



A Study of Depression in Depressed HIV Positive Patients At Tertiary Care Center At Lucknow

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ABSTRACT

Infection with the human immunodeficiency virus (HIV) is associated with high rates of depression. Studies have shown that depression is 2-4 times more prevalent in HIV positive patients in comparison to general population. Depression may alter the course of HIV infection by impairing immune function and influencing behaviour of person resulting in self neglect and noncompliance of treatment and care. It is mostly undiagnosed and untreated. Suicidal thoughts and ideas are also very prevalent as a part of depressive disorder, which needs to be addressed. With all this background, we designed a cross-sectional study to study depression in depressed HIV positive patients. Patients aged from 18 years to 60 years, diagnosed as HIV positive confirmed by a test as recommended by WHO and followed by NACO guidelines, registered at HIV clinic at least one month prior to assessment, suffering from depression on SCID 1 based on DSM IV were included in study sample after taking informed consent. These patients were administered HDRS scale for depression, and SCID2 for personality disorder. Our study sample consist of 28 depressed HIV positive patients, out of which 7.2% had personality disorder, 78.6% had moderate to severe depression, 53.6% had suicidal ideation and 7.1% had past history of depression. It all concluded that depression must be studied and properly managed in HIV patients.

KEYWORDS : DEPRESSION, HIV POSITIVE PATIENTS, SUICIDAL IDEAS

INTRODUCTION-

Depression is a major public health problem because it is frequent, causes disability and distress for patients and their families, and result in severe socioeconomic losses (Sartorius, 1993). It has been estimated that there are at least 100 million people suffering from some form of clinically recognizable depressive disorder who could benefit from qualified help. It has also been shown that socioeconomic losses which are either directly (e.g., in terms of productive day lost) or indirectly (e.g., in terms of family disruption) related to depressive disorder can be enormous and that appropriate public health intervention can reduce these cost in major way (Rutz et al., 1989). Depression in patient with physical illness is common, frequently unrecognized and leads to dilemmas in diagnosis and treatment (Mathew 1998). Depression may worsen disability caused by physical illness, accentuate pain, affect prognosis and reduce compliance with physical treatment. Depression is ignored in physical illness. One reason for the low detection rates of depression may be that it is seen as an understandable consequence of physical illness. The psychosocial aspects of depression are understandable in the context of what may be a devastating physical illness. Prevalence rates of depressive disorders among patient suffering from medical illness are considerable from 22% to 33 % (WPA, 1998). Acquired Immune Deficiency Syndrome (AIDS) is a lethal neuromedical disorder associated with infection by viruses of the retroviridae class known as human immunodeficiency virus (HIV) (Grant et al., 2000). AIDS was recognised the United States in 1981. HIV was demonstrated clearly to be the causative agent of AIDS in 1984. (Fauci et al., 2001). Two types of human immunodeficiency viruses are currently known – HIV-1 and HIV-2. Globally, the vast majority of AIDS cases result from HIV-1 infection, where as AIDS secondary to HIV-2 appears to be confined mostly to a region of West Africa. There may be other sub types of HIV, these are now classified as HIV-0 (Grant et al., 2000). The physical, psychological, social and economical implication of disease is devastating and still we are far from a definitive cure. Recent medical advances have begun to alter natural progression of the illness from one of the accelerating deterioration to more chronic course. With the prospect of long term survival of HIV infected individual optimization of health services is important and psychiatric care seems to be essential. Worldwide several studies have been done to know prevalence of psychiatric morbidity in HIV positive patients and they found high psychiatric morbidity that ranged from 40 -60% (Tross et al., 1987; Seth et al., 1991; Catlan et al., 1992; Fell et al., 1993; Lyketos et al., 1996; Kilbourne et al., 2001; Venkoba et al., 1991; Madan et al., 1997; Mathew et al., 1996). Among all psychiatric morbidity, depression is one of the most common psychiatric disorder. Studies have shown that depression is

