

When the Tide is not Turning: Exploring the Mental Health of a Select Group of Filipino Youth Living with Human Immunodeficiency Virus (YLHIV)



Benny S. Soliman¹, Allan B. de Guzman², and Marc Eric S. Reyes^{2,3}

¹College of Arts and Sciences, Tarlac Agricultural University, Philippines

²The Graduate School, University of Santo Tomas, Philippines

³College of Science, University of Santo Tomas, Philippines

Article history:

Submitted: 15 June 2022

Revised: 12 July 2022

Accepted: 9 August 2022

Keywords:

Psychology

Mental health

Filipino youth

Human Immunodeficiency virus

Descriptive phenomenology

Philippines

*Corresponding Author:

Benny S. Soliman*

bssoliman@tau.edu.ph

ABSTRACT. Literature from worldwide revealed that poor mental health is evident among youths living with HIV (YLHIV). However, literature exploring their mental health in the Philippines is limited despite the alarming increase of HIV cases among young people. Hence, this descriptive phenomenological study purported to characterize the mental health of a select group of Filipino YLHIV. In-depth interviews with ten fully consented male participants aged 18-30 were conducted. Field texts were subjected to Collaizi's (1978) seven-step data analysis method. Interestingly, the *Mental Health Tower of Youth Living with HIV* emerged after thoroughly analyzing the data. This model typifies the mental health of YLHIV, which operates in an environment where both internal and external pressures make them experience (a) disruptive thoughts, (b) depressive mood, and (c) deteriorative behavior. The study has vividly described the instability of the YLHIV's mental health. Therefore, it is vital to develop a mental health program specifically designed for youth living with HIV.

1.0. Introduction

In 2016 the World Health Organization (WHO) reported that the Human Immunodeficiency Virus (HIV) continues to be a major public health concern affecting approximately 36.7 million people worldwide, 1.8 million of whom were newly diagnosed (WHO, 2018). Although the rate of the disease varies between countries and regions, it remains most prevalent in Sub-Saharan Africa, which affects one in every 25 adults, almost two-thirds of the worldwide HIV population. Conversely, other parts of the world, like the United States of America, reported a 10% decline in HIV infection from 2010-2014 due to the HIV prevention efforts of the government. However, those men having sex with men (MSM) was the sole group that did not decline (Centers for Disease Control and Prevention [CDC], 2015). In Europe, despite the public health effort of the government, the significant transmission of the virus continued affecting 29, 444 people in 2016 (European Centre for Disease Control and Prevention, 2017).

Similarly, the Western Pacific region, including the Philippines, reported an increase in HIV infection from 1.25 million in 2010 to 1.48 million in 2016. For several years, the Philippines had a minimal increase in HIV infections. However, in recent years, cases of people with this disease amplified dramatically. The Philippines has been tagged as one of the countries with fast-growing HIV cases worldwide, with a more than 50% increase from approximately 4,300 cases in 2010 to an alarming 10,500 cases in 2016 (WHO, 2018).

Globally, it is estimated that 30% of all new HIV cases occur among young people aged 15-25. Alarmingly, the Philippines is one of the ten countries in Asia and the Pacific with increasing rates of HIV among young people (United Nations International Children's Emergency Fund [UNICEF], 2015). Consistent with the report of the Philippine government thru the Department of Health (DOH), the percentage of HIV cases among Filipino youth aged 15-24 years increased from 25% in 2006-2010 to 29% in 2011-2017. In April 2022 alone, the HIV/AIDS and ART Registry of the Philippines (HARP) recorded 1,198 new HIV cases, 29% of which occurred among youth aged 15-24 years (DOH, 2022).



This article published by Philippine Social Science Journal (PSSJ) is licensed under a Creative Commons Attribution-NonCommercial 4.0 International (CC BY-NC 4.0). You are free to share (copy and redistribute the material in any medium or format) and adapt (remix, transform, and build upon the material). Under the following terms, you must give appropriate credit, provide a link to the license, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use. You may not use the material for commercial purposes.

