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Psychological adjustment in children and teenagers living with HIV

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Resumen

El objetivo del estudio fue describir el ajuste psicológico en niños y adolescentes (n=14) entre 6 y 15 años que viven con VIH. Estudio cuantitativo, con diseño descriptivo. Se utilizó el Child Symptom Checklist CBCL/6-18 adaptado a población latina para evaluar el ajuste psicológico. La escala de competencias en actividades sociales y escolares mostró que el 79% de los participantes se ubicaron en el rango clínico y 21% en el rango normal. El 43% se ubicó en rango clínico, 36% borderline y 21% en rango normal en la escala síndromes. Se evidenció bajo nivel en las competencias sociales debido a poca participación y habilidades, sin vinculación a organizaciones de carácter social, con red social mínima y desempeño escolar por fuera de lo esperado. Asimismo, la mayoría de la muestra reflejó problemas de conducta psicósomática, agresividad y ansiedad, indicando un desajuste psicológico de tipo interiorizado y exteriorizado.

Palabras clave: VIH, SIDA, ajuste psicológico, salud mental.

Abstract

The main objective of this study was to describe the psychological adjustment in children and teenagers (n=14) between 6 and 15 years living with HIV. Quantitative study with descriptive design. Child Symptom Checklist CBCL/6-18 adapted to Latinos was used to assess psychological adjustment. Social competencies and school activities scale showed that 79% of the participants were in clinical range and 21% in the normal range. Syndrome scale showed that 43% of evaluated are in clinical range, 36% in normal range and 21% in borderline. The psychological adjustment perception referred by participant's caregivers evidences a low level in the social capacities due to the low participation and skills in diverse activities, without links with social character organizations, minimum social red and school performance out of the expected. Also, the majority of the sample reflects psychosomatic behavior problems, aggressiveness and anxiety, indicating a psychological maladjustment of internalized and externalized type.

Keywords: HIV, AIDS, psychological adjustment, mental health.

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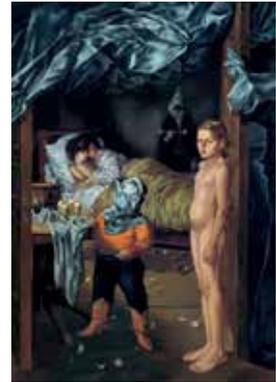
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Psychological adjustment in children and teenagers living with HIV

Ajuste psicológico en niños y adolescentes que viven con VIH

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Introducción

HIV is a major public health problem worldwide; globally, an estimated 2.1 million children under the age of 15 are affected by HIV, with around 160,000 new infections and 120,000 related deaths annually (World Health Organization, 2017). In fact, children affected with HIV become progressively immunosuppressed, a situation that increases the risk of acquiring common threats and potentially deadly childhood infections (Humphreys, Smith, Azman, McLeod, & Rutherford, 2010). Almost four decades ago, the world struggled with the emergence of this new disease, limited knowledge about HIV aroused in many societies, waves of fear, which caused a notable stigma and discrimination in the people who was affected. Surprisingly, despite significant obstacles in the field, fear, denial, stigma and discrimination are considerable dilemmas that many people living with HIV admit (Helms et al., 2017) and represent an important obstacle to public health programs (Brent, 2016; Grossman & Stangl, 2013).

As a consequence, in Colombia up to 2017 was estimated that 150.000 thousand people were living with HIV (UNAIDS, 2018). According to the Cuenta de Alto Costo (2017) statistics, from the people who were reported, 71.076 were affiliated to the Colombia's Sistema General de Seguridad Social en Salud. Additionally, the HIV/AIDS rate for the country is currently at 14.0 per 100.000 citizens. Moreover, there are several cities that are above the average value, but it's worth highlighting the five cities which obtained the highest value per 100.000 citizens in their order: Risaralda, Quindío, Cartagena, Barranquilla and Valle del Cauca. Indeed, according to the most recent epidemiological report, published by the Instituto Na-

cional de Salud, Barranquilla ranks fourth with 243 new reported cases, corresponding to 19.8 per 100.000 inhabitants and 16 deaths reported by the National Public Health Surveillance System during the course of the year (Instituto Nacional de Salud & Ministerio de Salud, 2018).

