Relationship Between HIV and Depressive Symptomatology in Patients From Northern Portugal: Analysis of Individual, Health, and Social Predictors

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Depression is the most prevalent mental disorder in people living with HIV. Our study involved 371 participants in outpatient treatment for HIV in hospitals in northern Portugal. Participants were referred to the study by the attending physician/nurse, and data were collected through an individual interview at a single evaluation moment. Participants were mostly male (70%), with an average age of 46.63 years (SD = 11.77), and a known diagnosis of HIV for an average of 10.13 years (SD = 6.42). Severe depressive symptoms were identified in 18% of participants.

We identified several significant predictors of depressive symptoms: being female, being in a situation of social exclusion, having adverse experiences throughout life, infection by sexual contact in a stable marital relationship, daily concerns regarding health, negative family relationships, and dissatisfaction with social support. Findings suggest the need to include regular mental health assessments and referral for specialized psychological support services.

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HIV, like other life-threatening diseases (e.g., cancer and cardiovascular disease), has major physical and psychological implications for patients and those in their social networks. Living with HIV entails physical complications of the disease and the possibility or inevitability of death, but also the possibility of disruptions in relationships with their families, friends, neighbors, co-workers, or anyone who learns of the diagnosis (Derlega & Barbee, 1998). Although social, economic, and ethnic contexts may affect the way HIV is handled, most, if not all, patients face various societal challenges including disclosure of diagnoses, coping with possible rejection or disapproval, dealing with the disease itself, finding a new meaning for life, and continuing life as normally as possible, even if this causes a breakdown in social interactions and relationships (Derlega & Barbee, 1998).

Indicators of mortality due to HIV have undergone major changes since the appearance of highly effective antiretroviral therapy (ART) in 1996, particularly in countries where it is most accessible (Joint United Nations Programme on HIV/AIDS, 2016). Still without a cure, HIV infection is now treatable and poses new challenges for infected people,
professionals, and society in general (Seidl, Rossi, Viana, de Meneses, & Meireles, 2005). Living with HIV is more than living with a chronic condition; it is a long-term condition that simultaneously entails social and psychological problems.

Depression is the most prevalent psychiatric disorder of people living with HIV (PLWH; Curran et al., 2011; Pyne et al., 2008; Rabkin, 2008; Rodkjær et al., 2011; Sherr, Clucas, Harding, Sibley, & Catalan, 2011; Taniguchi, Shacham, Onen, Grubb, & Overton, 2014; Vance, Moneyham, & Farr, 2008), with an estimated variable prevalence between 21% and 97% (Eller, 2006). Although studies have found different prevalence rates, depending on factors such as the diagnostic criteria used and the method followed in each one, it is estimated that more than 60% of PLWH have a significant depressive episode during the course of the disease (Pyne et al., 2008; Taniguchi et al., 2014).

A systematic review of the literature with 27 studies about the mental health of PLWH in Africa reported a prevalence of depression between 20% and 35% (Brandt, 2009). In Ethiopia, a study of 740 patients with HIV revealed depression rates of 45.8% (Mohammed, Mengistie, Dessie, & Godana, 2015). A study of 272 adults who started treatment with ART estimated a prevalence of depression between 33% and 38% (Yeji et al., 2014), while another study with 400 patients with HIV concluded that one in five participants met the criteria for depression throughout life, and 7% during the year prior to data collection. About two-thirds of participants with depression in the year prior to data collection had severe or very severe episodes. The number of depressive episodes and symptoms related to HIV was a significant predictor of depression in the previous year (Gaynes et al., 2012). A study of 130 patients living with HIV in Nigeria estimated a prevalence of depression of 23.1%, of which 46.7%, 50%, and 3.3% respectively, had low, moderate, or severe depression (Obadeji, O Ogunlesi, & O Adebowale, 2014).

PLWH are twice as likely to develop depression compared to the general population (Prachakul, Grant, & Keltner, 2007), and this probability is higher in women (Rabkin, 2008) than in the general population (Bromet et al., 2011). In one study, a higher risk of depression was significantly associated with females and with suicidal thoughts and/or attempts; no association was found between marital status and duration of diagnosis (Obadeji et al., 2014). In addition, experience of life-threatening adverse events has also been described as a predictor of depression in PLWH (Ollel, Seedat, & Nei, 2004). Conversely, another study concluded that being male and having low social support were significantly associated with depression (Mohammed et al., 2015).

Kagee and Martin (2010) found that many patients exhibited stress symptoms related to HIV infection, such as decreased energy levels and feelings of hopelessness. According to these authors, symptoms and feelings of hopelessness may have been related to the combination of illness and living in poverty. For example, excessive levels of concern about various domains of life may be the result of worrying about physical decline, access to treatment, incapacity for work, and consequent financial implications (Kagee & Freeman, 2008). Thus, it is likely that HIV is not the only stressor for mental health problems; living in poverty, poor living conditions, unemployment, gender inequality, and family problems may influence this condition (Kagee & Freeman, 2008).

Scientific research has identified other psychosocial factors related to depression in seropositive people. A study of 177 HIV patients in Florida concluded that gender moderated the relationship between depressive symptoms and adaptive coping (Henry, 2016). Optimism, social support, avoidance, alcohol consumption, and perceived stress partially mediated the relationship between negative events and depressive symptoms. Alcohol consumption predicted higher levels of depressive symptoms over time for women (Henry, 2016).

Both diagnosable psychiatric disorders and symptoms of subliminal psychological distress can have a negative effect on quality of life, family function, and adherence to ART (Kagee & Freeman, 2008). In a qualitative study of stress and coping strategies in PLWH, Lopes and Fraga (1998) found that the reactions of depression, sadness, and fear of dying were the most reported. These findings agreed with those of Grilo (2001), who proposed that depression appeared precisely when the severity of the illness became more evident. At that stage, typical reactions of a depressive disorder often appeared, including general disinterest, isolation, inertia, nonperformance
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