According to Bekker et al. (2015), the prevalence of HIV among youth is due to many transitions (e.g., social, psychological, structural, and developmental) they encounter during this period of their lifespan. Consequently, YLHIV is at high risk of experiencing mental health problems, as supported by several western studies. For example, a meta-analysis of 38 articles, mostly from the United States and Europe, indicated that youth living with HIV experienced behavioral and emotional problems higher than other high-risk groups (Mellins & Malee, 2013). The latter findings support the cross-sectional analysis of 1706 youth living with HIV, revealing that 727 (42.6%) participants reported clinical symptoms. Only 39.7% of 727 reported mental health care and 21.9% are taking medications for emotional concerns (Whitely et al., 2014). In another cross-sectional study conducted in Jamaica, youth with HIV ages 15- 25 years were found to have high rates of anxiety (71%), stress (64%), and depression (63%). The participants also reported smoking cigarettes (16.1%), drinking alcohol (11.4%), and use of marijuana (8%) (Brown & Morgan, 2013). In Rwanda, a cross-sectional analysis of 193 youth living with HIV revealed that 26% had depressive symptoms, and 12% had attempted suicide (Smith Fawzi et al., 2016). Another study in America found that 44% of youth with HIV aged 16-21 years were diagnosed with depression a year after HIV diagnosis (Pao et al., 2000).

Qualitative studies also revealed that people living with HIV are prone to experience mental health problems, like the study of Jena (2014) in South Africa depicting those adolescents with HIV showed sadness, anxiety, fear, and pain in their lived experiences. Particularly, they were anxious regarding death due to their illness and reported fear of rejection, stigma, and discrimination (Jena, 2014; MacQueen, 2017). Similarly, the Aboriginal people living with HIV in Canada reported feelings of depression. They responded to their medical condition with shock, disbelief, and often anger (Cain et al., 2013). Meanwhile, the explorative study of Landry (2014) indicated that youth living with HIV reported experiences of isolation, depression, and thoughts of suicide. This suicidal tendency is triggered by the burden accompanying the long-lasting implication of being HIV positive (Kalichman et al., 2000). Further, stigma, discrimination, low self-esteem, and lack of social support are other factors directly associated with suicidal thoughts and behaviors of people living with HIV (Casale et al., 2019; Wang et al., 2018). The study participants, being youth, may account for their vulnerability to being persuaded by a misconception about the said illness. Also, youths today tend to access information from the internet without checking its veracity. This may result in misleading information about their medical condition. Another phenomenological study in Africa, specifically in Botswana, showed that HIV-AIDS diagnosis resulted in internal (self) and external stigmatization that impacted the lives of people with HIV. The progression of the disease and stigmatization led to emotional disturbance, relationship problems, poverty, dependence, and concerns about their family members (Setlhare et al., 2015).

The foregoing discussions of foreign literature established that mental health problems are evident among youth living with HIV. This aspect of YLHIV's health is critical and often neglected (Vreeman et al., 2017) and calls for more empirical investigation adopting various theoretical and methodological lenses. Despite the alarming increase of HIV cases among Filipino youth in the Philippines, there is a lack of literature exploring their mental health status. Hence, this phenomenological study was conducted to characterize the mental health of a select group of Filipino YLHIV.

2.0. Methodology

Research design. In recent years, there has been a growing interest in the use of phenomenology to explore the experiences of people who have HIV and mental health issues (Sharma & Babu, 2017; Zhou, 2010; Cain et al., 2013; Jena, 2014; Landry, 2014; McLeish, 2015). The current study utilized the aforementioned design, particularly the descriptive phenomenology, which is appropriate for understanding the subjective experience of a select group of Filipino YLHIV. According to Lopez and Willis (2004), descriptive phenomenology aims to describe the universal essence of an experience as it is lived by the participants. Hence, it represents the true nature of the phenomenon being studied.

Participants. The ten male participants of the current study were recruited via Pinoy Plus Advocacy Pilipinas, Inc., a pioneer support group dedicated to the welfare of PLHIV in the Philippines. They were identified from the pool of potential participants of the study. The participants were purposively chosen based on the following inclusion criteria: (a) diagnosed with HIV; (b) 18- 30 years old, and (c) Filipino citizen.

The participants were diagnosed with HIV from the year 2007-2018. Regarding their employment, four (4) of them are currently studying, three were employed, and the other three (3) were

unemployed. One of those unemployed participants has a pending case against his employer for forcing him to resign because of his HIV status. Of the 10 participants, two worked as sex workers and were strongly convinced that they had acquired the virus from their customers. All of them signed informed consent and were given meal and transportation allowance for voluntarily participating in the study.

Data Collection procedure. Prior to the conduct of this qualitative inquiry, ethical clearance from the local ethics committee was secured. Permission from the study site- Pinoy Plus Advocacy Pilipinas, Inc., was also sought. Preliminarily, informed consent was secured from the participants, including the consent to record the interviews; participation was stressed to be voluntary without remuneration and that they are free to discontinue during the interviews without any bias.