However, the HIV epidemic in Colombia is considered concentrated, with a prevalence of less than 1 % in the general population and bigger than 5% in specific populations (men who have sex with men, people who inject drugs or sex workers) (Ministerio de Salud y Protección Social, 2008; 2014). With this proviso, it is considered that HIV prevalence is higher in urban areas due to environmental situations that favor sexual behaviors that increase the risk of infection. In turn, when reviewing statistics by age, it is visible that 1.19 % of people diagnosed with HIV are 13 years old and younger (Fondo Colombiano de Enfermedades de Alto Costo, 2017).

On the other hand, according to the results of a study conducted in children affected with HIV/AIDS in five Colombian cities, only 3.8 % (n:11) of the children were aware of their diagnosis of HIV/AIDS infection (Trejos, Tuesca, & Mosquera, 2011). The reasons to delay the diagnosis disclosure, reported by health professionals and caregivers of affected children [96,0 % (n:275)] were related to the protection of children from psychological damage or emotional stress, disagreement related to the age to deliver this information and lack of training to carry out this procedure. In Colombian context, these results indicate that revelation of the HIV infection diagnosis to children is not a consolidated practice (Instituto Colombiano de Bienestar Familiar, Save the Children, UNICEF, & Universidad del Norte, 2006). Following the previous ideas, different studies have shown more recently that the parental behavior of fathers and mothers are related to the development of their children (Cabrera, Fagan, Wight, & Schadler, 2011; Lamb, 2012; Putnick, y otros, 2015), as their global psychological adjustment (Khaleque, 2015; Khaleque & Rohner, 2012) and internalized (McLeod, Wood, & Weisz, 2007) or externalized behavior (Hoeve, et al., 2009).

In this context, according to Achenbach & Rescorla (2001), psychological adjustment is a clinical expression that denotes aspects of psychological dysfunction and mental health with two dimensions: internalizing and externalizing behavior. They specify the notion of adjustment in terms of low levels of these behaviors. The first of these dimensions refers to internal behavior problems such as anxiety and depression that involve feelings of loneliness, fear, inferiority feelings, guilt, sadness, distrust, anguish and neuroticism, which affect the self. The second refers to behavior problems

that affect others, such as: a) breaking rules that include vandalism such as stealing, escaping from home, staying in trouble, cheating, lying, absence of feelings of guilt, and rejection of authority and social norms. And b) aggression, understood as exercising antisocial behavior, arguing with vehemently, demanding much attention, assaulting, shouting, threatening, being irritable, annoying, envious, disobedient and tyrant (Achenbach & Rescorla, 2001). That's the reason this article aims to describe the psychological adjustment in children and adolescents living with HIV from two health care institutions in Barranquilla (Colombia).

Methods

Participants

The sample was composed of 14 children and adolescents between 6 and 15 years, diagnosed with HIV from birth, attending by health care institutions in Barranquilla. A non-probabilistic sampling with special purposes was used for the election of the participants.

Design and procedure

Quantitative study, with descriptive design (Hernández, Fernández, & Baptista, 2010). Data collection took place in 2 institutions that provides health services to children and adolescents affected by HIV in Barranquilla (Colombia). First, we proceeded to establish contact with the institutions to request their co-operation. Next, the institutional letter, the investigation protocol, the informed consent form and a measurement instrument copy were sent to be analyzed by the Ethics Committees of both entities. Once the assessment had been planned, the evaluators visited the institutions; participants signed an informed consent form in which the purpose of the investigation, procedure and rights were specified. After the form was signed, the participants completed the questionnaires. The data collection was carried out between August and November, 2014. Tabulation and descriptive analysis of the data was performed in SPSS 22nd version.

Instruments

- Child Behavior Inventory for Parents-Child Behavior Checklist (CBCL) 6-18 years. This instrument was developed by Achenbach and Rescorla (2001; Lacalle Sisteré, 2009) and contains two sections:

the first allows to obtain a profile by means of a direct score and a normative score or T, depending on the age and sex referred to the performance of the child as reported by parents in various activities and in their social and educational field through normal ranges (Total T > 35) borderline (Total T between 35 and 31) and clinical (Total T < 31). The second section assesses the presence of psychopathology in the child, in the last six months, also as reported by the parents.

- The syndrome scale allows to obtain a profile of internalized behavior problems such as anxiety, depression and psychosomatic problems. And a profile of externalized behavior such as rules breaking, aggressiveness and other problems through clinical ranges (Total T > 69), borderline (Total T between 69 y 65) and normal (Total T < 65); with an approximate duration of 30 minutes for its application.

