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Predictors of Depression among Seropositive Batswana Men and Women: A Descriptive Correlational Study

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A B S T R A C T

The purpose of this descriptive correlational study was to describe predictors of depressive symptoms among N = 70 seropositive Botswana men and women residing in Gaborne, Botswana. A demographic questionnaire, the Center for Epidemiologic Studies Depression Scale, (CESD-D), and the SF-36 [Quality of life] were administered. The questionnaires were translated and back translated in Setswana and administered by Batswana men and women. The results of the regression analyses resulted in two calculated models. In the first Model energy/fatigue explained 46% of the variance in depressive symptoms ($P = .000$), and in the second Model energy/fatigue and role limitations on emotional well-being explained 50% of the variance in depressive symptoms respectively. The study findings underscore the need for mental health services for seropositive Batswana men and women.

People living with HIV/AIDS (PLWHA) have an increasingly high risk for experiencing depression or other mental health issues (Lawler et al., 2011). Compared to other countries, Sub-Saharan Africa has one of the most devastating prevalence of HIV/AIDS. Alarmingly, a large population based study investigating the prevalence of depression among HIV-positive Batswanas reported a prevalence rate 25% among woman and 31% for men (Gupta et al., 2010). Depression has been documented to greatly affect seropositive individuals much more intensely due to their susceptibility to psychological stress (Simbayl et al., 2007).

Because of limited resources, there are limited treatment and screening services available for depression among seropositive Batswana men and women (Gupta et al., 2010). Hence, in order to effectively treat depression the integration of mental health and HIV/AIDS treatment will require a comprehensive strategic approach in Botswana. The lack of available mental health resources and services is problematic because of the increasing volume of depressive symptoms emerging in seropositive individuals in Sub-Saharan African (Olagunju, Ogundipe, Erinfolami, Akinbode, & Adeyemi, 2013).

Another concerning issue regarding depression in HIV-positive Batswanas is the lack of adherence to Highly Active Antiretroviral Treatment (HAART). Depression can have a major impact on how individuals comply with their treatment regimen (Nam et al., 2008). This study underscored Batswanas experiencing depressive symptoms were more likely not to adhere to their antiretroviral medication (Nam et al., 2008).

A study examining an older population in rural Sub-Subharan Africa noted that seronegative individuals exhibited a higher prevalence of depressive episodes compared to seropositive individuals (Nyirenda, Chatterji, Rochat, Mutevedzi, & Newell, 2013). Among the sample, three-percent of the participants reported they were formally diagnosed by a health care professional with depression. The four most commonly reported symptoms endorsed by the study participants were: sleep deprivation, psychomotor restlessness, anxiety, and loss of confidence and self-esteem. However, many of the reported symptoms were indicators of depression (Nyirenda et al., 2013). This underscores the need for training primary providers on how to recognize depressive symptoms.

Mall, Struthers, Sorsdahl, and Joska (2013) investigated depression in South Africa and identified a pragmatic approach for managing depression in HIV positive individuals. First, clinicians were urged to recognize the occurrence of depressive symptoms and understand how comorbidities, and substance use can increase depressive symptomatology among seropositive individuals. These data suggest, regular training of clinicians and staff members at local outpatient facilities and hospitals can potentially lead to effective recognition of depressive symptoms. Additionally counseling, education, and community involvement were found to be supportive resources for seropositive South Africans who were depressed (Mall et al., 2013).

The mental health and overall well-being of PLWHA in Sub Saharan Africa must be closely monitored. For example, screening individuals who lack community support or those experiencing HIV comorbidities for depression would greatly enhance our ability to identify individuals at risk for mental health comorbidities (Brandt, 2009). When clinicians

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are able to properly diagnose depressive disorders among seropositive individuals in Sub-Saharan Africa they will be better equipped to provide efficacious treatment and ultimately improve quality of life.

The aforementioned studies indicate the rates of depression are generally higher in developing countries where HIV/AIDS is prevalent, such as Botswana, Africa. As we investigate the prevalence of depression in Botswana it is essential to examine their attitudes and perspective about mental illness. For example, in South Africa, individuals were surveyed about their attitudes towards knowing someone with a psychiatric disorder taking medication, and how they would feel about reaching out to a mental professional for treatment (Sorsdahl, Mall, Stein, & Joska, 2010). The results indicated the participants attitudes towards psychiatric disorders were negative. These findings are concerning because this could potentially cause one not to seek out mental health treatment and suffer in silence.

Another study investigated the impact of HIV stigma on mental health (Vanable, Carey, Blair, & Littlewood, 2006). The authors summarized that HIV stigma is extremely challenging for seropositive individuals and has led to the development of depression. Additionally, these authors underscored a clear link exists between stigma-related experiences and depression, which could lead an individual to not seek care resulting in increased depressive symptoms. The study further concluded that addressing HIV stigma in a safe and supportive environment would be an effective strategy to mitigate the impact of depression in seropositive men and women (Vanable et al., 2006).

