Coping in People Living with HIV/AIDS (PLWHA) and its Association with Depressive Disoder

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Abstract

Introduction

Among PLWHA, fewer studies have done to assess the coping and their role in increasing the morbidity and mortality among people living with HIV/AIDS (PLWHA).

Objective

This study aims to study coping among PLWHA and their association with depression.

Methodology

This study was conducted at the outpatient HIV clinic in a tertiary center (TUTH). All relevantinformation was noted in a semi structured proforma designed for the study. BDI-II and brief COPE were the tools used.Result:Among the depressed and non-depressed groups, the mean scores on emotional support (and standard deviation), were found as 4.41 (1.104) and 5.32 (1.511) respectively.There is a negative correlation between depressive scores (BDI) and total score on brief COPE.Conclusion: PLWHA with lower level of depression were to found to score more on brief COPE.

KEY WORDS

PLWHA, depression, ART, outpatient HIV clinic, coping, BDI-

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INTRODUCTION

Broadly, coping strategies can be categorized as adaptive and maladaptive ones. There are various coping strategies - active, passive, confrontational, avoidant, problem-focused, emotion-focused, and religious coping to name a few.[1,2] Adaptive, active and problem-focused coping are associated with lower levels of depression, whereas maladaptive ones are associated with higher levels of depression.[3] Regarding avoidant and emotion-focused coping, results are contradictory. Some effective methods are rational actions, help-seeking behaviors, cognitive restructuring, religious activities, and humor.[4]

Denial correlated to faster disease progression. Problem-focused coping improved psychosocial functioning, while emotion-focused coping had contradictory effect on psychosocial functioning.[5,6] Personal beliefs and self-control also seem to correlate with depression. Lower social support and spiritual well-being were related to depression.[7-8]

Value of religion in coping with HIV/AIDS is found to be significantly negative correlation.[9,10] Prayer and rediscovering what is important in life is most prevalent coping response to HIV followed by positive coping strategies such as seeking information or making plans[11-12]

The objective of this study was to assess the ways of coping in people living with HIV/AIDS, and its association with depressive disorder. Limited studies had been conducted that give clear picture on this subject leaving us with scarcity of significant findings. Our study was supposed to add more information that would be beneficial to guide better management to these people.

MATERIALS AND METHODS

Study Design and subjects

A descriptive cross-sectional study was conducted with the aim of studying coping, and its association with depression for the 1-year-period (October, 2013 to September, 2014) among HIV positive patients under anti-retroviral therapy in an outpatient HIV clinic of the Tribhuvan University Teaching Hospital (TUTH), a tertiary level hospital located in the capital city Kathmandu of the country.

Samples collected (n=99) exceeded estimated sample size (n=94), which was calculated taking high prevalence of depression among HIV populations (approx. 40%). This sample was assumed to be reasonably sufficient, which consisted of almost equal number of males (50) and females (49), thus controlling the gender factor by itself.

Subjects were included based on strict criteria for inclusion (age 18-60 years; on ART for at least 6 months) and exclusion (speech disorder; mental retardation; delirium; dementia; serious medical illnesses like COPD, heart diseases, renal failure)

Procedure

The semi- structured proforma was filled with adequate information, the history taken from the patients and the informants. The socio-demographic information, the clinical medical information as well as information regarding HIV parameters were obtained by the principal researcher from the patients' medical records in the HIV clinic. After this preliminary data collection, contribution from other researchers were sought for the other important aspects of the study.

The clinical diagnoses were made after the Mental State Examination, and confirmed by the use of ICD-10-DCR. Beck Depression Inventory (BDI-II) was used for comparison with the clinical diagnosis of depression. The brief COPE scale was used on PLWHA to score them on various types of coping strategies.

Statistical tools

Data were analyzed using SPSS version 16 (Chicago, Illinois, USA). Descriptive analysis was performed, and mean, median, range were calculated. The data were mostly explained as mean± standard deviation (SD). Spearman's rank correlation was performed for ordinal dataset. Chi-square tests were applied for categorical data. Independent sample t test, ANOVA tests were applied wherever applicable. P- value of <0.05 was considered significant.

Ethical considerations

Ethical clearance was done from the Research Department (Institutional Review Board); Institute of Medicine, Tribhuvan University. Informed consent was taken from each participant and nearest possible relative in case the participant was not eligible to give informed consent due to his/ her mental illness. Confidentiality was maintained throughout the study. There was no harm to the patients from the study. No specific costs were involved in the study. However, patient had to bear his/her cost of treating depression.