Results

Table 1. Children and Teenagers Demographic variables

Variable	Item	F (%)
Age	6 - 8 years	8 (58%)
	9 - 11 years	2 (14%)
	12 - 14 years	2 (14%)
	15 - 17 years	2 (14%)
Gender	Female	5 (36%)
	Male	9 (64%)
Educational level	Pre-school	1 (7%)
	Primary school	9 (65%)
	High school	3 (21%)
	Do not study	1 (7%)
Diagnosis disclosure	+	4 (29%)
	-	10 (71%)
Caregivers HIV Diagnosis	+	4 (29%)
	-	10 (71%)
Mother HIV Diagnosis	+	14 (100%)
	-	0 (0%)
Father HIV Diagnosis	+	4 (29%)
	-	10 (71%)
Siblings HIV Diagnosis	+	1 (7%)
	-	13 (93%)
Socioeconomic	1	11 (79%)
	2	2 (14%)
	3	1 (7%)
Health Regime	Contributory Subsidized	2 (14%)
		12 (86%)

Psychological Adjustment

As a result to the psychological adjustment evaluation (Table 2), 79 % of the sample is in the clinical range and the remaining 21 % in the normal range. This result is derived from the following capacities: 36 % in normal range, the same percentage in borderline range and 29 % in clinical range, social activities (50 % in normal range, 29 % in borderline range and 21 % in clinical range) and school activities (86 % in normal range, 7 % in borderline range and 7 % in clinical range).

On the other hand, the syndromes and internalized problems profile revealed that 50 % of sample is in clinical range with internalized behavior problems such as anxiety, depression and psychosomatic problems, 43 % corresponds to the normal range and 7 % to the borderline range (Table 3). Thus, in the anxiety problems results, 86 % of the sample is in the normal range and the remaining 14% in the clinical range. In the same way, depression results evidence that 71 % of the sample are in the normal range, 14 % in the borderline range and the same percentage in the clinical range. Finally, refers to psychosomatic problems 71 % of the sample was in the normal range, 21 % in the clinical range and 7 % in the borderline range.

According with the scale of syndromes and externalized problems profile, 50 % of the sample is in the normal range referring to externalized behavior problems such as aggressiveness and rules breaking, 29 % in clinical range and 21 % remaining in range borderline. These externalized behavior problems are related to rule breaking problems, resulting in 93 % of subjects in normal range and 7 % in clinical range; and aggressiveness problems with 64 % in normal range, 29 % in clinical range and 21 % in borderline range. In conclusion, the psychological adjustment evaluation exhibit that 43 % of sample are in clinical rank with respect to their psychological adjustment, followed by 36 % who report a normal adjustment and 21 % borderline.

Table 2 CBCL Competences frequency distribution according to the range

Competences Scale	Range	F	(%)
Activities	Normal	5	36
	Borderline	5	36
	Clinical	4	29
Social	Normal	7	50
	Borderline	4	29
	<i>Clinical</i>	3	21
School	Normal	12	86
	Borderline	1	7
	Clinical	1	7

Table 3 CBCL Syndrome scale frequency distribution according to the range

Internalizing problems	Range	F	(%)
Anxiety	Normal	12	86
	Borderline	-	-
	Clinical	2	14
Depression	Normal	10	71
	Borderline	2	14
	<i>Clinical</i>	2	14
Psychosomatics	Normal	10	71
	Borderline	1	7
	Clinical	3	21
Externalizing problems	Range	F	(%)
Rule-Breaking Behavior	Normal	13	93
	Borderline		-
	Clinical	1	7
Aggressive Behavior	Normal	9	64
	Borderline	2	14
	<i>Clinical</i>	3	21
CBCL Total	Normal	5	36
	Borderline	3	21
	Clinical	6	43

Discussion

According to Benton, Lachman and Seedat (2018), HIV/AIDS is considered a biopsychosocial disease whose impact extends far beyond its physical symptoms. Stigma, social and economic factors and the political environment contribute to the disease burden. There are reports describing the rates of new cases, the HIV infection prevalence and the understanding of the extent of this disease, but they do not capture its real burden. It is observed that HIV cases number is not proportional to the disease impact, therefore, efforts to identify cases, treat HIV and prevent its evolution -and in many cases, decrease the number of new cases- have been effective. However, we have only begun to understand the effects of HIV on mental health in children, teenagers and their families.