2-4 times more prevalent in HIV in comparison to general population (Dew et al., 1997; Rabkin et al., 1997; Satz et al., 1997; Ciesla et al., 2001.). Despite the enormous advances in brain research in the past 20 years depression often goes under diagnosed and untreated. Although as many as one in three person with HIV may suffer from depression, (Bing EG et al., 2001), the warning signs of depression are often misinterpreted. People with HIV, their families, friends, and even their physician may assume that depressive symptoms are an inevitable reaction to being diagnosed with HIV. But depression is a separate illness that can and should be treated along with treatment for HIV or AIDS. Patients with a history of depression, homosexual men and women and intravenous drug users (IVDUs) are among HIV –infected individuals who may be at increased risk for depressive disorder (Maj et al., 1994, Williams et al., 1991, Knowlton et al., 1998). A history of depression is one of the strongest predictors of future depressive disorder episodes, and this illness runs a recurrent course in a majority of sufferers (Thase Me, 1999). So HIV –infected patients who have had depression in the past are especially susceptible to recurrence. Keeping all this in a view, this study was designed to study depression in depressed HIV positive patient at HIV clinic.

MATERIAL AND METHOD-

This was a cross sectional study of depression in depressed HIV positive patients, who were diagnosed to be suffering from depression on SCID 1 based on DSM-IV criteria. Those patients who were diagnosed as mood disorder due to HIV with major depressive episode were included in the study after informed consent. These patients were administered HDRS -17 ITEM scale for measuring severity of depression. Co morbid axis 2, personality disorder was assessed on SCID2 (Structured clinical interview for DSM –IV Axis –II Personality disorder). Semi-structured Performa containing identification data, socio-demographic variables, sexual history, psychiatric history, past history, family history, personal history, premorbid personality, physical examination and mental status examination, were filled for every patients. This study was conducted at KGMC, Lucknow at HIV clinic. Our study sample consists of 28 depressed HIV positive patients.

OBSERVATIONS AND RESULTS-

28 depressed HIV positive patients were included in the study after diagnosing them to be suffering from depression on SCID 1 (structured clinical interview for DSM IV FOR AXIS –I disorder). Out of 28 patients, 26 were symptomatic HIV positive patients and 2 were asymptomatic HIV positive patients.

TABLE-1
SOCIODEMOGRAPHIC VARIABLES

	N=28	%
Age (in years)		
18-30	13	46.4
31-45	12	42.9
46-60	3	10.7
Gender		
Male	19	67.9
Female	9	32.1
Domicile		
Urban	13	46.4
Rural	15	53.6
Marital status		
Married	22	78.6
Unmarried	2	7.1
Widow/widower	3	10.7
Separated	1	3.5
Religion		
Hindu	24	85.7
Muslim	4	14.3
Others	0	0
Education		
Illiterate	8	28.6
Up to 5 th class	4	14.3
6 th to 10 th	9	32.1
Intermediate	6	21.4
Graduate and above	1	3.6
Type of family		
Nuclear	15	53.6
Joint	13	46.4
Family income (inRs./month)		
Up to 2500	11	39.3
2,501-5000	10	35.7
5001-7500	6	21.4
7501-10000	1	3.6
Occupation		
Employed	19	67.8
Unemployed	9	32.14

Table 1 depicts sociodemographic variables of study subjects ,majority of patients were below 45 years of age(89.2%), male(67.9%),Hindu(85.7%),education more than primary level(57.1%),from rural background (53.6%) ,and from nuclear family(53.6%).

3 patients (10.7%) had positive history of psychiatric disorder in their family, 2 had family history of depression and 1 had bipolar disorder. 2 out of 28 had past history of depression.

TABLE -2
(SCID-2, ASSESSMENT OF PERSONALITY DISORDER IN DEPRESSED HIV POSITIVE PATIENTS)

	N=28	%
PERSONALITY DISORDER PRESENT	2	7.2%
OCPD	1	3.6%
HISTRIONIC	1	3.6%
ABSENT	26	92.8%

Table 2 shows personality disorder in study subjects, 2 patients had personality disorder along with depression, 1 had obsessive compulsive personality disorder and 1 had histrionic personality.

