The Correlation between Social Support and Disease Shame among Elderly AIDS Patients and Evaluation of Intervention Effects

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Abstract: With the acceleration of population aging and the continued risk of HIV transmission, the number of elderly AIDS patients increases year by year. Their physical and mental health and social adaptation problems are becoming more prominent. The elderly group has both age and disease disadvantages. They face unique social and psychological challenges. It is urgent to pay attention to the inner connection between social support and disease shame and to explore effective intervention strategies. Based on defining the core concepts of elderly AIDS patients, social support, and disease shame, this paper combines social support theory and disease shame theory to systematically analyze the current situation of social support and disease shame among elderly AIDS patients. It also discusses the interaction between the two. The study finds that the level of social support has a significant negative impact on disease shame. Emotional support, informational support, and instrumental support are key elements that help relieve disease shame. At the same time, disease shame weakens patients' social support systems, leading to self-isolation, reduced willingness to seek support, and insufficient use of available support. In terms of intervention effect evaluation, the study analyzes at three levels: individual, family and social support system, and medical and social environment. It finds that cognitive behavioral intervention, psychological support, family care guidance, peer group building, elderly-friendly medical services, and public awareness education can effectively improve the level of social support and reduce disease shame. The conclusion emphasizes that it is necessary to build a multidimensional and systematic intervention system. It should integrate individual, family, social, and medical resources to improve the quality of life of elderly AIDS patients and promote their social integration.

1. Introduction

1.1. Research Background

With the wide use of effective antiretroviral therapy, AIDS has changed from a fatal disease to a controllable chronic disease. The life expectancy of patients has been greatly extended. Aging has become a new trend in global AIDS prevention and treatment. Due to changes in physical function, slow knowledge renewal, and weak awareness of prevention, the infection rate among the elderly continues to rise worldwide. The number of elderly AIDS patients, who are a double disadvantaged group, keeps increasing. Compared with young patients, elderly AIDS patients face more complex physical, psychological, and social problems. They need to deal with chronic comorbidities caused by aging and bear a heavy mental burden and stigma caused by HIV infection. Social support is a key factor affecting the physical and mental health of chronic disease patients. It is especially important for elderly AIDS patients. Because of social misunderstanding, fear, and deep-rooted age discrimination, this group often lacks enough social support. They usually suffer from both internalized and externalized disease shame. This seriously restricts treatment adherence and the improvement of life quality. It is urgent to study the inner link between social support and disease shame among elderly AIDS patients and to evaluate the effects of related intervention strategies. This has real and practical value for optimizing health outcomes in this special group.

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1.2. Research Significance

This research has theoretical and practical value. Theoretically, in combination with the theory of social support and the theory of disease shame, the interaction mechanism between the two in elderly AIDS patients is explored. It has expanded the research fields of medical sociology and geriatric nursing, and provided a new analytical framework and theoretical basis for understanding the socio-psychological factors in the management of chronic diseases. In practical application, the research results have direct application value. Find out the key intervention points by analyzing the relationship between social support and disease shame. It provides empirical evidence for medical institutions and communities to design targeted psychosocial support programs. It scientifically evaluates interventions at the individual, family and social levels. It helps to identify effective strategies, such as cognitive behavioral therapy, home nursing guidance and public education. This helps to optimize the use of limited medical and social resources. Improve the mental health, treatment confidence and quality of life of elderly AIDS patients by improving social support and reducing the shame of the disease. It also promotes a more inclusive and friendly social environment and supports the goal of "healthy aging".

2. Definition of Core Concepts and Theoretical Basis

2.1. Definition of Core Concepts

2.1.1. Elderly AIDS Patients

In this study, “elderly AIDS patients” refers to individuals over 60 years old who are medically diagnosed as HIV carriers or have developed AIDS. This group has dual particularity. First, they face the physical, psychological, and social challenges caused by HIV, such as weakened immunity, side effects from long-term medication, and severe social discrimination. Second, they are in old age and face problems caused by aging, such as physical decline, chronic diseases (like hypertension and diabetes), cognitive decline, and social role change after retirement, which brings loneliness and economic pressure. These two dimensions of challenges interact and form a unique “disease and aging” dilemma. They differ greatly from young AIDS patients in medical needs, care methods, psychological adaptation, and social support. They are a special vulnerable group that requires urgent attention.