Therefore, several psychosocial adaptation studies converge in focusing their interest on childhood as a stage of numerous changes and enormous risks for minors. Maladaptation is the criterion that indicates the deviation of their behavior in relation to their own expectations with the prevailing expectations in their environment (Lewis, Cuestas, Ghisays, & Romero, 2004). Contrary to this, adaptation refers to an operational and functional personality criterion “in the sense that it reflects the idea of seeing to what extent individuals manage to be satisfied with themselves, and their behaviors are adequate to the requirements of the different circumstances what they have live” (Hernández y Jiménez, 2003, cited by Lewis et al., 2004, p. 128).

Following the previous ideas, this study evidenced that the psychological adjustment perception referred by participant’s caregivers indicates a low level in the social capacities due to the low participation and skills in diverse activities; without links with social character organizations, minimum social red and school performance out of the expected. Additionally, their emotional development would be limited for being part of isolation situations, which prevents them in some way to develop emotional links that allow interaction with others, also, giving a decrease in confidence and self-esteem, adding up an academic and recreational intermittency (Palacio, Amar, Madariaga, Llinás, & Contreras, 2007). It is necessary to emphasize that social support can impacts these psychological outcomes either by means of a direct effect, or by buffering the negative effects of specific stressors on these outcomes (Alloway & Bebbington, 1987; Casale, et al., 2015; Gellert, et al., 2018).

It should be said, that a major part of the sample reflects psychological maladjustment, because a large percentage of the children and teenagers affected with HIV are situated in clinical and borderline range, reflecting psychosomatic behavior problems, aggressiveness and anxiety, indicating a psychological maladjustment type internalized and externalized (Willis, Mavhu, Wogrin, Mutsinze, & Kagee, 2018), as a consequence of this discrepancy. The areas of competency scales are affected that's because there are a higher percentage of children who are unaware of their diagnosis, thus evidencing the relationship between the lack of knowledge about the disease and the psychological problems. Findings continue, that despite not having knowledge or knowing the name of the disease, may experience anxiety resulting from this (Instone, 2000; Wiener, Mellins, Marhefka, & Battles, 2007).

It should be mentioned in addition to other studies in children infected with HIV that suggest higher rates of psychiatric symptoms. A study conducted in Kenya that evaluated the psychiatric disorders of children and adolescents infected with congenitally acquired HIV, reported overall rates of 48 % for any disorder (major depression, social phobia, oppositional defiant disorder and ADHD) and 25 % of the study participants had more than one psychiatric disorder. The prevalence of psychiatric morbidity in HIV-infected children is higher than that found in children in the general population. There is therefore a need to integrate psychiatric services into the routine care of HIV-infected children (Kamau, Kuria, Mathai, Kange-the, & Atwoli, 2012).

In turn, a study conducted in Uganda with HIV-positive adolescents found that infection in adolescence was associated with considerable psychological problems, the presence of high rates of anxiety, depression, somatization and mania and major psychiatric disorders. Nevertheless, with the current increasing availability of effective antiretroviral therapy, many of these children are surviving into adolescence, thus calling for the development of adolescent friendly HIV medical and psychological support and treatment services in developing countries such as Uganda (Musisi & Kinyanda, 2009). Similarly, within the psychological disorders of the child affected with HIV/AIDS infection, others disruptive behaviors could appear such as disobedience, anger, aggression, that possibly be related to childhood depression, which may be associated with the family previous history and problems associated with the disease (Ruiz-Navia, Enríquez-Lara, & Hoyos-Hernández, 2009).

Consequently, is confirmed the importance of carrying out a good diagnostic disclosure process, because it has been associated with an increase in adherence to antiretroviral treatment and positive responses to this (Bikaako-Kajura et al., 2006; Nabukeera-Barungi et al., 2015; World Health Organization, 2011) mental health and wellbeing (Wiener, Mellins, Marhefka, & Battles, 2007). And supportive and strong parental relationships were related to good adherence (Mahloko & Madiba, 2012; South to South, 2010; Wiener, Mellins, Marhefka, & Battles, 2007), and the decrease in stigma associated with the disease (Hardon & Posel, 2012; Esacove, 2016).

