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HEALTH LOCUS OF CONTROL, MEDICATION ADHERENCE AND QUALITY OF LIFE AS PREDICTORS OF DEATH ANXIETY AMONG PEOPLE LIVING WITH HIV/AIDS

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ABSTRACT

Introduction: The diagnosis of an incurable disease can trigger a profound existential crisis as everyday life and the future are threatened for both patients and their families. As an existential issue, death anxiety stems from the conscious awareness of our own mortality.

Aim: The study therefore attempts to examine the potential influence that health locus of control, medication adherence, and quality of life could have on death anxiety among HIV/AIDS patients.

Methodology: The study utilized a cross sectional study design to recruit 120 people living with HIV/AIDS and receiving antiretroviral therapy in the ART unit of the General Hospital Ugep. The collected data was entered into a Microsoft Excel for initial processing. Subsequent analysis was conducted using the Statistical Package for the Social Sciences (SPSS) version 21.0. Quantitative variables were summarized and presented using means and standard deviations, while Hierarchical multiple regression was used to analyse the data for correlations.

Results: There was a significant and positive correlation between medication adherence and death anxiety ($r = -.20, p = .028$). However, there was no significant correlation between quality of life and death anxiety. Also, medication adherence was a significant negative predictor of death anxiety ($\beta = -.25, p < .015$). quality of life did not account for any significant additional variance in death anxiety and did not also significantly predict death anxiety.

Conclusion: Results showed that only medication adherence had a predictive negative relationship with death anxiety whereas health locus of control and quality of life did not have significant predictive relationships with death anxiety.

Keywords: Death Anxiety, Medication Adherence, Quality of life, Health Locus

1 INTRODUCTION

Human immunodeficiency Virus/Acquired immunodeficiency syndrome (HIV/AIDS) is a global pandemic. People living with HIV/AIDS have more social challenges. The psychological effects of living with HIV/AIDS includes: depression,

anxiety, loneliness, suicidal ideas, and poor medication or treatment adherence. They also see themselves as undesirable by others who feel they are “contagious” this view in itself is an emotional situation that can cause infected people to withdraw, become socially isolated and not disclose their feelings to anyone. This may lead to an emotional breakdown as these feelings continue to be suppressed; HIV/AIDS persons are normally living in fear because they have to adjust to a new lifestyle.^{2,3}

Studies have also shown that there exists a positive correlation between HIV/AIDS status and death anxiety.⁴⁻⁶ Death anxiety refers to the fear of and anxiety related to the anticipation, and awareness, of dying, death, and nonexistence. It typically includes emotional, cognitive, and motivational components that vary according to a person's stage of development and sociocultural life experiences.⁷ Human beings have conscious awareness of their mortality⁸, and patients who have life-threatening illnesses are forced to face their mortality.^{9,10} The diagnosis of an incurable disease can trigger a profound existential crisis as everyday life and the future are threatened for both patients and their families. As an existential issue, death anxiety stems from the conscious awareness of our own mortality.¹¹ According to Menzies, death anxiety arises not only by actual confrontations with death but also from experiences of unwanted endings, limitations of time or energy, or disproved ideals that threaten the meaning of life.^{12,13} In light of the evidence for death anxiety to occur across a range of psychological disorders, uncovering factors that may precipitate death anxiety seems worthwhile.