The researchers adopted the interview protocol of Seidman (2006), which consists of three phases, namely: (a) rapport-building phase, (b) exploratory phase, and (c) clarificatory phase. In the first phase, the researchers established rapport by displaying friendly gestures to the participants. Then, in the exploratory phase, a semi-structured interview guide was employed to uncover the lived experiences of the youth living with HIV in relation to mental health. Lastly, the researchers raised clarifications during the clarificatory phase to better capture the participants' responses.

Mode of Data Analysis. The recorded interviews were individually transcribed and converted into field texts. Since the language used by the participants is Filipino, their responses were properly translated into English and interpreted to preserve their original meaning. The translation was accomplished with the help of an English Editor with a Ph.D. degree in Language Education and a Master of Arts in Teaching English Language. Then, the researchers used Colaizzi's (1978) seven-step method to analyze the data. The process included: (1) familiarizing with the field texts by reading and reading them; (2) pulling out significant statements from the field texts; (3) formulating meaning units from the significant statement; (4) categorizing the meaning units into clusters of themes; (5) developing a full and inclusive description of the phenomenon by incorporating all the themes produced at step 4; (6) condensing the exhaustive description down to a short, dense statement that captures just those aspects deemed to be essential to the structure of the phenomenon; and (7) returned the fundamental structure statement to all participants.

3.0. Results

This qualitative study yielded interesting findings about the mental health of youth living with HIV. Three themes collectively described the mental health of YLHIV, namely (1) disruptive thoughts, (2) depressive moods, and (3) deteriorative behaviors.

Disruptive thoughts

Learning that they were infected with HIV was very disturbing for the participants. They experience disturbing or troubling thoughts such as irrational, anxious, and suicidal thoughts.

The participants were besieged by several irrational thoughts, such as overestimation of danger and illogical interpretation of their diagnosis. Particularly, they are terrified by the thoughts of dying at a young age and are worried about their future. As verbalized by the participants:

"That time, I keep on thinking that I was dying, that there is no treatment for HIV. I was worried for my family because I am the breadwinner" (Participant 2, personal communication, January 23, 2020).

"I thought I was dying. I was thinking what will happen to the dreams I have for my family. Moreover, I was bothered on how to tell my parents about my health condition" (Participant 10, personal communication, January 25, 2020).

Besides entertaining irrational thoughts, the participants were likewise disturbed by anxious thoughts as manifested by their fear of being rejected and discriminated against by family, friends, romantic partners, and the workplace. As expressed by the participants:

"How can I work if I have this illness? They might trace it through medical examination" (Participant 1, personal communication, January 23, 2020).

"I am afraid to form romantic relationship because I might transmit the virus, I don't want my partner to get sick because of me" (Participant 3, personal communication, January 23, 2020).

"My fear was rejection especially if it is from my own family" (Participant 10, personal communication, January 25, 2020).

Cognizant of their present health condition, the participants were also bombarded with suicidal thoughts, as evidenced by their death wish, thinking of killing themselves, and thoughts that other people are better off without them. As expressed, "Sometimes, I was thinking that instead of dying from the opportunistic infections of this virus, I wish I would not wake up the next day" (Participant 1, personal communication, January 23, 2020). Another participant verbalized, "There was a time that I thought of hanging myself to die. After knowing that I am HIV+, I seldom go to work, most of the time I locked myself in the room, I thought of slitting my wrist, and taking all my medicine at the same time" (Participant 4, personal communication, January 24, 2020).

The irrational and anxious thoughts of the participants were entrenched in certain triggers in their environment, particularly the lack of available information about HIV. They articulated that they have limited information about the illness and are mostly misconceptions about its transmission, treatment, and prevention. As expressed,

"During that time, I thought HIV and AIDS are the same. So for me, it is like a death sentence" (Participant 3, personal communication, January 23, 2020). This misconception elicited disturbing thoughts of dying at a young age and worrying about their future. Another participant verbalized, "I thought I cannot find a job anymore. I was so hesitant to apply for a job because they might discover that I am HIV+" (Participant 2, personal communication, January 23, 2020).

This wrong notion triggered the fear of being rejected and discriminated against in the workplace. Meanwhile, the suicidal thoughts of the participants are primarily triggered by an internal factor, internalized stigma- the internalization of negative beliefs, feelings, and attitudes about PLHIV. As verbalized,

"I would rather die than to be associated with this illness for a long time. I felt so gross/dirty. I am a mess" (Participant 10, personal communication, January 25, 2020).

