CASE REPORT

The implication of stigma on people living with HIV and the role of social support – A case report

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Abstract

Despite the advancements made in the knowledge and treatment of the human immunodeficiency virus (HIV) since it was first discovered, people living with HIV (PLWH) continue to be stigmatized. This paper presents the case of an HIV-infected patient who delayed the necessary treatment due to stigma and ultimately presented with AIDS. Through social support, however, he was able to overcome his internalized stigma; he was finally willing to start on antiretroviral treatment (ART). This case report addresses the effect of stigma on and the role of social support in the management of an individual with HIV.

Introduction

Patients infected with HIV can have internalized stigma, which is often compounded among men who have sex with men (MSM). Stigma can result in nondisclosure and delay the pursuit of treatment.[1] The case presented in this paper showcases the type and effect of stigma on a patient infected with HIV and how, through social support, he finally agreed to start on ART and improve his health outcome.

Case Presentation

A 32-year-old man presented with persistent diarrhea that started three weeks ago. He averaged nine episodes of diarrhea per day and had lost 10kg of his body weight since the problem emerged. There were no associated symptoms of fever, abdominal pain, joint pain, ulcers, or rashes. He described himself as a sexually active heterosexual. Three years prior, he was treated for latent syphilis; he denied being infected with HIV.

A physical examination revealed a normal hydration status, normal vital signs, and a normal body mass index. An abdominal examination was revealed no tenderness, mass, or hepatosplenomegaly. A per rectal examination revealed no presence of blood, melena, or mass.

An HIV rapid test was performed and came back as positive. A referral was made for further investigation and management of his chronic diarrhea. During the notification process, it was noted that a notification had been done in 2014. He admitted to being diagnosed with HIV during his episode of latent syphilis. However, his CD4+ T cell count was 600 cells/mm^3 and the patient was well after being treated for syphilis. He stopped attending his follow-up appointments after two months despite receiving multiple reminders from the clinic. He did this because he felt stigmatized for being infected with HIV despite never experiencing any form of external stigma. The severity of his internalized stigma was assessed using the Internalized HIV-Related Stigma Scale, on which he scored a three out of six. Despite being educated on the management, monitoring, and complications of HIV, he still ignored his follow-up appointments as a result of internalized stigma.

He was diagnosed with CMV colitis with a CD4+ T cell count of 171 cell/mm^3. He was treated for the CMV colitis with ganciclovir for two weeks. He was initially hesitant to start on ART despite been counseled on its importance. This was due to the self-perceived stigma; he would feel ashamed if others knew his status. However, after disclosing his status to his roommates, they were supportive, helpful, and encouraging; afterward, he finally agreed to start on treatment. Once treatment was initiated, his diarrhea was completely resolved and his weight increased. He did not experience any side effects from the ART; his subsequent appointment showed an increase in his CD4+ T cell count and a reduction in his HIV viral load.

Discussion

The Joint United Nations Programs on HIV/AIDS (UNAIDS) defines stigma and discrimination as "a process of devaluation of people either living with or associated with HIV and AIDS, discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status." Stigma and discrimination have an even more profound effect on groups that are associated with HIV, such as commercial sex workers, MSM, intravenous drug users, and prisoners.[2] Chollier et al.[3] detail how the experience of stigma ranges from effective stigma (whereby PLWH are the victims of an enacted stigma) to perceived stigma (whereby PLWH acknowledge that an enacted stigma is considered a norm) and internalized stigma (whereby PLWH acknowledge and validate their own stigma onto themselves).

Internalized stigma is the self-stigma, self-hate, and internalized shame felt by PLWH. It can cause self-loathing, isolation from society, fear of HIV testing, and poor adherence to treatment requirements.[3] Internalized HIV-related stigma can be determined by the Internalized HIV-Related Stigma Scale. It has six statements with which participants can "agree = 1", "disagree = 0," or remain "neutral = 0.5." Their marks are accumulated to assess the severity of their internalized stigma. The lowest possible score, 0, indicates low stigma while the highest possible score, 6, indicates high stigma.[4] The presence of stigma has been shown to result in nondisclosure of status[5]; it is the most important factor behind a patient's quality of life and adherence to treatment requirements.[1]

Social support is crucial in the battle against stigma toward PLWH. It has been shown to result in a lower incidence of depression and loneliness; ultimately, social support improves patients' quality of life.[1] Emotional support also helps PLWH improve their coping skills and reduce their negative emotions.[6] Support from friends and family helps PLWH rebuild their lives and even achieve success in their retroviral disease (RVD) treatment.[7]

Social support need not only comes from friends and family, however; it can also be obtained through support groups held by non-governmental agencies. Examples of such services available in Malaysia are MSM POZ, initiated by the Pink Triangle Foundation, and the Kuala Lumpur AIDS Support Services Society. Participation in support groups has been shown to increase adherence to ART.[8] Support group participation also leads to improvement in sexual practices—the people in these support groups are more likely to practice safe sex than are those who did not participate.[9] This can ultimately lead to a reduction in HIV-transmission rates. Support groups have also been shown to lead to an increased likelihood of treatment success, reduced morbidity, reduced mortality, and a higher quality of life in terms of confidence, self-esteem, coping skills, and a perceived reduction of stigma.[8]

Conclusion

Being infected with HIV can lead to stigma among patients. The ranges of stigma are effective, perceived and internalized stigma. Stigma has a significant negative effect on those affected such as poor quality of life and even poor adherence to treatment. Severity of stigma can be assessed using the Internalized HIV-Related Stigma Scale. Psychosocial management options, such as providing social support, are important in the management of HIV, as they can lead to better outcomes for stigmatized individuals.

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