Health locus of control (HLOC) is often mentioned as a factor relevant to health and illness behaviours. Rotter, postulated that a particular behaviour is more likely to occur if it is associated with high reinforcement, value and expectancy.¹⁴ HLOC is viewed from three dimensions: internal, powerful others, and chance.¹⁵ An internal HLOC is defined as the generalised expectancy that one stays or becomes healthy or sick as a result of his or her behaviour. According to Oxford dictionary of Psychology, locus of control is a cognitive style or personality trait characterized by a generalized expectancy about relationship between behaviour and the subsequent occurrence of reinforcement in the form of reward and punishment. People with internal locus of control tend to expect reinforcements to be the consequences of their own efforts or behaviour whereas people with external locus of control expects them to be the consequences of chance, luck, fate or the actions of powerful others. With the development of highly active antiretroviral therapy (HAART), adherence to a HAART regimen, defined as correspondence between the behaviour of a patient and the health care recommendations received, has the potential to decrease HIV-1 RNA (viral load), increase immune function, and enhance quality of life.^{16,17} HAART regimens have low tolerance of non-adherence such that optimal viral suppression requires correct use of HAART 90–95% of the time.¹⁸ This can be challenging for patients who must take these medications every day for an indefinite length of time. These circumstances, along with the negative side effects of HAART regimens, contribute to the difficulty faced by patients trying to maintain optimal levels of adherence.¹⁹ Moreover, non-adherence to antiretroviral medications may increase viral resistance to numerous classes of medications, thereby rendering various medication options ineffective. Adherence to antiretroviral therapy is a problem for many HIV-positive individuals, with an estimated 50%–80% of PLWHA unable to practice adequate adherence.²⁰ The reasons for non-adherence are varied. Adherence to antiretroviral regimens is logistically challenging, as the therapy often consists of three or four separate medications. If first-line or second-line treatments have been ineffective, the patient may be expected to take over twenty pills each day while following a strict diet.²¹ Additionally, side effects of HAART include nausea, vomiting, anaemia, and peripheral neuropathy, which can contribute to non-adherence.¹⁷ Furthermore, a variety of patient-related psychosocial factors have been associated with poor HAART adherence, including low patient self-efficacy, psychological distress, depression, exposure to trauma, forgetfulness, substance use disorders, low social support from family and friends, inadequate confidence in treatment effectiveness, and poor understanding of the relationship between non-adherence and viral resistance.^{22,23} Moreover, depression has been associated with disease progression among PLWHA.²² Although the mechanism by which psychosocial factors result in non-adherence is not fully known, there is evidence that the occurrence of psychological symptoms of distress is associated with disease progression through a decrease in adherence among PLWHA.¹⁸ Thus, it is critical to identify individuals living with HIV/AIDS and how the extent of their medication adherence influences their death anxiety.

Quality of life is a term used to refer to an individual's total well-being. The World Health Organization Quality of Life (WHOQOL) Group (1998) defines quality of life as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns.²⁴ The term health-related quality of life (HRQOL) is often used to indicate QOL as it relates to diseases or treatments.²⁵ Since QOL has to do with well-being, it is conceivable that if HIV/AIDS patients put in concerted efforts to enhance their QOL, they are less likely to experience death anxiety.¹² However, if there are insufficient indicators of good QOL, they may become more anxious about their own death as poor QOL may serve as a signal of their end of life. This study is needed to clarify consistencies in the relationship of health locus of control, medication adherence, and quality of life with death anxiety among HIV/AIDS patients and to suggest possible inroads for future interventions.

2 METHODS

2.1 Study area

The General Hospital, Ugep, Cross River State were selected. The Hospital is chosen because it is the oldest and most viable hospital in the central senatorial district/zone of the State and also happened to be one of the first facilities to start free ART for HIV/AIDS patients. This unit takes care of the highest number or population of PLWHA in the central senatorial district/zone.

2.2 Study design

The study utilized a cross sectional study design.

2.3 Study population

The study targeted a population of people living with HIV/AIDs (PLWHA) and receiving antiretroviral therapy (ART) in the ART unit of the General Hospital, Ugep, Cross River State.

2.4 Inclusion and criteria

The participants comprised of both male and female patients who were receiving treatment at the hospital at least six months prior to data collection exercise.