Likewise, the disclosure process should be systematically encouraged and organized for HIV-infected adolescents (Ngeno, et al., 2019). Parents and caregivers need to be provided with the necessary knowledge and skills on how to look after children who know their HIV status because stigma and disclosure issues continue to be the main barriers to adherence among adolescents (Abebe & Teferra, 2012; Nabukeera-Barungi et al., 2015), and HIV-stigma is a potential risk factor for poor mental and is linked to higher odds of suicidal ideation and attempts in adolescents (Casale, Boyes, Pantelic, Toska, & Cluver, 2019; Dow, et al., 2016; Katz, et al., 2013; Pantelic, Boyes, Cluver, & Meinck, 2017; Rueda, et al., 2016). Furthermore, a timely, accurate and diagnosis disclosure explanation with empathy within a safe and planned disclosure process is preferable to leave the child exposed to accidental revelations that may be detrimental to their psychological adjustment and therapeutic adherence (Trejos Herrera, Alarcón Vásquez, Reyes Ruíz, & Bahamón, 2017).

In turn, studies have shown the benefits obtained from the diagnosis disclosure in the relationship between caregivers and children associated with strengthening mental health and wellbeing and thus decreasing the levels of stress and depression in both (Bachanas, et al., 2001; Battles, Heilman, Sigelman, Pizzo, & Wiener, 1996; Battles & Wiener, 2002; Lipson, 1994). Similarly, when there is good information about the disease, you could learn to live with it and the family or fraternity bonds won't be broken by the taboos that often represent the lack of knowledge around the HIV/AIDS" (Alvarado y Passos, 2015, p.175; Pantelic, Boyes, Cluver, & Thabeng, 2018).

It is important to highlight the concern about the increase of new cases of people affected with HIV throughout the country as mentioned previously. From the most recent epidemiological report published by the National Institute of Health, Barranquilla ranks fourth with 243 new cases reported, which is equivalent to 19.8 per 100.000 inhabitants and 16 deaths

during the course of the year (Instituto Nacional de Salud & Ministerio de Salud, 2018).

In addition, the results of this study contribute evidence in the area of clinical practice for the design of customized treatment plans. This evidence reinforces the need to develop and improve emotional cognitive strategies in the management of the related affects in people who live with HIV (Vera-Villaruel, Contreras, & Valtierra, 2016). At the same time, it points out the need to carry out and focus works in childhood from multidisciplinary perspectives, taking into account both personal and social factors, in order to explain the behavior, divergence, child safety (Slobodskaya, Akhmetova, & Rippinen, 2014) and the need to develop culturally specific disclosure guidelines (Gyamfi, Okyere, Appiah-Brempong, Odotei Adjei, & Akohene Mensah, 2015).

Conflict of interest

None of the authors have any conflict of interest to declare.

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References

- Abebe, W., & Teferra, S. (2012). Disclosure of diagnosis by parents and caregivers to children infected with HIV: Prevalence associated factors and perceived barriers in Addis Ababa, Ethiopia. *AIDS Care*, *24*, 1097-1102.
- Achenbach, T., & Rescorla, M. (2001). *Manual for the ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont: Research Center for Children, Youth and Families.
- Alloway, R., & Bebbington, P. (1987). The buffer theory of social support – a review of the literature. *Psychological Medicine*, *17*(1); DOI:10.1017/s0033291700013015, 91-108.
- Alvarado, C., & Passos, E. (2015). La familia en el proceso de aceptación y acompañamiento en la enfermedad VIH/Sida en los pacientes afiliados a Comfamiliar EPS-S del distrito de Cartagena. *Métodos*, *13*, 175.
- Bachanas, P., Kullgren, K., Schwartz, K., Lanier, B., McDaniel, J., Smith, J., & Nesheim, S. (2001). Predictors of psychological adjustment in