2.1.2. Social Support

Social support means the various supportive resources that individuals can gain from their social relationship networks to enhance adaptation and well-being [1]. According to its content and form, this study focuses on three dimensions. The first is emotional support, which includes care, sympathy, listening, and understanding from family, friends, medical staff, or peers. It meets needs for belonging and respect and helps relieve psychological stress. The second is informational support. It refers to advice, knowledge, and guidance about disease management, medical resources, and welfare policies. It helps patients make wise decisions and solve problems effectively. The third is instrumental support, also called material support. It includes direct material help, financial assistance, or practical help such as accompanying medical visits and daily care. For elderly AIDS patients, a sound and multidimensional social support system is a protective factor that maintains treatment adherence, reduces disease shame, and improves quality of life.

2.1.3. Disease Shame

The theory of sick shame comes from Goffman's stigma theory. This study refers to the shame, guilt and inferiority complex caused by the negative labels, stereotypes and discrimination of elderly AIDS patients who are infected with the virus [2]. There are two main forms: one is perceived stigma, that is, the patient's premonition or experience of exclusion and discrimination from family, community and medical institutions; the other is internalization stigma, that is, patients accept negative social concepts and internalize them into self-evaluation, leading to self-deprecation, self-esteem decline and identity distress. This kind of psychological torture is often more serious than

physiological symptoms, which is the key reason why patients delay medical treatment, conceal the disease, have psychological disorders and cut off social support.

2.2. Theoretical Basis

2.2.1. Social Support Theory

Social support theory states that a sound social network provides diverse resources that help individuals cope with stress and maintain health. Its core mechanisms include the “stress-buffering model” and the “main effect model.” [3] The stress-buffering model shows that social support can buffer the impact of stress events, such as HIV diagnosis, on health. Emotional support helps reduce the psychological shock after diagnosis. Instrumental support helps with financial and life difficulties caused by treatment. The main effect model means that social support itself promotes well-being by meeting belonging needs and improving self-esteem, regardless of stress. In this study, the theory helps explain how elderly AIDS patients get emotional, informational, and instrumental resources from their social networks and how these resources help them cope with both disease and aging pressures. It also provides the theoretical basis for building multi-level social support interventions.

2.2.2. Disease Shame Theory

This study mainly refers to the model of disease shame proposed by Link and Phelan. The model defines stigma as a process that includes four key elements: labeling (linking the elderly with AIDS), stereotypes (linking AIDS with immoral behavior), social exclusion (distinguishing between "we" and "them"), and loss of status/discrimination [4]. The theory shows that disease shame is not inherent in disease, but a strong result of social construction. For elderly AIDS patients, age discrimination and disease stigma complement each other and exacerbate their marginalization. The theory explains the social and cultural roots of the shame of the disease and its manifestations, such as self-isolation and concealment of the disease when seeking treatment. More importantly, it shows how the shame of illness destroys the social support system. The patient was afraid of losing his status and being discriminated against, so he concealed his illness and withdrew from social relations. This limits their opportunities for social support, creating a vicious circle. This theory provides an in-depth analysis tool for understanding and intervening in the socio-psychological difficulties of patients.

3. Current Situation of Social Support and Disease Shame among Elderly AIDS Patients

3.1. Current Situation of Social Support for Elderly AIDS Patients

3.1.1. Main Sources of Social Support

The social support system of elderly AIDS patients shows a structure that is simple and limited in source. Family assistance forms the most central and stable support. This help mainly comes from spouses and children in daily care, emotional comfort, and partial financial support. Such support is often based on hiding the illness or keeping silent among family members. Its stability is easily affected by the family’s understanding and acceptance of the disease.

Official and institutionalized support is another key source. It mainly comes from staff of the Centers for Disease Control and Designated Hospitals. They provide professional medical information, medication guidance, and regular follow-ups. This support is vital for patients to gain scientific treatment and survival confidence. But such support is mostly limited to the medical setting, and relationships are defined by clear professional boundaries.

Peer assistance is becoming a new but still weak force. Support groups organized by the CDC or social organizations create a safe and open space for elderly patients to talk honestly. It helps reduce loneliness. Only a small number of patients receive scattered assistance from communities or non-governmental organizations. Such support has a small coverage, poor continuity, and often faces barriers from social prejudice. The social support network of elderly AIDS patients is narrow, overly dependent on family and the medical system, and lacks informal social interactions and assistance.