Summarily, the mental health condition of a select group of Filipino youth living with HIV is typified by certain disruptions which make them entertain irrational, anxious, and suicidal thoughts. These thoughts are provoked by internal and external factors, particularly internalized stigma and lack of available information.

Depressive mood

Accommodating the fact that they were infected by HIV was not easy for the participants. They were blasted with the emotional turmoil intruding on their daily activities at home, school, and even the workplace. Particularly, the participants articulated their experiences of emotional distress, persistent feelings of sadness, and hopelessness.

The participants' emotional distress is manifested in their experience of a deep state of agony and disbelief. As verbalized by the participants:

"I felt like I was going crazy that time, some of my friends told me not to stress myself, but it stresses me a lot. From time to time, it sinks in. I really don't know what to do" (Participant 1, personal communication, January 23, 2020).

"It seems that I was blown away when they told me about the result. I even tried to ask for a second opinion, I can't believe it. Gosh, I was extremely terrified that time. I'm sure, my parents will kill me, I uttered" (Participant 2, personal communication, January 23, 2020).

Other participants experienced a persistent feeling of sadness. They verbalized feelings of aloneness and loneliness, especially the undisclosed YLHIV. Generally, they feel miserable and unhappy instigated by their health condition. The following are some of the verbalizations of the participants:

"After knowing the HIV test result, I kept it for a long time. When I was with my parent, I pretend to be OK, but in reality, I felt so sad most of the time" (Participant 7, personal communication, January 24, 2020).

"I felt lonely; I have difficulty coping up with loneliness. I can't do the things that I previously enjoyed; I lose my interest in almost everything" (Participant 6, personal communication, January 24, 2020).

Likewise, the participants conveyed their experience of hopelessness as they struggled with HIV. They are uncertain about their future and express pessimism about life in general. As expressed,

"It is like, I lose hope in life, there was a time that I applied for a job and got hired, but I backed out because of the medical exam" (Participant 1, personal communication, January 23, 2020).

The indices of depressive mood such as emotional distress, persistent feeling of sadness, and hopelessness were prompted by discrimination. One participant shared that he experienced discrimination from his own family. He said,

"After telling my parents about it, I felt they avoided using the utensils we used to share like drinking glass, spoon, and fork. I even shared a room with my brother before, but now they asked my brother to move out of my room. I felt very sad, but I have to accept it. Maybe that is the consequence of having this illness" (Participant 1, personal communication, January 23, 2020).

Aside from their family members, the participants also received discrimination from their friends and workplace. As articulated:

"After I disclosed my status with my immediate supervisor, I noticed that most of my workmates kept distance from me. Almost every day, I was crying discreetly in the office because of the way they treated me" (Participant 2, personal communication, January 23, 2020).

Another factor that incited the depressive mood of the participants is an internal trigger, non-disclosure. They have difficulty disclosing their health condition due to the stigma associated with the illness. Since they are undisclosed, they feel they are brawl with the illness alone. As shared by one of the participants,

"Actually, right now my pressing concern is on how to tell my parent about it. Not even one from my family knows my status. I feel so empty and alone. Alone battling with this condition" (Participant 2, personal communication, January 23, 2020).

Another participant uttered,

"In my case, I am afraid to disclose because my family might throw me away. They will also discover the obscenity I have done in my life. I do not know when to tell them. I am really struggling" (Participant 5, personal communication, January 24, 2020).

Lack of social support is another factor that fueled the emotional struggles of the participants. They mentioned that it is more emotionally painful when they do not get support from their significant others. They badly wanted to feel the comfort of their family, friends, and other people significant to their lives. As verbalized by the participants:

"I feel so lonely, because until now I am fighting this illness alone. I disappointed my family, so it's very challenging to get support from them" (Participant 5, personal communication, January 24, 2020).

"It's very painful that I want to hug my friends as I usually do when I have problems. But right now, it seems that gradually they are moving away from me" (Participant 1, personal communication, 2020).

Collectively, the mental health of the selected Filipino YLHIV is characterized by depressive mood, which is manifested by emotional distress, persistent feelings of sadness, and hopelessness. These indices of depressive mood are aggravated by personal and environmental factors such as non-disclosure, discrimination, and lack of social support.

Deteriorative behavior

Besides disruptive thoughts and depressive moods, the participants also struggled with deteriorative behavior that impairs their physical and social well-being, such as loss of interest, self-neglect, and social withdrawal.

