



Perceived illness stigma is associated with depression in female patients with systemic lupus erythematosus

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ABSTRACT

Objectives: 1) To assess the prevalence of depression in a sample of female patients with systemic lupus erythematosus (SLE) 2) To evaluate the association between perceived illness stigma and depression in those patients.

Methods: In a cross-sectional study, 80 female SLE patients were evaluated for the presence of depression and perceived illness stigma. Depression was diagnosed using the Structured Clinical Interview for DSM-IV Axis I disorders, clinical version (SCID-I-CV), the severity of the depressive symptoms was evaluated using the Hospital Anxiety and Depression Scale-Depression Subscale (HADS-D), and the stigma of illness was assessed using the Stigma Impact Scale (SIS).

Results: The prevalence of depression among female SLE patients was 18.75% (15/80). The perceived illness stigma was higher among the depressed group than among the non-depressed group (SIS mean scores were 43.87 ± 7.87 and 26.62 ± 3.79 respectively $P < .001$), there was a significant positive correlation between SIS and HAD-D scores ($r = 0.73$, $P = .002$), and there was a significant association between perceived illness stigma and diagnosis of depression ($R^2 = 0.53$, $P = .002$, odds ratio = 3.2), which increased the severity of depressive symptoms ($R^2 = 0.64$, $P < .001$).

Conclusion: This study demonstrates a significant association between illness stigma and depression in female SLE patients which may be important in promoting optimal coping for these women.

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Introduction

Systemic lupus erythematosus (SLE) is a chronic multisystem autoimmune disorder that provokes inflammation in various parts of the body [1]. SLE can lead to a wide range of physical, mental and social problems; these include fatigue [2–5], sleeplessness [6], cognitive dysfunction [7], lack of control over the disease [8,9], reduced stress threshold [10], depression [11–13], anxiety [14], or both [15], and a poorer quality of life than is enjoyed by healthy subjects [16]. Major depression is one of the most frequent psychiatric disorders observed in patients with SLE, with point prevalence rates between 10.8% and 39.6% [17,18]. Factors leading to depression in SLE include direct brain damage, patients' responses to the burden of the disease, the social consequences of the disease [7], and the high doses of corticosteroids commonly used in its treatment [19]. Most episodes of depression in SLE patients appear to be caused by non-organic factors [7]. Many investigations have concluded that depression in SLE is a reaction to the stress and multiple losses associated with chronic debilitating illness [19,20], since SLE, largely a female-predominant disease of young

individuals, carries a potential for significant disfigurement [21]. Disease manifestations, specifically, skin rash, uneven pigmentation, vitiligo, scars, loss of teeth, alopecia, increased facial hair, fatigue, pain, and unpredictability of flares, may contribute to higher levels of perceived illness stigma that subsequently may be associated with depression in these patients. We hypothesize that depression in female SLE patients without CNS involvement is mostly due to non-organic causes, and perceived illness stigma is associated with depression in female patients with SLE.

To the best of our knowledge, this is the first study that assesses the association between perceived illness stigma and depression in female patients with SLE. Our study had the following aims:

- 1) To assess the prevalence of depression in a sample of female SLE patients.
- 2) To evaluate the association between perceived illness stigma and depression in those patients.

Methods

Participants

This research is a cross-sectional study that included 80 female patients with systemic lupus erythematosus (SLE). The patients were

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randomly selected (by systematic random sampling) from the patients that followed up regularly at the rheumatology outpatient clinic of King Abdulaziz University Hospital in Jeddah, Saudi Arabia, between March 2011 and March 2012. The diagnosis of SLE was made according to the revised American College of Rheumatology (ACR) criteria [22]. Exclusion criteria included any cognitive deficit (identified by the Mini Mental State Examination) [23], the presence of the neurologic syndrome of neuropsychiatric lupus (e.g. cerebrovascular disease, seizures, demyelinating lesions), other concomitant serious medical problems (other than those secondary to SLE, e.g. systemic arterial hypertension), and language barrier.

Physical and neurological examinations of SLE patients were performed to rule out neurologic syndromes of neuropsychiatric lupus and serious medical problems; the medical records of the patients include all the investigations that were used to exclude these organic conditions.

Sociodemographic data of the patients were recorded using a questionnaire developed by the study team. Informed consent was obtained from the patients who participated in this study, and ethical approval was obtained from the local ethical committee of King Abdulaziz University Hospital (Table 1).

Evaluation of depression

Diagnosis of depression was established using the Structured Clinical Interview for the DSM-IV Axis I disorders, clinical version (SCID-I-CV) [24], and the severity of depressive symptoms was assessed using the Hospital Anxiety and Depression Scale-Depression Subscale (HADS-D), a self-report questionnaire comprised of 14 items, with seven items assessing anxiety and seven assessing depression [25]. In the present study, only the seven-item depression subscale (HADS-D) was used. HADS was developed and validated specifically for use in the physically ill and does not rely on somatic symptoms of depression, as somatic items might be scored positively by people with SLE regardless of the presence of depression, thus potentially overestimating the prevalence of depression [26]. The items of HADS-D were scored on a four-point scale from zero (not present) to three (considerable). The item scores were added to result in total depression sub-scale scores from zero to 21.