3.1.2. Main Problems and Deficiencies in Social Support

The social support network of elderly AIDS patients faces obvious defects and structural shortcomings. The main challenge is that the support channels are too limited and unstable. Due to strong disease shame, patients often isolate themselves from their original social relationships. This cuts off informal support from friends, colleagues, and community members almost completely. The support system depends too much on family. Once family conflict or breakup occurs after disclosure of illness, the patient quickly falls into a situation without help.

Support resources are unevenly distributed. Current assistance focuses on “medical care” and basic “material security,” while emotional comfort and dignity protection are seriously lacking. Family members and medical staff focus more on medication adherence and physical status. They often ignore the multiple psychological needs caused by aging and illness, such as depression, anxiety, and low self-worth. There is a lack of emotional interaction and dignity protection.

The support network shows a knowledge gap. Both family members and community workers often lack understanding of AIDS and elderly AIDS. This causes unintentional prejudice, overprotection, or improper care during support. It even increases the psychological stress of patients. Formal support systems show a tendency to “ignore aging.” Current AIDS care policies and service models are designed for the general population and do not fully consider the special needs of the elderly, such as integrated management of multiple chronic diseases, home visits for those with limited mobility, and counseling suited to elderly psychology. These problems seriously affect the accessibility and effectiveness of services.

3.2. Current Situation of Disease Shame among Elderly AIDS Patients

3.2.1. Main Forms of Disease Shame

The shame of the disease in elderly AIDS patients shows complex and lasting characteristics. It can be divided into several dimensions. The first is the internalized sense of self-stigma. Patients absorb and internalize the negative labels of AIDS in society, resulting in a strong sense of shame, guilt and self-blame. They often think of themselves as "unclean", "immoral" or "disgraceful to the family". Their sense of self-worth declined sharply, accompanied by self-hatred and depression [5]. The second is the fear and isolation in interpersonal relationships. For fear of discrimination and exclusion, patients often keep their condition secret. They keep a distance from their relatives and friends, avoid family gatherings and community activities, and live in a closed space. During the visit, they hid their condition or true feelings for fear of being judged. The third is the perceived shame and prejudice. Even if they are not directly discriminated against, patients can still feel the strange eyes and private discussions of others. This expected fear makes them anxious and alert in social situations. The fourth is the institutional stigma. Some staff in non-communicable hospitals experience avoidance, refusal or overprotection in the course of medical treatment. When applying for a nursing home, patients will be denied admission because they are HIV positive. These experiences increase the feeling of being ostracized by society. For the elderly, the shame of the disease is also associated with the shame of "senile sex", which makes it more difficult to talk about the disease. They are under both mental and physical pressure.

3.2.2. Main Causes of Disease Shame

The strong sense of disease shame in elderly AIDS patients is the result of the interaction of many factors. Its social and cultural roots are the root cause. Since the discovery of AIDS, people have been associated it with negative labels such as "sexual disorder", "drug use" and "immoral behavior". The long-term shame deeply rooted in society has formed the background of disease shame. Age discrimination and social restrictions on the sexual behavior of the elderly are the catalysts. It is generally believed that the elderly should not or should not have an active sex life. This stereotype refers to elderly AIDS patients, especially those infected with AIDS through sexual transmission, as "indecent old people" or "morally corrupt people". Compared with young patients, they face stronger moral criticism and a heavier psychological burden. Third, lack of understanding and fear of diseases are the main driving factors. The public and even the families of patients still lack awareness that

AIDS is a preventable and controllable chronic disease. They still regard it as a "super plague" or a "deadly disease". Misconceptions about transmission, such as the fear of accidental contact, can lead to excessive fear and exclusion. Fourth, some life experiences are intrinsic triggers. Many elderly patients get infected after losing a spouse or feeling lonely, seeking sexual services, or starting a new relationship. Their behavior conflicts with their traditional moral beliefs, leading to guilt and self-disgrace. The response from their support system reinforced this point. Shock, blame, alienation from family members, or improper handling by medical staff all directly confirm and aggravate the patient's shame of the disease. This turns social concepts into personal painful experiences.

4. Correlation Analysis between Social Support and Disease Shame in Elderly AIDS Patients

4.1. Negative Impact of Social Support on Disease Shame

4.1.1. Emotional Support

Emotional support is the most direct and effective "buffer mechanism" for elderly AIDS patients to relieve the shame of the disease. Its core sources include unconditional acceptance from the family, companionship and understanding from partners, and sympathy and comfort from medical staff and peers [6]. When patients feel care, importance and respect in intimate relationships instead of being blamed, the internalized sense of self-stigma, such as "I'm guilty" or "I'm worthless", can be effectively reduced.