After knowing their HIV status, they started to engage in several deteriorative behaviors like losing interest. Particularly, the participants started to lose interest in their work, refused to go to school, and disengaged themselves with activities they previously enjoyed. As uttered by the participants:

"To the point that almost two months, I did not go to work. I lose my willingness to work" (Participant 5, personal communication, January 24, 2020).

"Before, I love going to the gym. I usually spend an hour or two for twice or three times a week. But now, I don't go to gym anymore" (Participant 6, personal communication, January 24, 2020).

"All I want is to stay home, I don't want to go to school. I don't even play with my pets anymore that I used to enjoy doing" (Participant 10, personal communication, January 25, 2020).

Moreover, the participants experienced self-neglect while living their lives with chronic illness. They disregard the regular intake of food and eat on an irregular schedule. As expressed,

"What happened to me was, I missed some meals in a day. There was a time that I ate for one meal a day. I had difficulty getting up to do the usual" (Participant 9, personal communication, January 25, 2020).

As a form of avoidant coping mechanism, some participants were even engrossed in dangerous vices like substance use. As expressed,

"The time that I learned my HIV diagnosis, I engaged in inappropriate behavior like smoking cigarettes, drinking alcoholic beverages, I even tried taking marijuana. I felt so devastated that is why I did not care about my health anymore" (Participant 1, personal communication, 2020).

For people living with HIV, doing the usual social interactions was challenging. The participants reported that they experienced withdrawal from other people, such as their friends and workmates. As expressed,

"Actually, I started to avoid mingling with my friends. I am afraid that every time I was with them, they might discover my health condition" (Participant 10, personal communication, January 25, 2020).

"I tend to isolate myself from my workmates, although I only disclosed it with my immediate supervisor. I felt that they know about my condition" (Participant 8, personal communication, January 25, 2020).

Some participants also avoid socializing activities like playing sports, as verbalized,

"I used to play badminton with my neighbors, but I choose to avoid playing with them" (Participant 1, personal communication, 2020).

Notably, personal and environmental factors contribute to the deteriorative behavior of youth living with HIV. For instance, their loss of interest and self-neglect are triggered by internalized stigma, specifically the thought of dying young. This negative notion about the illness fueled their unwillingness to perform their usual task. Meanwhile, engaging in dangerous vices is entrenched in denial of HIV status. They refuse to accept their diagnosis; hence, they engage in avoidant coping mechanisms. As uttered,

"During that time, it seems that I escaped from reality, after learning my HIV status, my coping was to drink alcohol and smoke cigarettes" (Participant 2, personal communication, 2020).

Further, the participants' experience of discrimination from family and friends provoked social withdrawal. They tend to detach themselves from social activities because they are repudiated by their own family. As stated,

"I do not want to hang out with my friends anymore. I feel that they will just reject me like what my family did" (Participant 6, personal communication, January 24, 2020).

By and large, deteriorative behavior, a characteristic of the mental health of a select group of Filipino youth living with HIV, is exhibited by loss of interest, self-neglect, and social withdrawal, which were shaped by internal and external factors such as internalized stigma, denial, and discrimination.

4.0. Discussion

After carefully analyzing the themes, this study allowed the emergence of an interesting model that typifies the mental health condition of the participants. Labeled as the *Mental Health Tower of Youth Living with HIV* (Fig.1), this model conceptualizes instability that permeates the thinking, feeling, and doing aspects of a young person suffering from this dreaded condition. Similar to a tower, YLHIV operates in an environment where both internal and external pressures make them entertain disruptive thoughts, depressive moods, and deteriorative behavior.

