

## Persistence of psychiatric disorders in a cohort of HIV/AIDS patients in South Africa: A 6-month follow-up study

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Received 24 June 2005

### Abstract

**Background:** Psychiatric disorders in HIV/AIDS are common, emerging soon after diagnosis or during the subsequent course of illness. However, there are few prospective studies on the rates of psychiatric disorders in HIV/AIDS, particularly in the context of the developing world. **Methods:** Sixty-five patients with recently diagnosed HIV were interviewed on presentation to a hospital-based HIV clinic and then 6 months later. On both interviews, the patients were assessed using the MINI International Neuropsychiatric Interview, the Carver Brief COPE, and the Sheehan Disability Scale. Exposure to negative life events and risk behaviors was also evaluated. **Results:** The overall prevalence of psychiatric disorders in the follow-up period remained high (56% of patients had at least one psychiatric disorder at baseline, and 48% of patients had at least one psychiatric disorder at 6 months). Depression and posttraumatic stress disorder (PTSD) were the most prevalent disorders at both baseline (34.9% and 14.8%) and follow-up (26% and 20%), respectively. More than half of all patients with depression at baseline improved (16 of 29; 55.1%). However, there was a new onset of both depression (4 of 49; 8.1%) and PTSD (12 of 17;

70.5%) on follow-up. In univariate analysis, depression on follow-up was significantly associated with: (a) disability in work/social/family functioning, (b) greater number of negative life events, and (c) a decline in CD4 lymphocyte count. Univariate analysis also revealed that a diagnosis of PTSD on follow-up was significantly associated with (a) a longer duration of infection and (b) baseline disability in work/social/family functioning. However, in multivariate analysis, only disability scores predicted the diagnoses of major depression and PTSD on follow-up assessment. Persistence of risky sexual behaviour was also noted, with a significantly higher number of participants reporting nonuse of condom on follow-up. There appeared to be a shift from maladaptive coping behaviors to more adaptive coping behaviors over the 6-month period. **Conclusion:** The rate of psychiatric disorders in HIV/AIDS patients was consistent over time. These findings emphasize the importance of regular evaluation for psychiatric disorders in HIV/AIDS patients, not only at the commencement of treatment but also during subsequent follow-up visits.

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**Keywords:** HIV/AIDS; South Africa; Psychiatric morbidity; Follow-up

### Introduction

While several studies have demonstrated high levels of psychiatric morbidity [1], especially depressive disorders [2], in HIV/AIDS in cross-sectional samples, few have

examined longitudinal stability or change over time. Findings of change in, or persistence of, psychiatric morbidity in HIV/AIDS have been mixed [3–11]. While some studies have found a modest increase in anxiety and depression on follow-up [3–5], other studies have found diagnostic status to be stable over time [6,7]. For example, in a recent national survey in the United States, Tsao et al. [4] found a declining prevalence of psychiatric disorders, including major depression, over 6 months in a nationally

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representative cohort of HIV/AIDS patients, using data from the HIV Cost and Service Utilization Study. However, major depression persisted across time in a subsample of patients, with a high baseline HIV symptom count and with a growing number of HIV symptoms increasing the likelihood of persistence and the development of new cases. Similarly, Joseph et al. [6], in the Chicago Multicenter AIDS cohort study group, found stable scores on self-rating scales of depression on six semiannual occasions despite illness progression. Across studies, the heterogeneity of HIV/AIDS samples may, to some extent, account for such inconsistent findings.

Several factors may predict the course of psychiatric disorders in HIV/AIDS. Stressful experiences may impact on the course of depression and anxiety, although data in this regard are inconsistent [12–14]. Conversely, there is some evidence of a relationship between perceived sufficiency of social support and improvement of depression in HIV/AIDS [6–8]. There have also been reports of a relationship between persistent depression and dysfunctional coping styles, such as denial or venting of emotion [12–16].

In this paper, we examine the potential effects of clinical and psychosocial factors on the stability of psychiatric diagnosis over 6 months in a cohort of HIV/AIDS patients. It has been suggested that antiretroviral treatments may improve the course and prognosis of psychiatric disorders in HIV/AIDS [17]; however, at the time that this study was performed, antiretrovirals were not available to the sample under study.

## Methods

### *Procedure*

One-hundred forty-nine patients (44 males, 105 females) with recent knowledge of their serostatus [months since diagnosis (mean±S.D.)=5.8±4.1] were recruited at the Infectious Diseases Clinic at Tygerberg Hospital (Cape Town, South Africa). Baseline data were collected between September 2002 and February 2003. Collection of follow-up data commenced in August 2003. Diagnostic interviews were conducted by two researchers (a doctoral-level clinical psychologist and a master's-level research psychologist) after interrater reliability had been established in the administration of the MINI International Neuropsychiatric Interview (MINI) [18]. On follow-up, patients were seen first by their treating physicians and thereafter interviewed by the same researchers who had conducted baseline assessment. Interviews lasting approximately 75 min were conducted in private.

We report on follow-up data that formed part of a prospective study. A full description of study methodology, recruitment procedures, and baseline psychiatric status of participants has been provided elsewhere [18].

### *Measures*

Data collection followed the same procedures as those at baseline. In addition to obtaining demographic data from patients (e.g., age, marital status, home language, years of education, religion, employment status, and date of HIV diagnosis), clinical data, including CD4/CD8 status, were collected from treating physicians. HIV staging was also determined, and patients were classified as symptomatic or asymptomatic. CD4 (helper/inducer) and CD8 (suppressor) T lymphocyte subsets were analyzed by staining peripheral blood specimens with flow cytometry enzyme-linked immunosorbent assay and Western blot analysis.

Psychiatric diagnostic status was assessed with the MINI, either the English version questionnaire or the translated Xhosa version (the predominantly spoken language in our sample) [19]. The MINI assesses “current” disorders, such as major depression, dysthymia, suicidality, panic disorder, agoraphobia, social anxiety disorder, obsessive–compulsive disorder, posttraumatic stress disorder (PTSD), alcohol and drug abuse/dependence, psychotic disorders, anorexia nervosa, bulimia nervosa, generalized anxiety disorder, antisocial personality disorder, as well as lifetime diagnoses for major depressive episode, panic disorder, psychotic disorders, and antisocial personality disorder. Coping styles were assessed with the abridged version of the COPE, called Brief COPE [20]. Functional impairment/disability was assessed with the Sheehan Disability Scale [21].

Negative life events were measured using a modified 42-item clinician-administered checklist that inquires about the number of events (positive and negative) and the degree of associated distress (impact score=0–2) in the past 6 months. Higher scores reflect greater stress impact [22]. Sexual risk behaviors were assessed using a 20-item interviewer rating measure adapted from the work of Kelly et al. [23] and Mckinnon et al. [24]. On follow-up, items were modified so as to inquire about sexual activities since baseline.

### *Data analyses*

Analyses were computed with SPSS software, version 10, for Windows. First, several univariate tests of association for categorical variables (chi-square tests) and continuous variables (Student's *t* tests) were performed to look for associations between demographic and clinical status and psychopathology. To examine changes in coping and disability scores between baseline and follow-up, a series of repeated paired *t* tests was performed. Variables identified as statistically significant in univariate analyses were then entered into two logistic regression models, with major depression and posttraumatic disorder (the two most prevalent psychiatric diagnoses on follow-up) as dependent variables. All statistical tests were two-tailed, with  $P < .05$  denoting significance and 95% confidence intervals (CIs).

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