A warm hug from family or words like “Do not worry, I will stay with you” can directly relieve patients’ fear of being abandoned by family and reduce shame. Respectful and unbiased attitudes from medical staff convey an important message: “You are a patient who needs treatment, not a morally flawed person.” This helps patients redefine their identity from “AIDS patient” to “ordinary person receiving treatment.” Peer support groups provide a unique platform for emotional expression and sharing experiences. When patients realize their struggles are not unique, feelings of loneliness and alienation decrease, which reduces disease shame. Sufficient emotional support rebuilds self-esteem, belonging, and emotional security, directly removing the psychological soil in which disease shame grows.

4.1.2. Informational Support

Informational support reduces disease shame by enhancing patients’ sense of control and certainty. Elderly AIDS patients generally lack in-depth knowledge of the disease. They are easily influenced by false information and traditional prejudices. Professional, accurate, and timely information from medical staff, including health education, detailed explanation of treatment plans, and objective prognosis assessment, helps patients understand AIDS as a controllable chronic disease. It breaks the fear of “death sentence” and “plague.” When patients clearly understand virus transmission, the scientific consensus of U=U (undetectable = untransmittable), and expected lifespan under proper treatment, excessive fear and self-blame caused by ignorance are greatly relieved.

Informational support also guides patients on how to face discrimination and disclose their illness. This enhances their ability to cope with negative social evaluations and reduces helplessness. Learning about other patients’ successful disease management through narratives provides hope and examples, weakening the special stigma of the disease. Informational support gives patients knowledge and skills, helping them reconstruct their understanding of the disease. They shift from passive and fearful victims to active and capable managers, rationally breaking down disease shame.

4.1.3. Instrumental Support

Instrumental support indirectly alleviates the shame of the disease by solving the urgent practical problems of patients. Such support includes financial assistance, daily care (such as shopping, cooking, cleaning), and medical visits and medication assistance. For many elderly patients, especially those who suffer from physical decline or economic difficulties due to illness, real-life stress and disease stigma are intertwined. Economic difficulties increase the guilt of "becoming a burden to the family". Inconvenient mobility or inability to take care of oneself strengthens the feeling

of "uselessness" and "abandoned by society". Timely and effective tools support to directly reduce the pressure of survival. It makes patients feel that social care continues despite illness. They are still members of the social support network.

For example, community medical services solve the problem of medical treatment and convey the message that "society has not abandoned you". When basic life needs are met, patients can shift their psychological resources from "survival anxiety" to "psychological adjustment". This strengthens their ability to cope with and resist the shame of the disease. Instrumental support is the pillar of maintaining the dignity and quality of life of patients. Its stability provides solid material and psychological support against shame disease.

4.2. Erosive Effect of Disease Shame on Social Support Systems

4.2.1. Self-Isolation

Social exclusion makes elderly AIDS patients choose to self-isolate. This hinders the formation of the social support system. Fearing that disclosure will result in prejudice, exclusion or moral condemnation, patients have formed strict "confidentiality" and "retreation" behaviors. They deliberately reduce or completely stop interacting with old friends, former colleagues and neighbors. They withdraw from community activities and interest groups and confin themselves to home or personal space.

This kind of behavior is a kind of psychological self-protection. Patients try to avoid possible social exclusion through preemptive isolation. The negative impact is destructive. Support from informal social networks such as friends and communities has almost disappeared. Patients can only rely on a formal medical system. Isolation limits emotional comfort, increases loneliness and depression, and forms a vicious circle. The stronger the sense of loneliness, the more negative the social perception and the deeper the sense of shame. And the heavier the sense of shame, the more the individual is afraid to contact the outside world. The degree of isolation is getting more and more serious, and patients seem to have built an invisible "island" by themselves and voluntarily give up the possibility of obtaining diversified social support.

4.2.2. Reduced Willingness to Seek Support

Strong disease shame reduces the willingness of potential supporters, especially family members, to help. Family members are often shocked, angry, frustrated and ashamed if the route of infection (such as extramarital sex or homosexuality) conflicts with family beliefs. The patient's shame of the disease will spread to family members, causing "related shame" or "family shame". Family members may feel embarrassed and ashamed in front of their neighbors and friends. Emotionally, their willingness to support is greatly reduced. Even if they fulfill their basic care duties, they may become emotionally alienated, indifferent, or verbally picky. Some very conservative families may take extreme exclusionary measures, such as refusing to live together or stopping financial support. Even close partners may be hindered by fear and distrust after learning the truth. The shame of the disease is like a corrosive agent, destroying the foundation of "love and acceptance" in the family. A home that should be warm becomes cold, full of contradictions and hostility. The willingness and level of support provided by the system have dropped sharply.