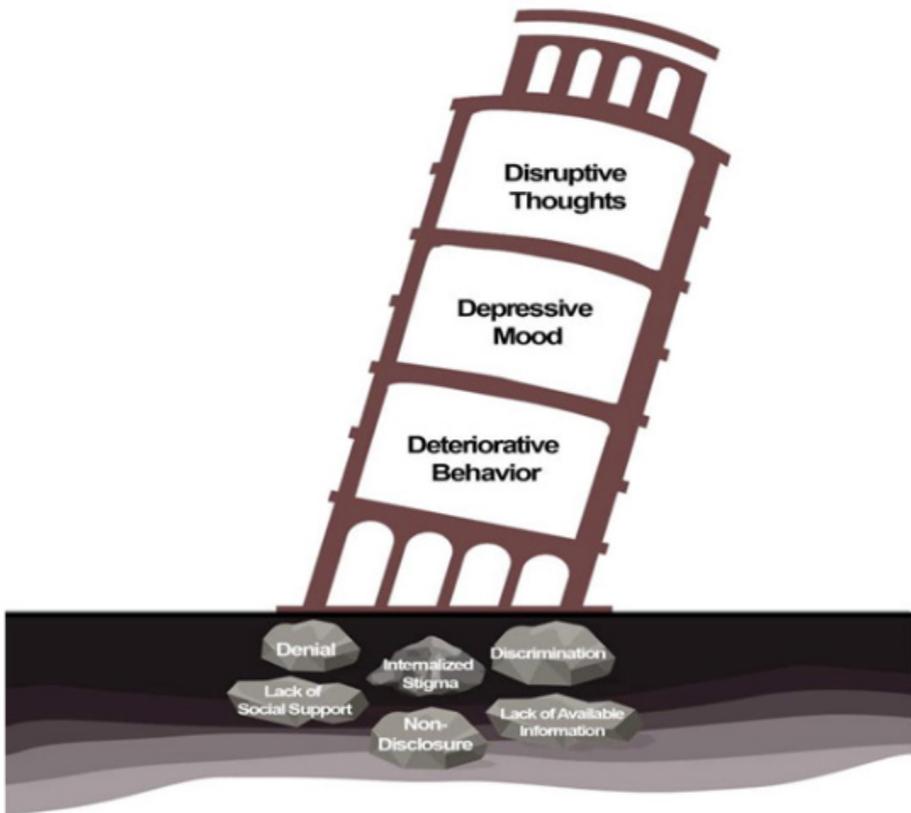


Figure 1. Mental Health Tower of Youth Living with HIV

The findings of the study indicated that YLHIV was bombarded with disruptive thoughts, depressive mood, and deteriorative behavior. This finding converged with the study of Jena (2014) in one wellness clinic in South Africa, indicating that adolescents living with HIV showed anxiety. They were anxious regarding death due to their illness and reported fear of rejection, stigma, and discrimination. Moreover, youth living with HIV were also bothered with suicidal thoughts such as thoughts of killing themselves and death wishes. According to Badiee et al. (2012), suicidal thoughts are common among people with HIV compared to the general population. Alarmingly, suicide rates have been reported at elevated levels in this population (Carrico, 2010).

The present study also revealed that young people infected by HIV faced emotional turmoil manifested by depressive symptoms such as distress, sadness, and hopelessness. This finds concurrence with the Joint United Nations Programme on HIV/AIDS (UNAIDS) (2018) that people with HIV have a higher risk of developing mental health conditions like depressive symptoms. The report supports the claim that medical conditions like HIV could be a major source of stress that negatively affects a person's mental health (US Department of Health and Human Services, 2020). Similarly, the study by Twesigye (2011) found that psychosocial issues experienced by PLHIV in Denmark include stress, frustration for those who could not live a normal life, and long-term sadness.

Besides disruptive thoughts and depressive mood, our study found that YLHIV displayed deteriorative behaviors that impair their physical and social well-being. This deteriorative behavior includes loss of interest, self-neglect, and social withdrawal. The loss of interest of people living with HIV is manifested by their unwillingness to perform usual activities (Andersen et al., 2015), like going to work and performing school tasks. YLHIV also display behaviors that harm their physical health, such as smoking cigarettes, drinking alcohol, and using marijuana (Brown & Morgan, 2013). These behaviors are coping mechanisms of YLHIV in dealing with psychological distress brought by their illness (Duko et al., 2019). Moreover, the deteriorative behaviors of the participants are manifestations of avoidance coping mechanisms. This mechanism is employed by people who are in denial of their medical conditions, that instead of facing reality, they choose to deny it by engaging in various inappropriate behaviors.

5.0. Conclusion

Using the phenomenological design, this study attempted to describe the mental health of a select group of Filipino youth living with HIV. Notably, the study afforded the development of a model identified as the Mental Health Tower of Youth Living with HIV, which typifies the mental health struggles of this group. Characteristically, their mental health is defined by disruptive thoughts, depressive moods, and depressive behaviors, which operate on the thinking, feeling, and doing levels, respectively. Such conditions of the participants were triggered by personal (denial, internalized stigma, and non-disclosure) and environmental factors (lack of available information, discrimination, and lack of social support).

