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# Trauma, Depression, and Resilience among Women Living with HIV/AIDS in Kenya

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**Abstract** Kenya has one of the world's worst HIV and AIDS epidemics. In 2011, an estimated 1.6 million people were living with HIV and nearly 62,000 people died from AIDS-related illnesses including Korogocho, the worst slum area with 14% HIV prevalence. Even though awareness of HIV and AIDS in Kenya is high, many people living with the virus still face stigma and discrimination. Studies have shown that although people are aware of the basic facts about HIV and AIDS, many do not have the more in-depth knowledge that address issues of stigma. Especially social stigma of HIV to women is an urgent issue in Kenya. Especially women with HIV suffered from stigma and discrimination to break themselves down. Their severe depression and psychological trauma is the most significant cause of their deprived quality of life. Kenya women have been exposed to intense and ongoing trauma and depression since diagnosis of HIV/AIDS. Among 122 women living with HIV/AIDS in Korogocho, Kenya, we examined the prevalence and severity of pre traumatic experience (PET), impact of event (IES-R), depression (CES-D), internal stigma (ISS), and resilience (RS). Results revealed a high prevalence in emotional impact of event in women living with HIV/AIDS (86%); 65.3% reported severe depression after diagnosis of HIV/AIDS. As expected, depression was significantly correlated with both impact of event and internal stigma. Hierarchical regression analyses revealed the association between IES-R score and CES-D scores persisted even after controlling for relevant demographic variables. The most difficulties on living with HIV/AIDS were emotional distress, physical health, social relationship, and financial problems. Implications for improving the psychological functioning and resilience of women living with HIV/AIDS are discussed.

**Keywords** Trauma, Depression, Resilience, Psychosocial distress, Women living with HIV/AIDS (WLHA)

## 1. Introduction

HIV-status disclosure by people living with HIV/AIDS is widely advocated as a means to prevent HIV transmission (UNAIDS/WHO, 2000) and as such has received much attention in the international health literature (Maman, et al., 2001; Medley et al., 2004). On an individual level, disclosure facilitates HIV-infected individuals to seek treatment and care and supports adherence to complex treatment regimens (Norman, Chopra and Kadiyala, 2005). Broadly speaking, disclosure may also assist HIV-prevention efforts in society as it enables others to learn from the experiences of people living with HIV (Paxton, 2002). The World Health Organization (WHO) suggests that activities used in support groups for people living with HIV may help HIV-positive women develop the confidence to share their status with others (UNAIDS/WHO, 2000). In the last decade, there has been a dramatic rise in the number of HIV/AIDS support groups in Kenya.

Despite these propose benefits, many women living with HIV choose not to disclose their status. Literature from sub-Saharan Africa cities fear of blame, violence and abandonment by a partner, as well as stigma and isolation within the home and community as major barriers to status disclosure by HIV-positive women (Greff et al., 2008). Disclosure has significant health implications, firstly because the negative outcomes of disclosure can be detrimental and severe for the women affected, and secondly because low rates of disclosure may increase cases of HIV transmission to others (UNAIDS, 2006).

The HIV epidemic remains one of the most significant problems affecting Kenya, with an estimated 5.6% of the population infected (KAIS, 2012). The proportion of women infected with HIV has risen in recent years, and it is estimated that women account for two-thirds of the HIV-positive adults in Kenya. HIV-prevention efforts are hindered by widespread poverty – almost 20% of people live on less than US$ 1.25 a day (UNDP, 2010).

Kenya, HIV prevalence has been reducing in the last five years due to better treatment and care. In this period the prevalence reduced from 7.6% in 2007 to 5.6% in 2012

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(KAIS, 2012). This survey revealed that fifty eight percent of HIV-infected persons aged 15 to 64 were eligible for ART but only 63% are currently on ART. In spite of the reported reduction in the prevalence of HIV and AIDS, the disease continues to impact women in Kenya significantly. The disease is more prevalent among women aged 15 to 64 years compared to men in all provinces. Central and Nyanza Province were the only regions where the prevalence of HIV and AIDS increased marginally with the rest of the country reporting reduction (KAIS, 2012).