2.5 Exclusion criteria

- Patients both male and females with HIV/AIDs who are just registered and have not started receiving treatment.
- Patients both male and females with HIV/AIDs who are treating other critical terminal illnesses

2.6 Sampling technique/Sample size

A total of one-hundred and twenty (120) people living with HIV/AIDs (PLWHA) and receiving antiretroviral therapy (ART) in the ART unit of the General Hospital, Ugep, Cross River State were selected.

2.7 Study Instruments

Four instruments were used for data collection. They include: Multidimensional Health Locus of Control Scale (MHLC) scales, Self-reported Medication-taking Scale, The World Health Organization Quality of Life Assessment (WHOQOL), and Death Anxiety Inventory (DAI). In addition to the scales, participants were also requested to provide demographic information on gender, age, and marital status.

2.8 Validation of Instruments

The instruments were validated among 50 HIV/AIDS patients drawn from Holy Family Joint Hospital, Ikom, Cross River State. Reliability of the data obtained from respondents was tested using a measure of internal consistency (Cronbach's alpha). The results showed that estimated Cronbach's alpha coefficients for the MHLC scales are: .72 for IHLC, .74 for PHCL, and .71 for CHLC. For the Self-reported Medication-taking Scale, estimated Cronbach's alpha coefficient of .75 was obtained. For the WHOQOL, the Cronbach's alpha coefficient was .74, while that of the DAI was .82. The internal consistencies of the scores on all scales satisfied the criterion of .70.²⁶ These results indicate that the instruments are internally consistent.

2.9 Method of data collection

Quantitative data was collected using a questionnaire by a trained research assistant from the General Hospital, Ugep, Cross River State where the study was conducted. The research assistant assisted in identifying HIV/AIDS patients in the hospital who have been on HAART for at least six months. The structured questionnaire was used to collect data from willing participate after being informed of the purpose and objectives of the research.

2.10 Data Management and Analysis

The collected data was meticulously cleaned, coded, and entered into a Microsoft Excel spreadsheet for initial processing. Subsequent analysis was conducted using the Statistical Package for the Social Sciences (SPSS) version 21.0. Quantitative variables were summarized and presented using means and standard deviations, Hierarchical multiple regression was used to analyse the data for correlations.

2.11 Ethical considerations

Ethical approval for this study was given by the Research and Ethics Committee of the University of Nsukka Nigeria, and further permissions were obtained from the management of the Ugep General Hospital. All participants were provided with comprehensive details about the study, after ensuring that the participants fully understand these details, they were asked to sign an informed consent form to confirm their voluntary participation in the study.

3 RESULTS

The data obtained from respondents were analysed using the Statistical Package for the Social Sciences (SPSS) version 21.0. Means, standard deviations, and correlations among the study variables are presented in Table 1. The results of the hierarchical multiple regression appear in Table 2.

Table 1: Means, Standard Deviations, and Correlations among the Study Variables

	Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8
1	Gender	1.59	0.49	—							
2	Marital status	1.63	0.48	0.00	—						
3	Age	35.86	11.04	-0.10	0.45***	—					
4	IHLC	25.10	5.39	-0.08	-0.05	0.05	—				
5	PHLC	25.73	5.90	-0.04	-0.07	0.10	0.66***	—			
6	CHLC	24.17	5.99	-0.07	-0.04	0.11	0.50***	0.64***	—		
7	Medication adherence	11.52	3.82	-0.01	0.25**	0.45***	0.04	0.18	0.12	—	
8	Quality of life	11.78	2.90	-0.05	0.02	0.03	0.08	0.19*	0.13	0.19*	—
9	Death anxiety	54.48	14.37	0.02	-0.02	0.04	0.07	-0.06	-0.11	-0.20*	-0.10

Note. *N* = 120, * = *p* < .05 (two-tailed), *** = *p* < .001 (two-tailed). OT = organisational tenure, IHLC = internal health locus of control, PHLC = powerful others health locus of control, CHLC = chance locus of control. Gender was coded 1 = male, 2 = female; marital status: 1 = unmarried, 2 = married. Age was coded in years such that higher scores represent older age.