4.2.3. Reduced Utilization of Support

Even if support systems exist and are willing to help, disease shame causes patients to reject or reduce acceptance of support. This lowers support utilization. This phenomenon has two main psychological roots. The first is “feeling unworthy.” The second is “fear of disclosure.” Patients suffering from self-stigma often believe they are “impure” or “a burden to the family.” When family or society offers help, they feel guilt and anxiety. They refuse support, thinking they are “not qualified” to receive care. Seeking support risks revealing illness and needs. For example, patients may refuse home check-ups due to fear of disclosure. They may reject children’s suggestions to accompany medical visits to avoid revealing test schedules. They may hide real physical or mental discomfort from doctors because of shame.

As a result, they cannot get targeted medical support. This “support utilization barrier” leaves valuable resources unused. Patients’ needs are unmet. The social support network may appear complete, but the actual support reaching patients is minimal. Disease shame acts like a valve, blocking the flow of support. Even within the network, patients feel isolated and helpless, trapped in the situation of “having support but unable to use it.”

5. Evaluation of Intervention Effects on Social Support Levels and Disease Shame in Elderly AIDS Patients

5.1. Individual-Level Intervention Effects

5.1.1. Effect of Cognitive Behavioral Intervention on Disease Shame

Cognitive behavioral intervention has been outstanding in reducing the sense of shame in elderly AIDS patients. The focus of the intervention is to assist patients in identifying and questioning irrational concepts and automatic negative ideas related to disease, such as "AIDS means the complete end of life" or "everyone will discriminate against me", with the help of structured training , guide patients to build a more realistic and positive cognitive framework. AIDS is regarded as a "controllable chronic disease" rather than a "punishment of moral defects" [7]. The intervention covers behavioral experiments, prompting patients to gradually practice self-expression and social interaction in a controlled situation. Evidence shows that there is a lack of basis for catastrophic prediction. The assessment results reveal that patients who have undergone systematic intervention have internalized the sense of disease shame. The score of the scale decreased significantly. With the improvement of the level of self-recognition, the symptoms of depression and anxiety can be alleviated, and patients are more likely to separate the disease from personal values, reduce self-reproachment, fundamentally shake the intrinsic psychological foundation of the sense of shame, and improve psychological resilience.

5.1.2. Effect of Psychological Support Intervention on Social Support Utilization

Psychological support intervention, humanistic therapy and motivational dialogue can significantly improve the acceptance and application of social support by elderly patients [8]. Such interventions focus on building trust and empathetic treatment connections, creating an absolutely safe emotional expression environment for patients to cope with the fear and shame caused by anxiety and exclusion. , during the intervention. The therapist will work with the patient to analyze the psychological root cause behind the refusal of support (such as the perception of "not being helped") and strengthen their willingness and ability to actively obtain and accept assistance. The effect evaluation shows that elderly patients who participate in psychological support interventions have significant scores in the "social support utilization" assessment tool. Growing up, they are more inclined to confide their inner feelings to trusted relatives or friends. More actively consult medical professionals about their health status and begin to explore the use of community service resources. This transformation helps to break the "self-isolation" model caused by the sense of disease and shame, and promote the existing social support system to give full play to its role, thus forming a positive support interaction mechanism.

5.2. Family and Social Support System Intervention Effects

5.2.1. Effect of Family Care Guidance on Emotional Support Provision

Providing professional care and counseling to family members can greatly improve the emotional support in the family. Fear and misunderstanding can be alleviated by teaching the families the fundamental knowledge of AIDs, mode of transmission, and improvements in the treatment. It also teaches them the skills of non judgmental communication and emotional support. This helps members of the family be more aware of the psychological hurdles of the patients, alleviate cruel or uncaring attitudes and seek to offer meaningful companionship and acceptance. Assessments show that the families receiving counseling have improved in function and intimate relationships. Their support has changed from basic tasks, such as preparing meals or delivering medicine, to high-quality emotional

support, such as listening, encouraging and respecting. A supportive family environment becomes a solid foundation for patients, meets the core emotional needs, and significantly alleviates the negative impact of shame[9].