- school-age children infected with HIV. *Journal of Pediatric Psychology*, 26, 343-352.
- Battles, B., & Wiener, S. (2002). From adolescence through young adulthood: Psychosocial adjustment associated with long term survival of HIV. *Journal of Adolescent Health*, 30(3), 161-168.
- Battles, H., Heilman, N., Sigelman, C., Pizzo, P., & Wiener, L. (1996). Factors associated with disclosure of diagnosis to children with HIV/AIDS. *Pediatric AIDS and HIV Infection*, 7, 310-324.
- Benton, T. D., Lachman, A., & Seedat, S. (2018). VIH/SIDA. Abordaje de las necesidades de salud mental de los niños afectados y sus familias. En *Manual de Salud Mental Infantil y Adolescente de la IACAPAP* (pág. 3). Ginebra: Asociación Internacional de Psiquiatría del Niño y el Adolescente y Profesiones Afines .
- Bikaako-Kajura, W., Luyirika, E., Purcell, D., Downing, J., Kaharuza, F., Mermin, J., & Bunnell, R. (2006). Disclosure of HIV status and adherence to daily drug regimens among HIV infected children in Uganda. *AIDS and Behavior*, 10 (Suppl.7) <https://doi.org/10.1007/s10461-006-9141-3>, 85-93.
- Brent, R. J. (2016). The value of reducing HIV stigma. *Social Science & Medicine*, 151, 233-240.
- Cabrera, N. J., Fagan, J., Wight, V., & Schadler, C. (2011). Influence of mother, father, and child risk on parenting and children's cognitive and social behaviors. *Child Development*, 82(6), 1985-2005.
- 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(15); DOI:<https://doi.org/10.1016/j.jad.2018.10.102>, 82-90.
- Casale, M., Cluver, L., Crankshaw, T., Kuo, C., Lachman, J. M., & Wild, L. G. (2015). Direct and Indirect Effects of Caregiver Social Support on Adolescent Psychological Outcomes in Two South African AIDS-Affected Communities. *American Journal of Community Psychology*, 55(3-4); DOI:[10.1007/s10464-015-9705-3](https://doi.org/10.1007/s10464-015-9705-3), 336-346.
- Dow, D., Turner, E., Shayo, A., Mmbaga, B., Cunningham, C., & O'Donnell, K. (2016). Evaluating mental health difficulties and associated outcomes among HIV-positive adolescents in Tanzania. *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 28(7); DOI:[10.1080/09540121.2016.1139043](https://doi.org/10.1080/09540121.2016.1139043), 825-833.

- Esacove, A. W. (2016). *Modernizing Sexuality: US HIV Prevention in Sub-saharan Africa*. Oxford: Oxford University Press.
- Fondo Colombiano de Enfermedades de Alto Costo. (2017). *Situación del VIH en Colombia*. Bogotá: Cuenta de Alto Costo - Fondo Colombiano de Enfermedades de Alto Costo.
- Gellert, P., Häusler, A., Suhr, R., Gholami, M., Rapp, M., Kuhlmeier, A., & Nordheim, J. (2018). Testing the stress-buffering hypothesis of social support in couples coping with early-stage dementia. *Plos One*, *13*(1); DOI:10.1371/journal.pone.0189849.
- Gyamfi, E., Okyere, P., Appiah-Brempong, E., Odotei Adjei, R., & Akohene Mensah, K. (2015). Benefits of Disclosure of HIV Status to Infected Children and Adolescents: Perceptions of Caregivers and Health Care Providers. *Journal of the Association of Nurses in AIDS Care*, *26*(6); DOI:https://doi.org/10.1016/j.jana.2015.08.001, 770-780.
- Hardon, A., & Posel, D. (2012). Secrecy as embodied practice: beyond the confessional imperative. *Cult. Health Sex.* *14* (Suppl. 1), 1–13.
- Helms, C. B., Turan, J. M., Atkins, G., Kempf, M., Clay, O. J., Raper, J. L., & Raper, B. (2017). Interpersonal mechanisms contributing to the association between HIV-related internalized stigma and medication adherence. *AIDS and Behavior*, *21*, 238-247.
- Hernández, R., Fernández, C., & Baptista, P. (2010). *Metodología de la Investigación*. McGrawHill.
- Hoeve, M., Dubas, J. S., Eichelsheim, V. L., Van Der Laan, P. H., Smeenk, W., & Gerris, J. M. (2009). The relationship between parenting and delinquency: A meta-analysis. *Journal of Abnormal Child Psychology*, *37*(6), August, 749-775.
- Humphreys, E. H., Smith, N. A., Azman, H., McLeod, D., & Rutherford, G. W. (2010). *Prevention of diarrhoea in children with HIV infection or exposure to maternal HIV infection*. Cochrane Database Syst Rev, CD008563.
- Instituto Colombiano de Bienestar Familiar, Save the Children, UNICEF, & Universidad Del Norte. (2006). *vida, apoyo social y utilización de servicios de salud y educación en niños, niñas y adolescentes y sus acudientes afectados con VIH/SIDA en cinco ciudades-región colombianas: Cali y Buenaventura y Barranquilla, SantaMarta y Cartagena*. Barranquilla: Universidad del Norte: Dirección de Investigaciones y Proyectos (DIP).
- Instituto Nacional de Salud, & Ministerio de Salud. (2018). *Informe de Evento VIH/SIDA, Colombia, Período VI de 2018*. Bogotá: Ministerio de Salud.