An assessment of the psychosocial challenges and health needs of women living with HIV in an area where the prevalence has been increasing in the recent past is necessary in order for health practitioners and the government to implement successful interventions. Hence this study aimed at determining the psychosocial and health needs of women living with HIV in Central Province, Kenya. The study further explored the coping strategies employed by the women to mitigate against the effects of the HIV and AIDS on them.

# 2. Methods

This was exploratory study carried out in Central Province in Nairobi, Kenya. Participants were drawn from Korogocho and Nyeri. They comprised 122 women living with HIV and AIDS aged between 24 to 60 years. An interview schedule was used to determine the challenges that the women faced and how they coped. The schedule interrogated women on their background education levels, occupation, when they got infected, how infection with HIV altered their lives, the psychosocial and health needs that they faced and how they coped with them.

**Measures**

***General Information***

Participants completed measures addressing demographics (age, education status, employment status, marital status, the number of family member, experience of losing their child (ren), income), the number of HIV-related physical symptoms, needs after notifying HIV-positive, social support, number of pre-experience traumatic event etc.

***Psychological Status***

Psychological distress were used to assess to psychological Impact of trauma, depression, internal stigma from their surrounds through IES-R (Impact of Event Scale – Revised), CES-D (Center for Epidemiologic Studies - Depression), ISS (Internal Stigma Scale). The 22-item *IES-R* (Greenberg, 2013) was used to assess psychological trauma from HIV-positive with factors of intrusive, avoidance, hyper-arousal, and chance using a 5-point likert-type response ranging from 0 (not at all) to 4 (always). Participants were asked to respond during past 7 days. Depression were assessed using measures 20-item *CES-D* (Radloff, 1977; 1986). Participants were asked to respond on 4-point scale ranging from 0 (few, under 1 day) to 4 (quite often, 6~7 days) during last week. The 28-item *HIV stigma scale*; internal stigma scale (Sowell et al., 1997) were used to assess persons' internalized stigma from their community, and based on a 7-day period using five response items from 0 (not at all) to (always).

***Benefit Findings***

The extent to which participants found benefits in their situation was assessed using a short-version 6-item resilience scale (Cambell-Sills & Stein, 2007) from original version 27-item the Connor-Davidson Resilience Scale; CD-RISC using 6-point response items from 0 (not at all) to 5 (very much).

# 3. Results

***General Information***

The demographic, general information, symptoms, and traumatic experience before HIV-positive of the sample are presented in table 1.

Half of PLWH (People Living with HIV) in Nairobi were Kikuyu. Most (72%) of PLWH living under 1 USD during a month have lived slum. All of PLWH did not earn a couple of USD a month. After HIV-positive 14% for maintaining the marital status, one-third of PLWH have lost their child vertical transmission, that number is reached in 1 to 6. Mean number of previous traumatic experience of PLWH before HIV-positive was 4.5 for instance, close people got hurt or sick(68%), emotional abuse(50%), domestic violence(50%), physical abuse(43.3%) etc. as well as they have a number of symptoms; cough(39.3%), headache(36%), fatigue(29.5%), pneumonia(28.7%), back pain(23%), gynecological symptoms(23%) etc. They have no choice but to have a complex trauma. Given the culture, it appears relatively low rate of sexual abuse (27.9%) is not surprising.

***Psychological Status***

The psychological status such as trauma from HIV-positive, depression, internal stigma from community, neighbors of the sample are presented in table 2.

Considering that cut-off point of IES-R was 21 points, mean score of trauma (IES-R score) was 53.26 means that PLWH have received a very various severe shock. 86% of PLWH was severe and very severe trauma about HIV-positive, 64% of PLWH was severe and very severe depression from HIV-positive. Figure 1 showed percentage of PLWH's trauma and depression.