TABLE-3
(SEVERITY OF DEPRESSION ON HAMILTON DEPRESSION RATING SCALE FOR DEPRESSION -17 ITEMS)

	N=28	%
MILD(8-13 SCORE)	6	21.4
MODERATE(14-18 SCORE)	14	50.0
SEVERE(19-22 SCORE)	8	28.6%

Table 3 shows severity of depression on HDRS scale, majority of patients had moderate depression.

TABLE-4
(PRESENCE OF SUICIDAL THOUGHTS OR SUICIDAL TENDENCY)

	N=28	%
PRESENT	15	53.6%
ABSENT	13	46.4%

Table -4 shows very important and significant finding that 15 out of 28 depressed HIV positive patients had suicidal thoughts.

DISCUSSION-

The present study was a cross sectional study of a depression in depressed HIV positive patients. We had taken 28 depressed HIV positive patients who were diagnosed to be suffering from depression on the SCID1, based on DSM IV. Those patients were not considered for the studies that were on medication which can cause depression such as ATT, zidovudine and other drug mentioned in SCID1. There has been a case report by Judith rabkin,1997 that zidovudine can cause depression. Similarly, it is also known that some anti tubercular drugs like D-cycloserine, ethinamide and prothinamide can cause depression (Rutz, 1989,.). Taking this into consideration, the patients on above mentioned drugs were not taken in the study. In the present study we had very few numbers of asymptomatic HIV positive patients. Reason of less numbers of asymptomatic HIV positive patients may be that HIV clinic runs in the department of medicine and all individuals who were declared HIV positive at the voluntary counselling and testing centre(VCTC) were advised to go to HIV clinic but this advise is not mandatory. It has been observed that mostly symptomatic patients approach the HIV clinic. Due to this reason, majority of the subjects in this study were symptomatic HIV positive patients. In the present study, 2(7.1%) out of 28 HIV depressed patients had past history of depression. HIV infected patients with past history of depression may be at an increased risk of depressive disorder (Maj et al., 1994 , Williams et al., 1991 , Knowlton et al., 1998). According to study done by Thase ME , 1999 , a history of depression is one of the strongest prediction of future depressive episode. 7.1% of HIV depressed patients had axis-II personality disorder. Rate of personality disorder was much higher in comparison to estimated general population prevalence in India (Reddy et al., 1998) in whom 0.06% rate was reported . the possible explanation could be that the present study was hospital based. In comparison to the present study, Rundell and Brown(1990) and Perkins et al., (1993) have reported that 30-36% of HIV positive subjects had personality disorder .The reason of higher percentage in these western studies may be that Rundell and Brown (1990) assessed military personals and Perkins et al., (1993) evaluated homo sexual HIV positive individuals, hence their results cannot be generalised .In these studies antisocial personality disorder were common but in the present study , we found obsessive compulsive personality disorder(3.6%) and histrionic personality disorder (3.6%)and no anti-social personality disorder patient was found. This would be because they had assessed HIV positive patients where as in the present study we have assessed HIV depressed group and it has been well studied that person with certain personality disorder like obsessive compulsive , histrionic may be at a greater risk for depression than person with anti social or paranoid personality disorder(Kaplan and Saddock's, 2000). In the present study, 53.6% of patients had suicidal thoughts. Suicide has been reported to be an important concomitant of HIV infection. Grassi et al., (2001) in their study reported that about one third of HIV infected patients had thought of suicide. Schneider et al 1991, found that 27% of HIV infected homo sexual and bisexual had suicidal ideation over the previous six months, while Judd and

Mijch (1996) reported a 40% prevalence of suicidal thoughts among 100 homo sexual and bisexual patients. The higher percentage in the present study is because of difference in study sample. The above mentioned studies included all HIV positive patients but in the present study only those HIV positive patients who were depressed were assessed. The finding is also supported by the study done by Hintz et al., 1990 who found 47% of depressed HIV positive patients having suicidal ideations. Although small sample size of this present study is limitation of this study but it convey very strong message that depression need to be addressed in HIV positive patients.

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