RESULTS

Table 1: *Correlation between depressive scores (BDI) and coping strategies (brief COPE)*

	depression group	N	Mean	Std. Deviation	Significance
Total BCI score	no depression	65	53.22	6.911	
	depression	34	49.41	4.554	.005
Self-distraction	no depression	65	4.31	1.446	
	depression	34	4.06	1.229	.395
Active coping	no depression	65	4.14	1.685	
	depression	34	3.53	1.212	.065
Denial	no depression	65	2.25	.811	
	depression	34	2.21	.592	.799
Substance use	no depression	65	3.20	2.137	
	depression	34	3.09	2.050	.803
Emotional support	no depression	65	5.32	1.511	
	depression	34	4.41	1.104	.002
Use of instrumental support	no depression	65	4.69	1.667	
	depression	34	4.59	1.438	.758
Behavioral disengagement	no depression	65	3.43	2.872	
	depression	34	2.85	1.019	.260
Venting	no depression	65	4.46	.985	
	depression	34	4.03	1.167	.055
Positive reframing	no depression	65	4.77	1.401	
	depression	34	4.56	1.211	.460
Planning	no depression	65	3.65	1.316	
	depression	34	3.26	1.024	.144
Humor	no depression	65	2.05	.276	
	depression	34	2.00	.000	.332
Acceptance	no depression	65	5.94	1.184	
	depression	34	6.24	1.350	.262
Religion	no depression	65	2.60	1.058	
	depression	34	2.18	.459	.028
Self-blame	no depression	65	2.42	.705	
	depression	34	2.41	.609	.980

Table 1 shows association among depression and emotional support of the brief COPE. Among the depressed and non-depressed groups, the mean scores on emotional support (and standard deviation), were found as 4.41 (1.104) and 5.32 (1.511) respectively.

Table 2: *Correlation between age, depressive scores (BDI) and coping scores (brief COPE)*

Variables	age	BDI score	BCI score
Age	-	-.091	-.036
BDI score	-.091	-	-.327**
Coping score	-.036	-.327**	-

Table 2 There is a negative correlation between depressive scores (BDI) and total score on brief COPE index (BCI), which is significant at the 0.01 level (2-tailed).

DISCUSSION

Significant association (Chi-square X2=0.002) among depression and emotional support of the brief COPE in the HIV population was seen. Among the depressed and non-depressed groups, the mean scores on emotional support (and standard deviation), were found as 4.41 (1.104) and 5.32 (1.511), respectively (Table 1). A negative correlation (r=-0.327) between depressive scores (BDI), irrespective of disorder diagnoses, and total score on brief COPE, significant at the level 0.01 (2-tailed) was found. However, no association between clinically significant major depressive disorder and coping scores was found.

Our study which had used brief COPE as a measure of coping showed that people scored low on religiosity/spirituality compared to other items like emotional support, instrumental support and venting (Table 2). This is in contrast to finding of the 2006 study which had showed that depressed HIV positive men used religiosity/spirituality as a method of coping. Another study also found religious/spiritual coping as the primary method of coping among those depressed and anxious.[13]

Some studies have shown inverse relationship between spirituality/religiosity and depressive symptoms.[14,15] Other studies showed direct relationship between avoidance and disengagement strategies of coping with depression.[16-18] However, our study showed inverse relationship between emotional support and depressive symptoms among PLWHA.

Women face a lot of conflicts and have to maintain social relationships, while men have guilt about their high-risk behaviors and burden of financial situation. This is consistent with recent Indian study.[19,20]

Danish study had showed that lesser degree of depression was directly related to higher degrees of coping self-efficacy and living with HIV/AIDS openly/partly openly. Coping self-efficacy is not concerned with the method of coping but the perceived capacity to deal with the situation.[21,22]

This is a cross-sectional study. Therefore, it is difficult to establish causality with certainty for the adaptive and maladaptive coping with depression among PLWHA. The results cannot be generalized as this is limited to a tertiary hospital setting.

CONCLUSION

Adequate emotional support to PLWHA is found to be associated with fewer symptoms of depression. Other factors like perceived stress, stigmatization and disclosure, coping efficacy and strategies, and their association with depression among PLWHA needs to be studied further.

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