**Table 1.** Demographic and general information (N=122)

| characteristic | N | % | M | SD | Range |
|---|---|---|---|---|---|
| Age | | | 39.25 | 8.49 | 24-60 |
| Ethnicity | | | | | |
| Kikuyu | 58 | 47.5 | | | |
| Kamba | 6 | 4.9 | | | |
| Luhya | 17 | 14 | | | |
| Luo | 30 | 24.6 | | | |
| Others | 11 | 9 | | | |
| Residency | 122 | 100 | | | |
| Nyeri | 14 | 11.5 | | | |
| Korogocho | 98 | 88.5 | | | |
| Family | | | | | |
| Number of family members | | | 4.7 | 1.68 | 1-7 |
| Child | | | | | |
| Experience of losing child (ren)-yes | 37 | 30% | | | 1-6 |
| Number of losing child (ren) | | | | | |
| Income (Ksh, monthly) | | | | | |
| >1,000 | 93 | 76.2 | | | |
| 1,001~2000 | 29 | 23.8 | | | |
| 2,001~3,000 | 0 | 0 | | | |
| 3,001< | 0 | 0 | | | |
| Marital status | | | | | |
| Single | 47 | 38.5 | | | |
| Married | 18 | 14.8 | | | |
| Separated/separated | 34 | 27.9 | | | |
| Widowed | 22 | 18 | | | |
| Other | 1 | 0.8 | | | |
| Other symptoms (multiple answers) | | | | | |
| URTI (upper respiratory tract infection) | 20 | 16.4 | | | |
| TB (tuberculosis) | 24 | 19.7 | | | |
| Malaria | 20 | 16.4 | | | |
| Cough | 48 | 39.3 | | | |
| Diarrhea | 14 | 11.5 | | | |
| Skin problem | 26 | 21.3 | | | |
| Fatigue | 36 | 29.5 | | | |
| Pneumonia | 35 | 28.7 | | | |
| Back pain | 28 | 23 | | | |
| Gynecological symptoms | 28 | 23 | | | |
| Headache | 44 | 36 | | | |
| Arthritis symptoms | 17 | 14 | | | |
| Nausea | 24 | 19.7 | | | |
| Vomiting | 18 | 14.8 | | | |
| Pre-experience traumatic event before HIV-positive | | | 4.5 | 3.94 | 1-12 |
| Close people got hurt or sick | 84 | 68.9 | | | |
| Neighboring violence | 39 | 32 | | | |
| Witnessed incident | 52 | 42.6 | | | |
| Domestic violence | 61 | 50 | | | |
| Confinement of Family | 21 | 17.2 | | | |
| Physical abuse | 53 | 43.4 | | | |
| I have thought I should die. | 40 | 32.8 | | | |
| Parents' divorced | 68 | 55.7 | | | |
| Neglected from parents | 19 | 15.6 | | | |
| Sexual abuse | 34 | 27.9 | | | |
| Close people have attempted suicide | 25 | 20.5 | | | |
| Natural disaster | 41 | 33.6 | | | |
| Emotional abuse | 61 | 50 | | | |
| Life threat | 26 | 21.3 | | | |

**Table 2.** Psychological status (N=122)

| Characteristic | | N | % | M | SD | Range |
|---|---|---|---|---|---|---|
| Trauma (IES-R) | | 122 | 100 | 53.26 | 19.34 | 4-88 |
| Intrusive | | | | 18.44 | 7.71 | 1-24 |
| Avoidance | | | | 19.43 | 7.08 | 1-32 |
| Hyper-arousal | | | | 13.7 | 6.62 | 1-32 |
| Mild | (0~20) | 8 | 6.6 | | | |
| Moderate | (21~32) | 9 | 7.4 | | | |
| Severe | (33~44) | 17 | 14 | | | |
| Very severe | (45~88) | 88 | 72 | | | |
| Depression (CES-D) | | 122 | 100 | 32.63 | 12.64 | 1-58 |
| Mild (0~16) | (0~16) | 22 | 18 | | | |
| Moderate | (17~30) | 22 | 18 | | | |
| Severe | (31~45) | 61 | 50 | | | |
| Very severe | (46~88) | 17 | 14 | | | |
| HIV Stigma (ISS) | | | | 59.72 | 26.4 | 10-124 |