This study advances the current literature about the mental health struggles of Filipino YLHIV by crafting a model which can serve as an interesting platform for understanding the lived experiences of youth living with HIV. The model shows the mental health conditions of YLHIV that need to be addressed. Further, it invites the need to consider personal and environmental factors in developing a mental health program specifically designed for this population. As illustrated, the model has vividly described the instability of the YLHIV's mental health and the factors affecting such conditions, which can serve as valuable inputs for policy-making bodies, government and non-government organizations, and support groups to consider mental health in their respective programs for YLHIV. Particularly, early assessment of the mental health status of YLHIV should be considered alongside the development and provision of a mental health program for this group.

6.0. Declaration of Conflicting Interest

The authors have no conflict of interest to declare.

7.0. Funding

This study did not receive any funding.

REFERENCES

- Andersen, L., Kagee, A., O'Clearigh, C., Safren, S., & Joska, J. (2015). Understanding the experience and manifestation of depression in people living with HIV/AIDS in South Africa. *AIDS Care*, 27(1), 59-62. <https://doi.org/10.1080/09540121.2014.951306>
- Badiee, J., Moore, D. J., Atkinson, J. H., Vaida, F., Gerard, M., Duarte, N. A., Franklin, D., Gouaux, B., Mccutchan, A., Heaton, R., Mearthur, J., Morgello, S., Simpson, D., Collier, A., Marra, C., Gelman, B., Clifford, D., & Grant, I. (2012). Lifetime suicidal ideation and attempt are common among HIV+ individuals. *Journal of Affective Disorders*, 136(3), 993-999. <https://doi.org/10.1016/j.jad.2011.06.044>
- Bekker, L. G., Johnson, L., Wallace, M., & Hosek, S. (2015). Building our youth for the future. *Journal of the International AIDS Society*, 18, 20027. <https://doi.org/10.7448/IAS.18.2.20027>
- Brown, T., & Morgan, K. A. D. (2013). Psychological distress and substance abuse in Jamaican youths living with HIV/AIDS. *West Indian Medical Journal*, 62(4). <https://doi.org/10.7727/wimj.2013.024>
- Cain, R., Jackson, R., Prentice, T., Collins, E., Mill, J., & Barlow, K. (2013). The experience of HIV diagnosis among aboriginal people living with HIV/AIDS and depression. *Qualitative Health Research*, 23(6), 815-824. <https://doi.org/10.1177%2F1049732313482525>
- Carrico, A. W. (2010). Elevated suicide rate among HIV-positive persons despite benefits of antiretroviral therapy: implications for a stress and coping model of suicide. *American Journal of Psychiatry*, 167(2), 117-119. <https://doi.org/10.1176/appi.ajp.2009.09111565>
- Casale, M., Boyes, M., Pantelic, M., Toska, E., & Cluver, L. (2019). Suicidal thoughts and behaviour among South African adolescents living with HIV: Can social support buffer the impact of stigma? *Journal of Affective Disorders*, 245, 82-90. <https://doi.org/10.1016/j.jad.2018.10.102>
- Colaizzi, P. (1978). *Phenomenological research as a phenomenologist views it*. Open University Press.
- Centers for Disease Control and Prevention (CDC). (2015). HIV by age. <https://www.cdc.gov/hiv/group/age/youth/index.html>
- Department of Health (DOH). (2022). HIV/AIDS and art registry of the Philippines: Summary of newly diagnosed cases. https://doh.gov.ph/sites/default/files/statistics/EB_HARP_April_AIDSreg2022.pdf
- Duko, B., Ayalew, M., & Ayano, G. (2019). The prevalence of alcohol use disorders among people living with HIV/AIDS: a systematic review and meta-analysis. *Substance Abuse Treatment, Prevention, and Policy*, 14(1), 1-9. <https://doi.org/10.1186/s13011-019-0240-3>
- European Centre for Disease Prevention and Control. (2017). HIV/AIDS surveillance in Europe 2017-2016 data. <https://www.ecdc.europa.eu/en/publications-data/hiv/aids-surveillance-europe-2017-2016-data>
- Jena, P. P. (2014). *Exploring the lived experiences of adolescents living vertically acquired HIV*. (Unpublished doctoral dissertation, University of South Africa).
- Joint United Nations Programme on HIV/AIDS (UNAIDS). (2018). Better integration of mental health and HIV services needed. <https://www.unaids.org/en/resources/presscentre/featurestories/2018/october/mental-health-and-hiv-services>
- Kalichman, S. C., Heckman, T., Kochman, A., Sikkema, K., & Bergholte, J. (2000). Depression and thoughts of suicide among middle-aged and older persons living with HIV/AIDS. *Psychiatric Services*, 51(7), 903-907. <https://dx.doi.org/10.1176/appi.ps.51.7.903>
- Landry, T. M. (2014). Navigating life with HIV: The lived experiences of youth living with HIV. <https://ir.lib.uwo.ca/etd/2646>
- Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their Contributions to nursing knowledge. *Qualitative Health Research*, 14(5). <https://doi.org/10.1177/1049732304263638>
- MacQueen, K. M. (2017). Young people, HIV, and life goals. *Journal of the International AIDS Society*, 20(1). <https://doi.org/10.7448/IAS.20.1.22267>
- McLeish, O. (2015). Stigma and resilience: Lived experiences of people with HIV in a northern community (Doctoral dissertation, University of Northern British Columbia). <https://www.bac-lac.gc.ca/eng/services/theses/Pages/item.aspx?idNumber=1243162900>
- Mellins, C. A., & Malee, K. M. (2013). Understanding the mental health of youth living with perinatal HIV infection: lessons learned and current challenges. *Journal of the International AIDS Society*, 16(1). <https://doi.org/10.7448/IAS.16.1.18593>
- Pao, M., Lyon, M., D'Angelo, L. J., Schuman, W. B., Tipnis, T., & Mrazek, D. A. (2000). Psychiatric diagnoses in adolescents seropositive for the human immunodeficiency virus. *Archives of pediatrics & adolescent medicine*, 154(3), 240-244. <https://doi.org/10.1001/archpedi.154.3.240>
- Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. Teachers College Press.
- Sharma, P. & Babu, M. (2017). A study to explore the lived experiences of PLHIV at selected ART centres: A pilot study. *International Research Journal of Natural and Applied Sciences*, 4(12), 260-278.
- Smith Fawzi, M. C., Ng, L., Kanyanganzi, F., Kirk, C., Bizimana, J., Cyamatare, F., Mushashi, C., Kim, T., Kayiteshonga, Y., Binagwaho, A., & Betancourt, T. S. (2016). Mental health and antiretroviral adherence among youth living with HIV in Rwanda. *Pediatrics*, 138(4). <https://doi.org/10.1542/peds.2015-3235>
- Twesigye, R. (2011). Lived experiences of immigrants with chronic illnesses in Denmark: A case of HIV patients. Doctoral dissertation, Syddansk Universitet.

