychological symptoms measurable with an anxiety scale. The psychological effects observed among the placebo group subjects (HIV seronegative persons) after group support, appear to have been exerted mostly on all the variables (death anxiety, somatisation and self esteem), all of which are features of existential distress in a stressful social environment. This existential distress is also operating in persons living with HIV/AIDS who in addition have to grapple with the distress that result from the disease and its impacts. Although clearly effective, it could be argued that the psychological interventions applied in this study would probably have exerted more effects if applied for a longer duration. This issue is pertinent in view of the vehement protests of the subjects studied when informed that the sessions would no longer continue. Since the post-intervention assessment was conducted after this manifestation of distress, one is not sure whether its accompanying features contributed to the overall patterns observed in the experimental group. It is only a follow-up study that can determine clearly whether a longer duration of intervention would have made a difference in the outcome. The effectiveness of psychological intervention raises the need for incorporation of relevant psychological strategies in the care of HIV/AIDS patients and other people suffering chronic disorders. There are indications that such psychological treatment methods are as legitimate as medical and social measures in the therapy of HIV/AIDS disease. For instance, without psychosocial interventions, the therapy of depression among HIV/AIDS patients would be incomplete and ineffective.

2. CONCLUSION

The problem of HIV/AIDS provides a continuing challenge, which must be tackled by means of a multi-dimensional approach. The psychological problems of persons living with HIV/AIDS certainly add to the range of disabilities and impairments observed in the disease. This study has shown that death anxiety, low self esteem and somatic manifestations of psychological distress (somatisation) are contributors to the lowered quality of life observed in the context of living with HIV/AIDS. These manifestations of psychological distress are observed more frequently in persons living with HIV/AIDS than persons who are seronegative. The experience of psychiatric distress among persons living with HIV/AIDS is an effect of the disease, the individual's perception of the disease, and the consequences of the society's attitudes towards a deadly disease like HIV/AIDS. It is also pertinent to note that the features of psychological distress among persons living with HIV/AIDS are amenable to psychological interventions. The effectiveness of psychological interventions in this regard has been underscored by the observed effect of client centred therapy administered in an encounter group setting, in association with deep muscle relaxation training in reducing the psychological distress observed among people living with HIV/AIDS. However, most of the effects of these interventions were exerted mostly on reduction of somatic symptoms of psychological distress and improvement of self esteem through the instillation of hope and reinforcements inherent in the therapies. It is also noteworthy that the use of encounter group support was found useful in reducing the existential anxiety encountered by HIV seronegative persons living in a metropolitan city. The major effects of such unstructured group approaches are observed in any of the manifestations of existential anxiety and low self esteem.

3. RECOMMENDATION

The major findings of the study could be applied as a spring board for the design of further studies on the assessment and management of psychological distress among persons living with HIV/AIDS in Nigeria. It is advisable to consider using more discriminating instrument in future studies of self esteem among persons living with HIV/AIDS in Nigeria. However, imperative for further studies in this domain is necessitated by the many gaps and questions raised by the study. Governmental agencies saddled with the responsibility of care giving to victims should put into consideration psychological treatment as principal to lessen the burden of the disease. Also, establishment of psychotherapeutic centers across Teaching Hospitals as well as other hospitals that attend to HIV/AIDS victims where Clinical Psychologists would be proactively involved should be considered imperative in order to delve into the blue world of the victims and edify their emotional states, will make them more functional and productive in the society. Baseline should be provided in future studies and interventions geared towards improving well being and quality of life among HIV/AIDS victims.

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