- Instone, S. L. (2000). Perceptions of children with HIV infection when not told for so long: Implications for diagnosis disclosure. *Journal of Pediatric Health Care*, 14, <https://doi.org/10.1067/mp.2000.107338>, 235-243.
- Kamau, J. W., Kuria, W., Mathai, M., Kangethe, R., & Atwoli, L. (2012). Psychiatric morbidity among HIV-infected children and adolescents in a resource-poor Kenyan urban community. *Aids Care-Psychological and Socio-Medical Aspects of Aids/Hiv*, 24(7), 836-842.
- Katz, I., Ryu, A., Onuegbu, A., Psaros, C., Weiser, S., Bangsberg, D., & Tsai, A. (2013). Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis. *Journal of the International AIDS Society (JIAS)*, 16(3S2); DOI:<https://doi.org/10.7448/IAS.16.3.18640>, 18640.
- Khaleque, A. (2015). Perceived parental neglect, and children's psychological maladjustment, and negative personality dispositions: a meta-analysis of multi-cultural studies. *Journal of Child and Family Studies*, 24(5), 1 May, 1419-1428.
- Khaleque, A., & Rohner, R. P. (2012). Transnational Relations Between Perceived Parental Acceptance and Personality Dispositions of Children and Adults: A Meta-Analytic Review. *Personality and Social Psychology Review*, 16(2), May, 103-115.
- Lacalle Sisteré, M. (2009). *Tesis Doctoral: Escalas DSM del CBCL y YSR en niños y adolescentes que acuden a consulta en servicios de salud mental*. Bellaterra: Universidad Autónoma de Barcelona.
- Lamb, M. E. (2012). Mothers, fathers, families, and circumstances: factors affecting children's adjustment. *Applied Developmental Science*, 16(2), April, 98-111.
- Lewis, S., Cuestas, M., Ghisays, Y., & Romero, L. (2004). La adaptación social y escolar en niños con y sin trastorno por déficit de atención con hiperactividad (TDAH) de la ciudad de Barranquilla (Colombia). *Revista Psicología Desde El Caribe*, (14), Versión digital disponible en: <http://rcientificas.uninorte.edu.co/index.php/psicologia/article/view/1782/5274>.
- Lipson, M. (1994). Disclosure of diagnosis to children with human immunodeficiency virus or acquired immunodeficiency syndrome. *Journal of Developmental & Behavioral Pediatrics*, 15, S61-S65.
- Mahloko, J. M., & Madiba, S. (2012). Disclosing HIV diagnosis to children in Odi District, South Africa: Reasons for disclosure and non-disclosure. *African Journal of Primary Health Care and Family Medicine*, 4(1), <https://doi.org/10.4102/phcfm.v4i1.345>, 1-7.

- McLeod, B. D., Wood, J. J., & Weisz, J. R. (2007). Examining the association between parenting and childhood anxiety: A meta-analysis. *Clinical Psychology Review*, 27(2), March, 155-172.
- Musisi, S., & Kinyanda, E. (2009). Emotional and behavioural disorders in HIV seropositive adolescents in urban Uganda. *East African Medical Journal*, 16-24.
- Nabukeera-Barungi, N., Elyanu, P., Asire, B., Katureebe, C., Lukabwe, I., Namusoke, E., & Tumwesigye, N. (2015). Adherence to antiretroviral therapy and retention in care for adolescents living with HIV from 10 districts in Uganda. *BMC Infectious Diseases*, 15(1). <https://doi.org/10.1186/s12879-015-1265-5>, 520.
- Ngeno, B., Waruru, A., Inwani, I., Nganga, L., Ngugi Wangari, E., Kataana, A., . . . Rutherford, G. (2019). Disclosure and Clinical Outcomes Among Young Adolescents Living With HIV in Kenya. *Journal of Adolescent Health*, 64(2); DOI:<https://doi.org/10.1016/j.jadohealth.2018.08.013>, 242-249.
- Palacio, J., Amar, J., Madariaga, C., Llinás, H., & Contreras, K. (2007). La calidad de vida en salud en los menores trabajadores de Tolúviejo (Sucre). *Investigación y Desarrollo*, 15(2), 366-393.
- Pantelic, M., Boyes, M., Cluver, L., & Meinck, F. (2017). HIV, violence, blame and shame: pathways of risk to internalized HIV stigma among South African adolescents living with HIV. *AIDS Society*, 20(1); DOI:10.7448/ias.20.1.21771 , 21771.
- Pantelic, M., Boyes, M., Cluver, L., & Thabeng, M. (2018). “They say HIV is a punishment from god or from ancestors”: cross-cultural adaptation and psychometric assessment of an HIV stigma scale for South African adolescents living with HIV (ALHIV-SS). *Child Indicators Research*, 11(1); DOI: 10.1007/s12187-016-9428-5, 207-223.
- Putnick, D. L., Bornstein, M. H., Lansford, J. E., Malone, P. S., Pastorelli, C., Skinner, A. T., . . . Oburu, P. (2015). Perceived mother and father acceptance-rejection predict four unique aspects of child adjustment across nine countries. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 56(8), 1 August, 923-932.
- Rueda, S., Mitra, S., Chen, S., Gogolishvili, D., Globerman, J., Chambers, L., . . . Rourke, S. B. (2016). Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ*, 6(7); DOI:10.1136/bmjopen-2016-011453, e011453.