*Note. Trauma: IES-R (Impact of Event – Revised); Depression: CES-D (Center for Epidemiological Studies – Depression); HIV Stigma: ISS (Internal Stigma Scale)*

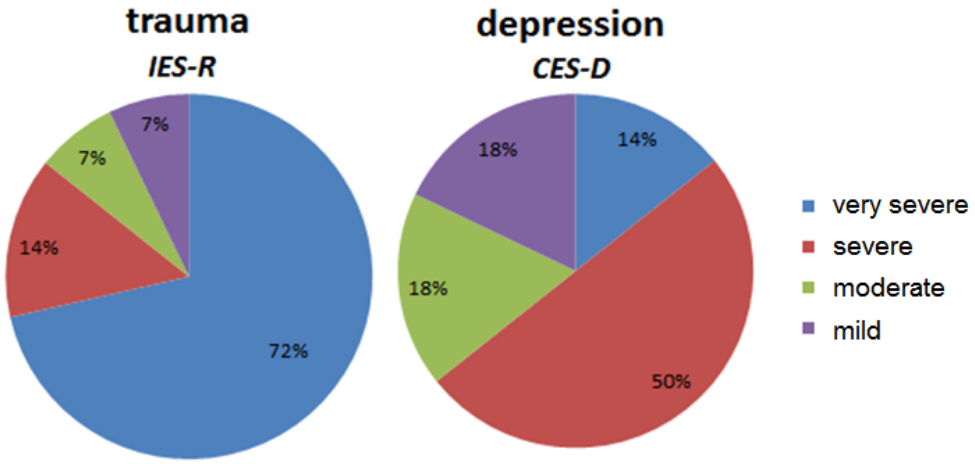


**Figure 1.** Severity of trauma (IES-R) and depression (CES-D)

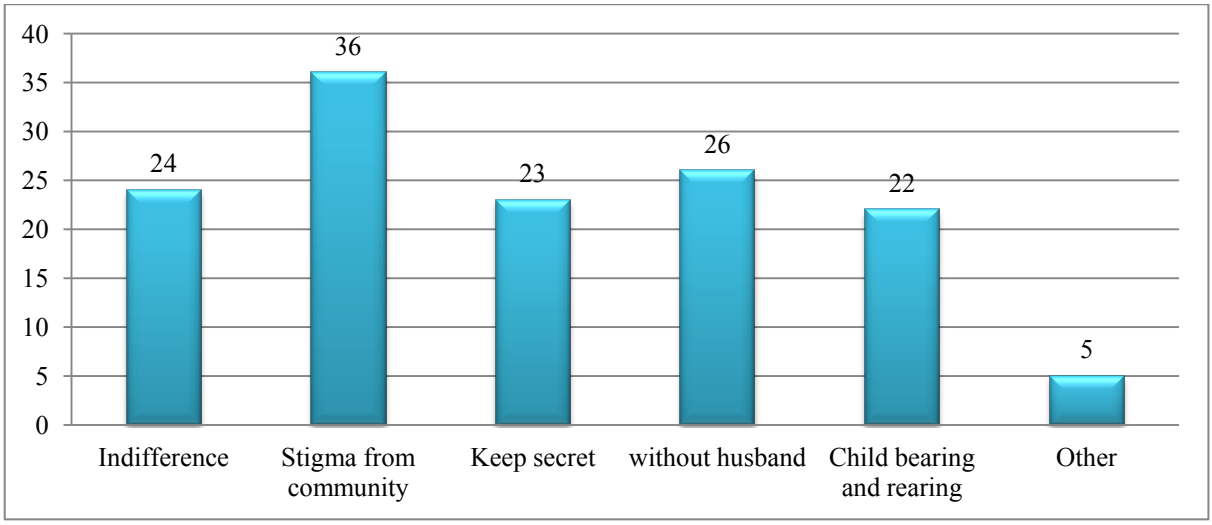


**Figure 2.** Difficulties of Women living with HIV

They have afraid of stigma and indifference from their community as figure 2. Figure 2 was multiple answers from question 'socially, what difficulties do you experience; HIV-positive?' The first answer was stigma of community, the second was living without husband. Indifference and keep secret were sort of stigma also. HIV-positive is more frightening from social isolation than from the disease itself.