Evaluation of illness stigma

Illness stigma was evaluated by using the Stigma Impact Scale (SIS) [27]. This scale has 24 items and assesses four domains of perceived stigma comprising social rejection (e.g. some family members

have rejected me because of my illness), financial insecurity (e.g. my job security has been affected by my illness), internalized shame (e.g. I feel I need to keep my illness a secret), and social isolation (e.g. I feel set apart from others who are well). Response to all the 24 items are rated on a 4-point Likert-type scale, with 4 representing “strongly agree” and 1 representing “strongly disagree”, so that the maximum total score is 96. A high SIS score indicates a greater level of perceived stigmatization. Cronbach α coefficients for the subscales of the SIS ranged from 0.85 to 0.90 [27].

SLE disease activity evaluation

SLE disease activity, defined as the reversible manifestations of the underlying inflammatory process, was measured using Systemic Lupus Erythematosus Disease Activity Index (SLEDAI) [28]. This instrument consists of 24 weighted attributes, grouped into 9 domains, called organ systems (weightings in parentheses): central nervous system (8), vascular (8), renal (4), musculoskeletal (4), serosal (2), dermal (2), immunologic (2), constitutional (1), and hematologic (1). The sum of all weighted attribute scores constitutes the final SLEDAI score. Final SLEDAI scores range between 0 and 105, with 0 being no disease activity and higher scores reflecting a greater number and/or severity of manifestations. SLEDAI is a reliable and valid instrument for measuring the clinical state in patients with SLE [29].

To measure the cumulative irreversible damage due to the disease, therapy complications, or concurrent diseases, we used the Systemic Lupus International Collaborating Clinics/American College of Rheumatology Damage Index (SLICC/ACR Damage Index). The Damage score is grouped into 12 different domains: ocular (2), neuropsychiatric (6), renal (3), pulmonary (5), cardiovascular (6), peripheral vascular (4), gastrointestinal (7), musculoskeletal (7), and skin (3). Damage scores are also given for premature gonadal failure (1), diabetes mellitus (1), and malignancy (2). Irreversibility is defined as the presence of any given item for at least 6 months continuously. A score of 0 is given to patients without irreversible damage, and the maximal possible score is 47 [30–32].

Statistical analysis

The data analysis was performed using the statistical package for social sciences software (SPSS version 17) [33]. The qualitative data were presented in the forms of number and percentage. The quantitative data were presented in the forms of mean and standard deviation. Groups were compared using an independent sample *t*-test for quantitative parameters (95% CI). The Pearson Correlation and linear multiple logistic regression were used in the analysis of the data. A *P* value < .05 was considered to indicate statistical significance.

Results

Fifteen patients (18.75%) among SLE female patients were diagnosed as having depression according to the structured clinical interview for the DSM-IV axis I disorders, clinical version (SCID-I-CV). Nine patients who were diagnosed with major depressive disorder and seven patients with depressive disorder not otherwise specified type minor depression, without past history of depression, without family history of depression, without substance abuse, without any other psychiatric comorbid disorder.

There was a significant increase in HADS-D and SIS mean scores in depressed versus non-depressed SLE patients; otherwise, there was no significant differences between the 2 groups as regard age, duration of illness, SLEDAI and SLICC/ACR damage index mean scores and prednisone mean daily dose (Table 2).

There was a significant positive correlation between HADS-D scores and SIS scores ($r=0.73$, $P=.002$) as shown in Table 3.

There was a significant association between perceived illness stigma (reflected by SIS scores) and diagnosis of depression, ($R^2=.53$, $P=.002$, odds ratio=3.2) (Table 4).

The increased severity of perceived illness stigma (reflected by higher SIS scores) was significantly associated with increased depressive symptoms severity (reflected by higher HADS-D scores), ($B=0.24$, $R [2]=0.64$, $P<.001$) as shown in Table 5.

Table 1

Demographic characteristics of the patients (no=80).

Variable	Statistics
Age(yrs), mean(SD)	34.83(11.22)
Nationality, no(%)	
Saudi	29(36.25%)
Non Saudi	51(63.75%)
Marital status, no(%)	
Single	21(26.25%)
Married	54(67.50%)
Divorced	2(2.50%)
Widowed	3(3.75%)
Work status, no(%)	
Employed	18(22.50%)
Retired	4(5%)
House wife	51(63.75%)
Unable to work	3(3.75%)
Student	4(5%)
Duration of illness, mean(SD)	6.89(4.21)

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