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IMPACT OF RESILIENCE ON DEATH ANXIETY AND DEPRESSION AMONG HIV PATIENTS

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Abstract

The objective of the study was to investigate the impact of resilience on death anxiety and death depression among HIV/AIDS patients. The study used cross sectional design based on survey method. The sample (N = 200) was taken from different HIV/AIDS control canters of Rawalpindi, Okara, Jhelum and Chakwal included both male and females. The age range of participants was from 19-60 years. For the data collection three instruments were utilized, including AIDS Related Resilience Scale (Gottert et. Al., 2019), Death Anxiety (Goreja & Pervez, 2000), and Death Depression Scale (Templer et al., 1990). Findings of study revealed that resilience negatively predicted death anxiety and death depression among HIV patients. Gender differences revealed that women experienced more death anxiety as compared to men.

INTRODUCTION

Acquired Immunodeficiency Syndrome (AIDS) is one of the world's most significant public health challenges. AIDS is a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV). By damaging the immune system, HIV interferes with the body's ability to fight infections and diseases (Garrido & Alonso, 2017).

HIV debilitates the immune system by destroying CD4 positive (CD4+) T cells, a type of white blood cell that is essential for fighting off infections. HIV is a sexually transmitted infection (STI) and can also be

spread through sexual contact with an infected individual, as well as from mother to child during pregnancy, childbirth, or breastfeeding (Betancourt et al., 2013). According to UNAIDS, there were approximately 3.8 million people worldwide living with HIV/AIDS in 2019, among these 36.2 million were adults and 1.8 million were children under the age of 15. Almost 1 million individuals die from HIV/AIDS each year, and in some countries, it is the leading cause of death. HIV/AIDS is one of the world's most lethal infectious diseases, particularly in Sub-Saharan Africa, where the virus has significantly impacted health outcomes and life expectancy in recent decades. HIV/AIDS is considered a pandemic, as it is widespread across multiple regions and continues to spread actively (Chukwuorji et al., 2020). In Pakistan the estimated overall prevalence of HIV was found to be 0.041% (n = 4,882,450; SE = 1.79). The lowest prevalence was observed among healthy blood donors (0.012%; SE = 0.013%) and the general population (0.32%). The literature reviewed in this study indicates very low HIV prevalence in the general population, highlighting the need for further research to explore this trend more comprehensively. In contrast, the highest rates of infection were reported among injection drug users (15.05%; SE = 4.27%), followed by Afghan refugees (2.63%), sex workers (2.21%), and prisoners (1.32%) (Ali et al., 2017).

Particularly, death anxiety is very common in HIV patients. Death anxiety refers to the fear, apprehension, or distress experienced when individuals contemplate the concept of death, including their own mortality (Pifer et al., 2022). It encompasses a range of emotional, cognitive, and physiological responses to thoughts or reminders of death, including existential concerns, fear of the unknown, and concerns about the cessation of existence. Additionally, death anxiety is common among patients with HIV. It refers to the fear, apprehension, or distress experienced when individuals contemplate the concept of death, including their own mortality (Miller et al., 2012). This anxiety encompasses a range of emotional, cognitive, and physiological responses to thoughts or reminders of death, such as existential concerns, fear of the unknown, and worries about the cessation of existence.

Death anxiety is a significant psychological concern for individuals living with HIV, a chronic illness associated with increased mortality rates and existential uncertainties. The coexistence of HIV infection and death anxiety presents unique challenges to the mental health and well-being of those affected. According to Terror Management Theory (TMT), individuals reminded of their mortality may experience heightened death anxiety, particularly when confronted with life-threatening illnesses such as HIV (Greenberg, 2004).

On the other hands death depression is also common among HIV patients. Depression is a mental health disorder characterized by persistent feelings of sadness, hopelessness, and a loss of interest or pleasure in activities once enjoyed (American Psychiatric Association, 2013). It encompasses a range of symptoms, including changes in appetite or weight, sleep disturbances, fatigue, difficulty concentrating, feelings of worthlessness or guilt, and thoughts of death or suicide (Parveen & Bano, 2021; American Psychiatric Association, 2013).

Depression is a significant mental health concern among individuals living with HIV. The co-occurrence of depression and HIV presents substantial challenges to the overall well-being and quality of life of those affected. According to the World Health Organization, depression is the leading cause of disability worldwide, affecting over 264 million people globally (World Health Organization, 2022). Among HIV patients, depression not only exacerbates psychological distress but also impacts disease progression, treatment adherence, and overall health outcomes (Ironson & Hayward, 2008).

The current prevalence of depression among HIV patients remains significantly higher compared to the general population, with recent studies indicating rates ranging from 20% to 50%, depending on the region and population studied. A meta-analysis by Nanni et al. (2015) found that approximately 31% of HIV-positive individuals experience depressive disorders, while more recent research by Pence et al. (2018) reported that 40% of HIV patients in the United States exhibit clinically significant depressive symptoms. In low- and middle-income countries (LMICs), the prevalence is even higher, with studies such as Cholera et al. (2017) reporting rates as high as 50% in some regions. In Asia, a study by Yu et al.