- Ruiz-Navia, A. M., Enríquez-Lara, S. L., & Hoyos-Hernández, P. A. (2009). Adherencia al tratamiento en niños y niñas con VIH. *Pensamiento Psicológico*, 5(12), 175-190.
- Slobodskaya, H., Akhmetova, O., & Rippinen, T. (2014). Does personality matter more in difficult circumstances? *Journal of Research in Personality*, 48. DOI:10.1016/j.jrp.2013.10.005, 33-44.
- South to South. (2010). *Disclosure process for children and adolescents living with HIV: A practical guide*. Retrieved from http://www0.sun.ac.za/southtosouth/toolkits/aps/trainingmaterial/Disclosure%20Process%20for%20Children%20and%20Adolescents%20Living%20with%20HIV_Participant%20Manual.pdf.
- Trejos Herrera, A. M., Alarcón Vásquez, Y., Reyes Ruíz, L., & Bahamón, M. J. (2017). ¿Por qué no se revela el diagnóstico a los niños y niñas seropositivos para VIH/SIDA? Factores asociados a la revelación y no revelación en Cuidadores y Profesionales de la Salud. En A. M. Trejos Herrera, L. Reyes Ruíz, Y. Alarcón Vásquez, M. J. Bahamón, O. González Gutiérrez, G. G. Gaviria García, & A. J. Acosta Hoyos, *El derecho de los niños y las niñas a conocer su diagnóstico de VIH/SIDA: la revelación del diagnóstico a través del modelo clínico "DIRÉ"* (pág. 53). Barranquilla, Colombia: Ediciones Universidad Simón Bolívar.
- Trejos, A., Tuesca, R., & Mosquera, M. (2011). Niñez afectada con VIH/SIDA: Uso y acceso a Servicios de Salud en cinco ciudades colombianas. *Revista Salud*, 27, 2.
- UNAIDS. (2018). *Fact Sheet - July 2018 - 2017 global HIV statistics*. UNAIDS.
- UNESCO. (2011). *International Standard Classification of Education (ISCED)*. Recovered from <http://www.uis.unesco.org/Education/Documents/isced-2011-en.pdf>.
- Vera-Villarroel, P., Contreras, D., & Valtierra, A. (2016). Affectivity as mediator of the relation between optimism and quality of life in men who have sex with men with HIV. *International Journal of Clinical and Health Psychology*, Volume 16, Issue 3. Doi: <https://doi.org/10.1016/j.ijchp.2016.07.001>, 256-265.
- Wiener, L., Mellins, C. A., Marhefka, S., & Battles, H. B. (2007). Disclosure of an HIV diagnosis to children: History, current research, and future directions. *Journal of Developmental and Behavioral Pediatrics*, 28(2) <https://doi.org/10.1038/jid.2014.371>, 155-166.
- Willis, N., Mavhu, W., Wogrin, C., Mutsinze, A., & Kagee, A. (2018). Understanding the experience and manifestation of depression in

- adolescents living with HIV in Harare, Zimbabwe. *Plos One*, 13; DOI:10.1371/journal.pone.0190423, e0190423.
- World Health Organization. (2011). *Guideline on HIV disclosure counselling for children up to 12 years of age*. Retrieved from: <http://apps.who.int/iris/bitstream/10665/44777/1/978924150>.
- World Health Organization. (2017). *HIV/AIDS data and statistics*. Accessed at: <http://www.who.int/hiv/data/en/>. (December): World Health Organization.