*Socially, what difficulties do you experience?*

We provided to participants the question 'if you stopped taking ARVs, why did you do so?' we have found a sort of internal stigma from answers of the question. The priority of stopping ARVs is afraid of noticing anyone else.

*If you stopped taking ARVs, why did you do so?*

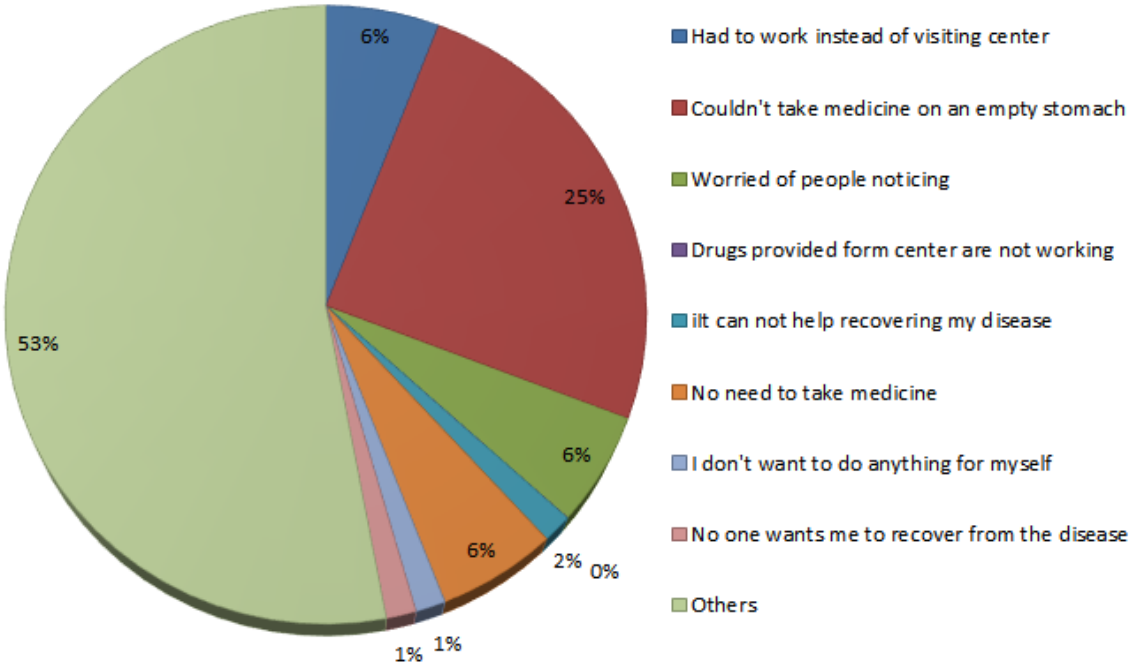


**Figure 3.** Internalized stigma of PLWH

*Stigma and discrimination*

The prevalence of stigma and discrimination against women living with HIV in Central Province of Kenya was very high in spite of the intensive efforts to educate the masses about HIV and AIDS. High stigma led to failure to disclose one's HIV status for fear of being ridiculed. The women reported that they had been divorced or separated because of their HIV status. There were cases of self-stigma with women was high with some choosing to leave their homes for fear of ridicule from relatives.

> *It is still difficult to tell people. I have only told my two sisters and a close friend. If I was employed, I would not tell people of my HIV status because I will not need their support.*
> *Some view HIV positive individuals negatively as if HIV is something we picked from a supermarket. People hate a HIV positive person. Some laugh at us but we later meet at their counselor's place. When I find them there I really laugh at them. I tell them welcome to our "church."*
> *When I got TB, I was isolated to avoid infecting others. AIDS is a very bad disease. You can just think of it and die.*

***Benefit Findings***

Table 3 showed resilience with PLWH. According to table 3, PLWH have possessed lots of resilient component compare to amount of their complex trauma. 82%, above 15 of resilience score means strong resilience; 86% have received trauma in PLWH. Which means that women living with HIV/AIDS had suffered from HIV-positive but they have competence from themselves. They can struggle and overcome trauma of HIV-positive.