(2019) in China found that 35% of HIV patients experienced depression, while research in India by Gupta et al. (2020) reported a prevalence of 42%. In Pakistan, a study by Ali et al. (2021) revealed that 45% of HIV patients suffered from depression, with higher rates observed among women and those experiencing social stigma.

Despite all this resilience plays as protective psychological factor among HIV patients (Dulin et al., 2018). Resilient individuals living with HIV demonstrate greater psychological adjustment, lower levels of depression and anxiety, and higher levels of adherence to antiretroviral therapy, contributing to improved health outcomes and overall well-being (Katz et al., 2013). Understanding the factors that promote resilience among HIV patients is essential for developing effective interventions and support services tailored to their unique needs. Protective factors associated with resilience in HIV patients may include adaptive coping strategies, social support networks, positive self-perceptions, and a sense of meaning or purpose in life (Ironson et al., 2005; Chukwuorji et al,. 2025). Previous studies have shown that higher resilience is associated with improved mental health outcomes in people living with HIV (PLWH), including reduced psychological distress and improved immune functioning (Qi et al., 2021). The present study aims to examine the impact of resilience on death anxiety and depression among HIV patients. Pakistan, like many other countries, faces significant challenges in addressing mental health issues among HIV patients. Death anxiety and depression are common psychological issues faced by individuals living with HIV/AIDS, which can severely impact their quality of life and overall well-being. Investigating the impact of AIDS-related resilience on death anxiety and depression among HIV patients is crucial. Conducting this study in Pakistani society is particularly significant due to the unique cultural, social, and religious factors that shape attitudes toward HIV/AIDS and influence individual coping strategies. By examining these relationships within the Pakistani context, the study can generate culturally relevant insights that can inform the development of tailored interventions and support services for HIV patients, ultimately improving their mental health outcomes and overall quality of life.

Methodology

In the present study, the sample of HIV patients (*N* =200) with age range 19 to 60 year was collected from different HIV/AIDS control centers in Rawalpindi, Okara, Jhelum, and Chakwal Pakistan. Data was collected by using purposive sampling technique and G power software will be used for the further sampling size. For the data collection three instruments were utilized, including AIDS Related Resilience Scale (Gottert et. Al., 2019), Death Anxiety (Goreja & Pervez, 2000), and Death Depression Scale (Templer et al., 1990). An institutional approval letter was obtained to conduct the research. The list of the targeted HIV/AIDS control centers and DHQ Hospitals was compiled and connected with higher authorities of targeted HIV AIDS centers and DHQs for permission letter for data collection from the hospitals. The researcher was personally approached the HIV/ADIS patients for data collection. Data was obtained from individual patients. The nature, aim and objective of the research have been shared with patients (participants) for repute building. A query as to data about the consideration standard was asked by the research members and only those patients who had further attached to the research those who met the standard prerequisite were asked to take part in the research study. The study aim was shared with the agreed participants. It was very clearly stated that the information received will stay private and entirely be used for studies purpose. The research members were asking to sign the informed agreement. The investigator provided structured instructions about scale completion, nature of question, time and rating scale. The researcher answered the question of participants before, during and after the finished scale. The study was not time bound, but 30 to 40 minutes had consumed by the members in scale. After completion of scale by the participant researcher scanned the scales for identifying the errors and incomplete questions, researcher requested to complete the incomplete questions. The researcher had to pay thanks to the patients (participants) for giving their valuable time and willingly and actively participate in the research without taking any attractive benefits and at the end the researcher calculated the response.

Results

Table 1

Regression Coefficients for Impact of Resilience on Death Anxiety (N=200)

Variable	*β*	B	*SE*
(Constant)	9.61*		1.94
Resilience	-.90*	-.60*	.08
R^2	.365		

Table 1 showed the impact of resilience on death anxiety. The R^2 value of .365 revealed that the predictor variable explained 36.5% variance in the outcome variable by predictor with $F(1,198)= 114.02$, $p<0.01$. The findings revealed that resilience significantly and negatively predicts death anxiety. Individuals with higher levels of resilience tend to have lower levels of death anxiety. This finding was supported by the statistically significant regression coefficient and the overall significance of the regression model as indicated. The R^2 value suggested that resilience explained 36.5% of the variability in death anxiety scores among the study participants, which was a relatively strong explanatory power.

Table 2

Regression Coefficients for Impact of Resilience on Death Depression (N=200)

Variable	*β*	B	*SE*
(Constant)	13.92*		2.94
Resilience	-1.00*	-.48*	.12
R^2	.238		

Note. *$p< .05$

Table 2 showed the impact of resilience on death anxiety. The R^2 value of .23 revealedthat the predictor variable explained 23.8% variance in the outcome variable with $F(1,198) = 61.73$, $p<0.01$. The findings revealed that resilience significantly and negatively predicted death anxiety. Specifically, individuals with higher levels of resilience tend to have lower levels of death anxiety. This finding was supported by the statistically significant regression coefficient and the overall significance of the regression model as indicated by the F-statistic. The R2 value suggested that resilience explained 23.8% of the variability in death anxiety scores among the study participants.