Andersen, Kagee, O'Cleirigh, Safren, and Joska (2014) purport an extensive assessment including demographics, stage of HIV disease (HIV), and support systems will enable clinicians to understand the complex determinants of depression in PLWHA. In addition to an extensive assessment, they recommended early detection and treatment were key to providing effective management and treatment (Andersen et al., 2014). They underscored that in Sub-Saharan Africa where HIV is highly prevalent it is incumbent upon health care providers to provide comprehensive mental health services to seropositive individuals. They posit that implementing educational strategies about the incidence and prevalence of depression and providing sufficient clinical resources to seropositive men and women will result in better mental health outcomes.

The author supports this conclusion and similar to other studies (Andersen et al., 2014; Kagee & Martin, 2010; Lewis, Mosepele, Seloilwe, & Lawler, 2012) urges sufficient resources are provided to improve the psychological well-being of seropositive individuals in Botswana. As strongly proposed by the aforementioned studies, community resources are needed to implement educational strategies for medical professionals, families, and seropositive individuals in Botswana that will lead to effective coping with HIV. Screening methods are key to early detection; these resources must be expanded in Botswana and other South African countries in order to effectively mitigate the impact of the HIV epidemic on mental health.

The treatment of HIV and the overall management of psychological health are sound strategies for researchers and clinicians to implement in order to maintain optimal mental health in seropositive Batswanas. The aforementioned literature underscored how significant early detection screening is for depression in seropositive individuals in the Sub Saharan African region. However, there is a dearth of studies that have examined the correlates of depression among seropositive Batswanas. Therefore, the purpose of this descriptive correlational study was to describe predictors of depressive symptoms among N = 70 seropositive Botswana men and women residing in Gaborne, Botswana and to underscore the need for expanding mental health services.

METHODOLOGY

Design and Sample

Upon receiving institutional review board and Ministry of Health Approval we used a descriptive correlational design to recruit a convenience sample of seropositive N = 70 Batswana men and women from an HIV clinic in Gaborne, Botswana. Batswana men and women who volunteered to participate in study recruitment recruited participants during their clinic visits.

The participants were interviewed in a private area in the clinic and were provided an explanation of the study's purpose, procedures, risks, and benefits. Confidentiality was assured and written consent was obtained from each participant. The consent form and the study measures were translated in the local language Setswana, and back translated to English by Batswana men and women working with the study team. The participants were provided $10.00 (pula) for participating in the study. The median age of the sample was 35 years (range 18–57). Of the sample, 33% (n = 23) were male and 67% (n = 47) female, 55% (n = 39) were single, 55% (n = 39) resided in a house, 37% (n = 26) lived with parents. The majority 70% (n = 53) reported being unemployed, and 70% (n = 53) were not receiving mental health treatment.

MEASURES

Study participants completed a demographic questionnaire, the CESD (Radloff, 1977) and the SF 36 [Quality of Life measure] (Ware & Sherbourne, 1992). The independent variables selected for the analyses were, age, education, relationship status, gender, physical functioning, role limitations, social functioning, general health, and energy fatigue. The dependent variable was depression. The author developed the demographic questionnaire. Data on age, education, gender, and relationship status were collected.

CESD Questionnaire

The CESD is a 20 item scale that rates depressive symptoms from 0 to 60, with the higher score indicating higher depressive symptomatology. The items are rated 0 = rarely, 1 = some of the time, 2 = occasionally, and 3 = most of the time. The scale has established content, construct validity. The reliability calculated for this study was .90. The scale has a cut off score of 16. If individuals score 16 or higher this suggests they are experiencing depression. The CESD has been used in research and clinical studies extensively in South Africa and internationally. The instrument has been translated and back translated and has maintained stable reliability and validity (Chishinga et al., 2011; Kitshoff, Campbell and Naidoo, 2012).

SF 36 Item Health Survey

The SF-36 is a 36 item scale that measures eight health concepts: physical functioning, bodily pain, role limitations, role limitations due to emotional problems, emotional well-being, social functioning, energy/fatigue, and general health. Each item is scored 0–100 so that the highest score captures higher functioning.

The SF-36 has well-established construct, content, concurrent and divergent validity. The reliabilities calculated for this study were: Physical Functioning .83, Bodily Pain =.81, Role Limitations due to Physical Health = .85, Role Limitations due to Emotional Problems = .89, Emotional Well-Being = .77, Social Functioning = .67, Energy/Fatigue = .74, and General Health = .83. The SF-36 has been extensively administered world-wide including South Africa (Nemeth, 2006; O'Keefe & Wood, 1996). The instrument has been translated and back translated in numerous languages internationally and has maintained stable reliability and validity.

RESULTS

The majority 83% (n = 58) reported living with someone while 17% (n = 12) lived alone. Thirty-five percent (n = 24) had at least a middle to greater than high school education. A majority 64% (n = 45) endorsed their mother was the most supportive compared to other family

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