- United Nations International Children's Emergency Fund (UNICEF). (2015). Adolescents: Under the radar in the Asia-Pacific AIDS response. <https://www.unicef.org/eap/reports/adolescents-under-radar>
- U. S. Department of Health and Human Services. (2020). HIV and mental health. <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/27/92/hiv-and-mental-health>
- Vreeman, R. C., McCoy, B. M., & Lee, S. (2017). Mental health challenges among adolescents living with HIV. *Journal of the International AIDS Society*, 20, 21497. <https://doi.org/10.7448/IAS.20.4.21497>
- Wang, W., Xiao, C., Yao, X., Yang, Y., Yan, H., & Li, S. (2018). Psychosocial health and suicidal ideation among people living with HIV/AIDS: A cross-sectional study in Nanjing, China. *PLoS One*, 13(2), e0192940. <https://doi.org/10.1371/journal.pone.0192940>
- Whiteley, L. B., Brown, L. K., Swenson, R., Kapogiannis, B. G., & Harper, G. W. (2014). Disparities in mental health care among HIV-infected youth. *Journal of the International Association of Providers of AIDS Care (JIAPAC)*, 13(1), 29-34. <https://doi.org/10.1177%2F2325957413488172>
- World Health Organization (WHO). (2018). HIV and youth. http://www.who.int/maternal_child_adolescent/topics/adolescence/hiv/en/
- Wright, A., Couper, I., & Setlhare, V. (2014). The experiences of people living with HIV/AIDS in Gaborone, Botswana: stigma, its consequences, and coping mechanisms. <https://doi.org/10.1080/20786190.2014.975484>
- Zhou, Y. R. (2010). The phenomenology of time: Lived experiences of people with HIV/AIDS in China. *Health*, 14(3), 310-325. <https://doi.org/10.1177/1363459309358596>

Additional Author's Information:

BENNY S. SOLIMAN
bssoliman@tau.edu.ph
<https://orcid.org/0000-0001-8219-386X>

ALLAN B. DE GUZMAN
abdeguzman@ust.edu.ph
<https://orcid.org/0000-0002-3611-4013>

MARC ERIC S. REYES
msreyes@ust.edu.ph
<https://orcid.org/0000-0002-5280-1315>