**Table 3.** Resilience score (N=122)

| Characteristic | N | % | M | SD | Range |
|---|---|---|---|---|---|
| Resilience (RS) | 122 | 100 | 19.94 | 4.93 | 6-30 |
| 1-10 | 5 | 4 | | | |
| 11-15 | 17 | 14 | | | |
| 16-20 | 40 | 32.8 | | | |
| 21-25 | 44 | 36.1 | | | |
| 26-30 | 16 | 13.1 | | | |

Although PLWH have suffered trauma and depression severely, and not enough earned money, they need psychological support.

*What was the most helpful services?*

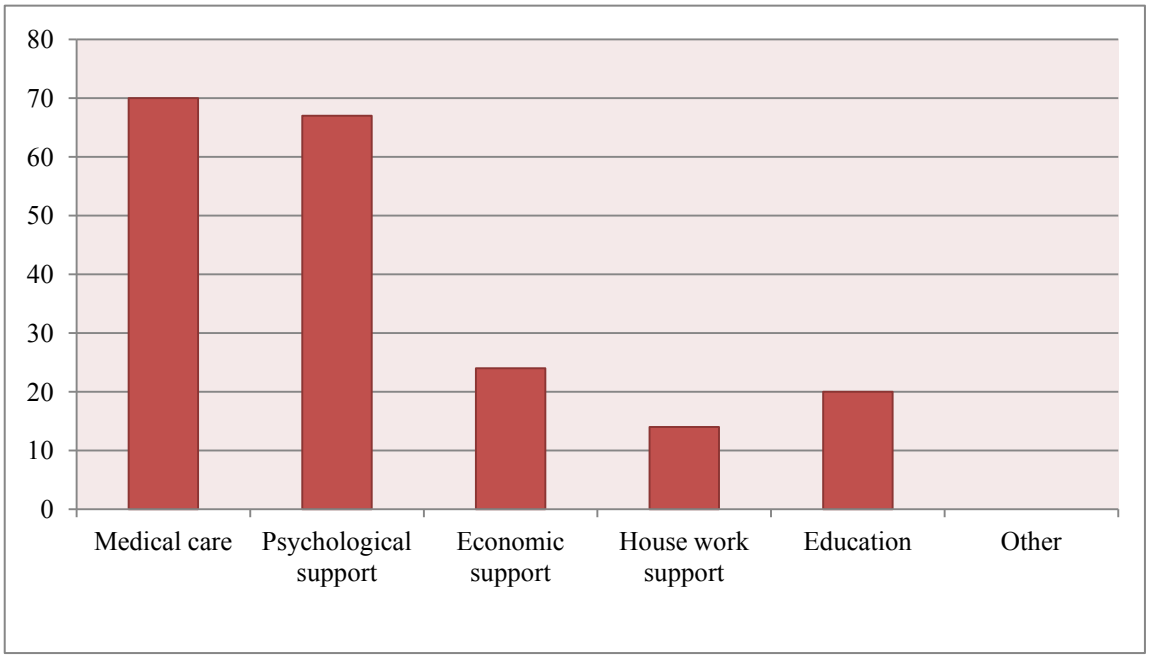


**Figure 4.** Most helpful services for PLWH

## 4. Conclusions

The women living with HIV showed resilience with determination to live in spite of the tangible threats of a well-known chronic disease. Perceived or self-stigma added to the impact. Psychological and social support is necessary to address the impact of the disease. The government should include counseling as a pertinent component of therapy and provide the basic nutrition for these women. Support to establish small scale business is crucial in order to discourage vulnerable women from moving into commercial sex. Stigma has been defined as 'an undesirable of discrediting attribute that an individual possess, thus reducing that individual's status in the eyes of society (Brown et al., 2001; Goffman, 1963)'.

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