Table 3

Mean Standard Deviation and t for Comparison on Optimism and Resilience (N=200)

	Men	(n=100)	Women(n=100)				
Variables	M	*SD*	M	*SD*	*t*(198)	*P*	Cohen's *d*
Resilience	22.73	4.15	22.61	3.83	.16	.86	
Death Anxiety	29.54	6.06	31.85	5.81	2.29	.02	.34
Death Depression	36.56	9.10	37.08	5.36	.36	.71	

Table 3 showed that there were significant mean differences in level of death anxiety with $t(198)= 2.29$, $p<.05$. Women were significantly higher on death anxiety ($M = 31.85$, $SD = 5.81$) as compared to men ($M = 29.54$, $SD = 6.06$). The value of Cohen's d was.34 (<.50) which means small effect size. Results were non-significant on resilience and death depression.

Discussion

Findings of study revealed that resilience negatively predicted death anxiety among HIV patients (i.e., table 1). One of the most frequent HIV/AIDS side effects, as well as one of the most common psychological problems among these people, is depression. Depressive illness is reported to be prevalent in 47.3 percent of HIV patients, which is five times greater than the overall population. Even if there are no symptoms, HIV positive persons who are depressed may experience more discomfort than HIV positive people who are not sad. Long- term HIV patient studies have discovered strong connections between general health, physical function, occupational function, and therapeutic feelings of sorrow and anxiety (Mirzapour et al.,2022).

It was also found that resilience negatively predicted death depression among HIV patients (i.e., table 2). Resilience, according to Manyena (2006) is described as the process of efficiently changing capacity or message in challenging and extended circumstances, which includes not only invulnerability in emergency situations but also increased capacities in hiding terrible events. A study was conducted on 40 AIDS-infected convicts in Khuzestan prisons to see if there was a relationship among resilience and life expectancy and suicide. The findings reveal that suicide has a strong link to HIV patients' resilience and life expectancy, with resilience and life expectancy variables accounting for 67% of the key variable, suicide.

Sadness, worry, irrational ideas, and negative sentiments are all mental characteristics of people who are afraid of dying, and each of these factors can influence HIV patients' life expectancy and resilience. Patients with a shorter lifespan are more prone to use the wrong drugs, squander time, and lead a sedentary lifestyle (Yousuf et al., 2019). Lower resiliency in HIV patients is characterized as an inability to cope with life's challenges, social inconsistencies, and inability to handle issues, lack of social efficiency, and a lack of empathy(Peplinska et al., 2025).

Gender differences were also investigated in the current study (i.e., table 3). It was also investigate that women were greater on death anxiety as compared to men. Although gender is a key concept in HIV sexual risk, few studies have looked at how risk and protective factors interact with HIV incidence in relationships (Nikolova et al., 2015). Men's results were associated to previous HIV testing, residing in a city, being insured, and having a higher level of education. Prior sexual assault, prior HIV testing, urban location, number of children, and preparedness to care for an AIDS-affected family were all predictors of women's indicators (Peless et al., 2015).

Conclusion

The study used correlational research design based on survey design. Findings of study revealed that resilience negatively predicted death anxiety and death depression between HIV patients. Gender differences revealed that women experience more death anxiety as contrast to men. Study has implications in clinical settings.

Limitations and Suggestions

The study was based on HIV patients and this study was an excellent study however ithas some limitations. First, if researcher would add a comparison group such as comparisons of HIV patients with diabetes patients and drug user then a beer conclusion with respect on mental health can be drawn. Secondly data was collected from limited cities of Pakistan and the study can be more generalize able if data should also be collected from other provinces of Pakistan. Thirdly, an implementation plan should be suggested in future research on the basis of existing findings of research on HIV patients.

Implications

Research on resilience, death anxiety, and depression among HIV patients has several implications for clinical practice, policy development, and future research endeavors including the understanding the factors that contribute to resilience among HIV patients can inform the development of interventions aimed at enhancing coping strategies and psychological well-being. Mental health professionals working with HIV patients can incorporate resilience-focused approaches into their clinical practice, emphasizing strengths-based interventions that promote adaptive coping skills and emotional regulation. Screening for death anxiety and depression should be a routine part of HIV care, with healthcare providers addressing these concerns through early identification, appropriate referrals, and targeted interventions.

Future Research

Further research is needed to explore the mechanisms underlying resilience among HIV patients, including the role of social support, coping strategies, and individual characteristics. Longitudinal studies can help elucidate the trajectories of death anxiety and depression over time among HIV patients, as well as identify factors that promote resilience and mitigate psychological distress. Comparative studies examining cultural and contextual differences in the experience of death anxiety and depression among HIV patients can provide valuable insights into the diverse needs of this population.

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