
The Impact of Mental Wellness on HIV Self-Management

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As people living with HIV age, they face increasing self-management work related to HIV infection plus the prevention and mitigation of multiple chronic health conditions, including daily health practices (i.e., physical activity, nutrition), engaging in a supportive community, and accepting the chronicity of HIV. Our purpose was to describe the relationship between HIV self-management practices and mental wellness (depressive symptoms, perceived stress). Ninety-three adult people living with HIV on antiretroviral therapy were enrolled and completed a survey. We used descriptive statistics to summarize variables, and Spearman rank correlation and quantile regression to study associations between variables. Participants' average age was 48.6 years, 56% were male, and 87% were African American. Daily self-management practices were associated with depressive symptoms ($r = -0.19$; $p \leq .01$) and perceived stress ($r = -0.14$; $p = .06$); engaging with a supportive community and accepting the chronicity of HIV were not associated with mental wellness (all $p > .05$).

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More than 1.2 million Americans were living with HIV in 2012 (Centers for Disease Control and Prevention, 2015a) and, despite advances in HIV

treatment, people living with HIV (PLWH) have remained at high risk for other health problems, especially cardiovascular disease, cancers, and kidney disease. Accordingly, substantial self-management work is necessary for this growing population, in order to help them live and age well (Martin et al., 2014). However, PLWH experience unique psychosocial and behavioral challenges related to HIV (e.g., comorbidities, high symptom burden, and HIV-related stigma; So-Armah & Freiberg, 2014) that can limit their abilities to initiate and maintain behaviors that improve health. A self-management approach can address these challenges and is important for PLWH in the chronic phases of the illness (Swendeman, Ingram, & Rotheram-Borus, 2009;

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Webel et al., 2012; Webel et al., 2013). Self-management is a “dynamic, interactive, daily process in which individuals engage to manage a chronic illness” (Schulman-Green et al., 2012, p.136).

Historically, HIV self-management has focused on HIV-specific tasks including antiretroviral therapy (ART) adherence, symptom management, and working in partnership with the health care team (Millard et al., 2014; Swendeman et al., 2009). However, the aging of PLWH has necessitated additional self-management skills, including health promotion activities such as physical activity, eating a healthy diet, stress reduction, and healthy sleep habits. This more global self-management work also has included additional comorbid disease management tasks such as taking medications for other conditions (leading to polypharmacy) and coordinating health care visits and recommendations from non-HIV providers (Swendeman et al., 2009). Today, HIV self-management can be thought of as having three related components: (a) daily self-management tasks (e.g., physical activity, diet, symptom management), (b) social support, and (c) addressing the chronic nature of HIV (e.g., understanding chronicity, taking steps to control HIV; Webel et al., 2012). When fully practiced, self-management improves health and quality of life, decreases morbidity and mortality, and decreases health care costs (Grey, Schulman-Green, Knaf, & Reynolds, 2015). Additionally, recent evidence has revealed that two specific HIV self-management tasks, engaging in regular comprehensive health care and adhering to ART medications, also decreases transmission of HIV, which is a global public health goal (White House Office of National AIDS Policy, 2015).

Despite the significant benefits of self-management, strategies to sustainably improve and maintain self-management remain elusive. Several barriers to active self-management have been described. Jerant, von Friederichs-Fitzwater, and Moore (2005) qualitatively investigated the perceived barriers to self-management among adults living with multiple chronic conditions. They found that poor communication with health care providers, lack of social support, health information complexity/education, financial/transportation issues, and symptoms of depression and fatigue led to decreased self-management. These findings have

been shown to be consistent across populations, including seniors with multiple chronic illnesses (Bayliss, Ellis, & Steiner, 2007) and those living with diabetes (Ahola & Groop, 2013). These barriers, in particular the lack of social support and symptoms (i.e., depression and stress), have been associated with reduced HIV self-management behaviors, including adhering to medical treatment and appointments, monitoring symptoms, and engaging with health care providers (Bottonari, Safren, McQuaid, Hsiao, & Roberts, 2010; Pence et al., 2015; Rabkin, 2008). Depressive symptoms and stress are aspects of mental wellness and, when elevated, may serve as barriers to HIV self-management behaviors. Yet, despite the known relationship between mental wellness and specific self-management behaviors, the association between mental wellness and a comprehensive measure of HIV self-management has not yet been explored.

Our purpose was to describe the relationship between HIV self-management and mental wellness (depressive symptoms and perceived stress). Additionally, as women often report lower levels of mental wellness and as there are potential differences in mental wellness between those with high and low ART adherence, we examined the relationship between HIV self-management and mental wellness separately in men and women and then in those who reported optimal medication adherence ($\geq 90\%$) and suboptimal medication adherence ($< 90\%$; Pence et al., 2015). We hypothesized that: (a) higher levels of HIV self-management were related to lower levels of depressive symptoms and perceived stress, and (b) the relationship would be stronger in women and those who had achieved optimal HIV medication adherence.

Methods

We conducted a prospective cohort study to examine the relationships between HIV self-management, age, gender, and mental wellness (Webel et al., 2014). In this cohort study, ($n = 102$), participants completed two data collection visits 1 year apart. Subjects were purposively enrolled into four strata: men younger than 50 years, men 50 years of age and older, women younger than

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