The results in Table 1 indicated that none of the demographic variables (i.e., gender, marital status, and age), was significantly correlated with death anxiety. There was also no significant correlation between the three dimensions of health locus of control (i.e., IHLC, PHLC, CHLC) and death anxiety. There was a significant and positive correlation between medication adherence and death anxiety ($r = -.20$, $p = .028$). However, there was no significant correlation between quality of life and death anxiety.

Table 2: Hierarchical Multiple Regression for Predictors of Death Anxiety

Variable	Step 1 <i>B</i>	Step 2 <i>β</i>	Step 3 <i>β</i>	Step 4 <i>β</i>
<i>Controls</i>				
Gender	0.03	0.03	0.04	0.04
Marital status	-0.06	-0.07	-0.05	-0.05
Age	0.07	0.10	0.20	0.20
<i>Predictors</i>				
IHLC		0.23	0.196	0.194
PHLC		-0.13	-0.077	-0.071
CHLC		-0.15	-0.147	-0.146
Medication adherence			-0.25*	-0.25*

Quality of life				-0.04
Adjusted R^2	-0.021	-0.004	0.039	0.032
ΔR^2	0.005	0.041	0.049	0.001
ΔF	0.193	1.629	6.104*	0.148

Note.*= $p < .05$.

The results of the hierarchical multiple regression in Table 2 were death anxiety was the outcome variable indicated that the demographic variables (i.e., gender, marital status, and age), entered in Step 1 of the equation as controls, did not collectively account for any significant variance in death anxiety. None of them also made any unique significant contribution to the prediction of death anxiety. When the three dimensions of health locus of control (i.e., IHLC, PHLC, CHLC), they did not collectively and individually account for any significant variance in death anxiety. The entry of medication adherence in Step 3 of the equation accounted for additional 4.1% variance in death anxiety. Medication adherence was a significant negative predictor of death anxiety ($\beta = -.25, p < .015$). The introduction of quality of life in Step 4 of the equation did not account for any significant additional variance in death anxiety. Quality of life did not also significantly predict death anxiety.

4 DISCUSSION

This study attempted to predict death anxiety through health locus of control, medication adherence, and quality of life. The three dimensions of health locus of control: Internal, Powerful others, and Chance failed to predict death anxiety according to the results from this study. These mean that Internal, Powerful others, and Chance do not have substantial influence on death anxiety. These findings are not in congruence with some previous studies.²⁷ A possible reason could be that unlike these previous studies that focused on general locus of control on participants other than people living with HIV/AIDS, the present study focused on health locus of control from three dimensions, namely: Internal, Powerful others, and Chance. Moreover, cultural differences may have in part, contributed to the different findings in the present study and those of previous studies conducted outside Nigeria. To that effect, the findings of the present study appears to corroborate that of Chukwuma and Olaidipo in Nigeria who found that locus of control was not a significant factor in death anxiety among people living with HIV/AIDS.^{28,29} This may explain why health locus of control was not significantly related to death anxiety in the present study.

This finding suggests that the more HIV/AIDS patients adhere to their medication the less likely they would experience death anxiety. In that sense, death anxiety is less likely to occur when HIV/AIDS patients are adhering to the medications. This finding is at variance with that of Adejumo et al. who found a significant positive association between medication adherence and death anxiety. However, it is possible that the nature of the medication involved may have influenced the different outcomes in the present study and that of Adejumo et al. For instance, while the present study focused on HIV/AIDS medication, that of Townsend et al. focused on psychiatric medication.³⁰