5.2.2. Effect of Mutual Aid Groups on Expanding Social Support Networks

The establishment of a mutual aid organization for elderly AIDS patients plays a key role in expanding the social support system [10]. The organization provides patients with a social space full of a sense of belonging and trust. In the collective, members can exchange experiences, exchange information, and comfort each other. This kind of "empathy" of empathy can significantly alleviate individuals. The sense of loneliness and alienation. The effectiveness assessment shows that the social support evaluation of patients participating in mutual aid organizations has made the most outstanding progress at the level of "friendly support". Collective activities have built new social ties and enhanced members' self-esteem and self-control with the help of group empowerment. Many members have changed from passive recipients to active helpers. This conversion itself is an effective means to fight the sense of shame. Mutual aid organizations have successfully created a "spiritual harbor" for patients that transcends family boundaries and is full of understanding and support.

5.3. Medical and Social Environment Intervention Effects

5.3.1. Effect of Elderly-Friendly Medical Services on Medical Experience

Advocating the elderly-friendly medical model can significantly optimize the patient's medical experience and reduce the burden of illness in the medical environment. Such intervention measures include improving the medical procedures (providing integrated services, shortening the waiting time), adjusting the spatial layout (equipped with warm seats, clear guidelines), and carrying out for the medical team Special training. Focusing on eliminating prejudice, maintaining personal privacy, using respectful language and patient communication, the effectiveness evaluation is carried out with the help of patient satisfaction questionnaires and sickness evaluation tools. The results show that patients who receive elderly-friendly services have a higher degree of trust in medical institutions, and the anxiety and shame related to diagnosis and treatment are significantly alleviated. When patients are in the whole Feel respected and cared for in the process of individual consultation. Instead of being scrutinized and treated indifferently, the medical system itself can be transformed from a potential stigmatization site to a key supporting force, thereby improving the treatment cooperation and confidence of patients.

5.3.2. Effect of Public Education on Reducing Social Discrimination

Systematic public education is a core measure to reduce social prejudice and improve the support environment. Through media, community activities, and school education, accurate scientific information about AIDS transmission, U=U (undetectable = untransmittable), and antiretroviral treatment effects is disseminated. Education also promotes anti-discrimination attitudes toward infected groups, especially elderly patients. Effectiveness is measured using pre- and post-intervention surveys. Continuous and broad education significantly corrects public misconceptions and rigid beliefs about AIDS. Fear and moral condemnation decrease. Social exclusion reduces. This directly reduces the external stigma patients perceive. Patients are better able to integrate into society and access help from diverse social networks. Public education creates favorable conditions for reducing individual disease shame.

6. Conclusion

This study systematically reviews the intervention effects on the correlation between social support and disease shame in elderly AIDS patients. The following conclusions are drawn:

Elderly AIDS patients' sense of shame and social support show an obvious negative correlation. Improving the level of social support can effectively reduce patients' sense of shame. Among them, emotional, information and instrumental support all play a key role. Emotional support alleviates the

psychological burden by strengthening patients' self-identity and group belonging. Information support helps patients understand the disease scientifically. Avoid fear and shame caused by lack of cognition; Instrumental support reduces the pressure of patients' lives and reduces their dependence on the outside world by providing practical assistance. In addition, the sense of shame will destroy the social support network, make patients self-end, weaken the willingness of others to provide support, and reduce the patient's acceptance of social support. Finally form a negative cycle.

In the improvement of the psychological state and social support network of elderly AIDS patients, intervention measures have shown a significant role. Cognitive behavioral intervention and psychological support can effectively reduce the sense of shame at the individual level and improve the patient's ability to apply social support. The intervention of the family and social support system enhances family care and builds mutual aid groups. , greatly improve the acquisition of emotional support. Broaden the social support network; interventions at the medical and social environmental levels use elderly-friendly medical services and public education to optimize patients' medical experience, reduce social prejudice, and create an inclusive external environment for patients.

In order to improve the social support status of elderly AIDS patients and reduce their sense of shame, it is necessary to adopt multi-angle and multi-gradient intervention methods. In the future, we should continue to integrate the social resources of individuals, families and medical systems, build a comprehensive support network, and provide more humanistic care and professional services for elderly AIDS patients, so as to promote the improvement of their physiological and psychological well-being and social participation.

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