The results from the study showed that quality of life was not significantly predictive of death anxiety. This finding suggests that the quality of life of HIV/AIDS patients does not substantially impact upon their death anxiety. This finding is at variance with that of Sherman *et al.*³¹ who found that greater death anxiety was associated with lower quality of life. Although the finding in the present study was unexpected, it is possible that restriction of range may have affected the results obtained in this regard. Data that are restricted in range may produce a threat to interpretation of outcomes because they artificially reduce the size of the regression coefficient.³⁰ This is because restriction of range would be reflected in a smaller variance and standard deviation of one or both marginal distributions.³⁰ For instance, when regression analyses include multiple predictor variables, measurement error and restriction of range in one predictor can cause inflation as well as attenuation in coefficients for other predictor variables.³⁰

4.1 Implications of Findings

As the results revealed, medication adherence was the only variable that explained death anxiety among people living with HIV/AIDS whereas health locus of control and quality of life did not. This implies that medication adherence appears to be more effective in minimising death anxiety among this group of individuals whereas health locus of control and quality of life are not. People living with HIV/AIDS are likely to be anxious about death given the incurable nature of disease. Thus, to minimise such anxiety, it is proper for them to adhere strictly to their medication in order to minimise death anxiety and associated consequences. Interventions should, therefore, be targeted at increasing medication adherence in order to have less death anxiety. Hence HIV/AIDS counsellors and health care practitioners

should encourage people living with HIV/AIDS to strictly adhere to their medications. In so doing, they should sensitive them of the dangers of death anxiety and the need to try and avoid anything that might aggravate death anxiety in them.

4.2 Limitations of Findings

Limitations of this study include the use of self-reported medication adherence data, which can involve recall bias and be less accurate than electronic medication monitoring or pill counting strategies. For example, it is likely that, since the sample was engaged in routine comprehensive HIV care, they may have reported higher rates of medication adherence due to the effect of a social-desirability bias.

Moreover, while the present study yielded both expected and unexpected findings regarding the relationship of health locus of control, medication adherence, and quality of life with death anxiety that is consistent and inconsistent with the existing relevant literature, the sample size may not fully account for the variability observed in the general population of persons living with HIV/AIDS.

Another limitation was that the data were collected using cross-sectional research design, which inherently preclude assessment of causal relations. Therefore, the results obtained may not hold up over time or may occur in a different order.

4.3 Suggestions for Future Research

Limitations to the current study also suggest important lines for future studies. First, while a rigorous systematic review of adherence measures indicated that self-report items similar to the one used in the present study were valid measurements of medication adherence (Simoni, Kurth, Pearson, Pantalone, Merrill, & Frick 2006), future research might improve upon the present study by using a more objective measure of pill taking–medication adherence behaviour in the form of an electronic data-monitoring system that compiles an electronic record when a pill bottle is opened between assessment points.

Moreover, research needs to be conducted to replicate the findings in the present study with larger diverse samples and examine demographic and disease-related variables that may be associated with death anxiety, such as age, sex, and severity of HIV disease.

A longitudinal, prospective design, assessing the course and individual variation in health locus of control, medication adherence, quality of life, and death anxiety, would be a major advance to this research literature.

5 SUMMARY AND CONCLUSION

This study investigated the relationships among health locus of control, medication adherence, and quality of life with death anxiety among a sample of HIV/AIDS patients. It was found that only medication adherence had a predictive negative relationship with death anxiety whereas health locus of control and quality of life did not have significant predictive relationships with death anxiety. This study contributes to the body of knowledge in the direction of providing practical interventions aimed at minimizing the magnitude of death anxiety experience by HIV/AIDS patients. Researchers are encouraged to continue along this line of research and also re-examine the unexpected findings obtained in this study.

STATEMENTS ON COMPLIANCE WITH ETHICAL STANDARDS

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Statement of ethical approval

Ethical approval for this study was given by the university of Nusuka Research ethical committee.

Statement of informed consent

All participants were provided with comprehensive details about the study, after ensuring that the participants fully understand these details, they were asked to sign an informed consent form to confirm their voluntary participation in the study. I agree to the publication of this article

Data availability

The dataset used during the study are available from the corresponding author on reasonable request.

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