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Health related quality of life and depressive symptoms among seropositive African Americans

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ABSTRACT

The primary aim of this descriptive correlational study was to determine which domains of health related quality of life (HRQOL) after controlling for demographic correlates predict depressive symptoms among $N = 70$ seropositive African American men and women on Active Antiretroviral Therapy (ART). A demographic questionnaire, the Center for Epidemiological Studies Depression Scale (CESD-D), and the SF-36 Health Related Quality of Life (HRQOL) scale were administered. The regression analyses resulted in three models. The first model indicated that emotional well-being explained 38% of the variance in depressive symptoms ($P = 0.000$) and in model two, emotional well-being and role limitations on emotional health explained 50% of the variance ($P = 0.000$) and in the final and best fitting model emotional well-being, role limitations on emotional health and pain explained 53% of the variance in depressive symptoms ($P = 0.000$) respectively. The findings underscore the need to explore the impact of HRQOL on mental health, and to also screen and treat seropositive African American men and women on (ART) for depressive symptoms.

1. Introduction

Among the 1.2 million people living with HIV/AIDS (PLWHA) 30% ($n = 360,000$) are diagnosed with depression (Bengtson et al., 2016). The prevalence of depression among (PLWHA) has been confirmed by other Studies (Berg & Ross, 2014; Wong, 2013; Bird & Voisin, 2013; Overstreet, Earnshaw, Kalichman, & Quinn, 2013; Galvan, Davis, Banks, & Bing, 2008 & Reid, Dovidio, Ballester, & Johnson, 2014). An additional study, (O'Cleirigh, Magidson, Skeer, Mayer, & Safren, 2015) described depression among a sample of seropositive gay and bisexual men. The majority of the sample identified as white (75.1%) and the average age was 41.9 ± 8.3 years. The Patient Health Questionnaire (PHQ) was used to identify common mental health problems. Depression was identified during screening. Among the sample, 21.9% met the diagnostic criteria for a depressive disorder and only half of those who were screened for a depressive disorder had already begun treatment, suggesting that some patients were misdiagnosed or not receiving mental health services.

Depression impacts PLWHA across the age span. For example, Bogart et al. (2011) screened a sample of 181 older seropositive African American MSM for mental disorders, and 49% ($n = 89$) of the sample screened positive for depression. Bogart et al. (2011) explored the relationship between depression and discrimination by race, serostatus, and sexual orientation. The findings indicated that African Americans experiencing all three types of discrimination reported higher depression scores compared to those who only experienced one form of discrimination or combined sexual and racial discrimination. In another study, Le et al. (2016) investigated depression among seropositive African American men and women using focus groups to elucidate the unique issues affecting this segment of the population. The results confirmed that depression was highly prevalent and that participants reported having few coping skills to manage depression.

In addition to elucidating the prevalence of depression, additional studies underscored the importance for clinicians to examine the nexus between depression and health related quality of life (HRQOL) among PLWHA. For example, Lari, Faramarzi, Shams, Marzban and Joulaei (2013) reported that poorer HRQOL was highly correlated with depression, among PLWHA. Mekuria, Sprangers, Prins, Yalew, and Nieuwkerk (2015) investigated HRQOL among (PLWHA) on antiretroviral therapy and reported that poorer HRQOL scores were strongly associated with depression. Both studies underscored the importance of examining the impact of HRQOL on mental health particularly depression among PLWHA. Other studies investigating HRQOL in PLWHA also reported the strong association between poor HRQOL and depression (Mwesiga et al., 2015; Nieves-Lugo et al., 2016). The previously cited studies emphasize the need for clinicians to screen PLWHA for

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depression, and the importance of exploring the interaction between HRQOL and depression among PLWHA living with HIV/AIDS.

1.1. Gaps in the existing literature

The current body of literature underscored the lack of studies examining HRQOL and depressive symptoms among African American men and women living with HIV/AIDS. The research on depression and HRQOL primarily focused on majority populations (Brennan, Emlet, & Eady, 2011; Grov, Golub, Parsons, Brennan, & Karpiak, 2010; Le et al., 2016; Bogart et al., 2011). Hence the author posits more research investigating HRQOL and depressive symptoms among African American men and women living with HIV/AIDS is urgently needed.

1.2. Study aim

Although there is strong evidence underscoring the impact of HRQOL on depression among PLWHA the lack of studies examining the association of quality of life and depression among African American men and women living with HIV/AIDS on Antiretroviral Therapy (ART) is staggering. Therefore, the primary aim of this descriptive correlational study was to determine which domains of HRQOL after for controlling for demographic correlates predict depressive symptoms among N = 70 African American men and women on a HAART regimen.

2. Conceptual framework

The study was guided by the Wilson and Cleary's conceptual framework of Health Quality of Life (HRQOL), which has been extensively used to guide HRQOL studies conducted with (PLWHA) (Wilson & Cleary, 1995; Liu, Weber et al., 2006; Liu, Johnson et al. 2006; and Vidrine, Amick, Gritz, & Arduino, 2005). Health Related Quality of Life (HRQOL) is conceptualized as one's ability to function physically and emotionally, and their overall perception of well-being.

Given the increasing numbers of African Americans now living with HIV/AIDS, (HIV in the United States: At a Glance, 2014) this subgroup faces the challenge of maintaining their HRQOL, given the unpredictable nature of HIV infection. The Framework purports the HRQOL is influenced by chronic illness or conditions that interfere with functional status and or health (Wilson & Cleary, 1995; Liu, Weber et al., 2006; Liu, Johnson et al., 2006), and that a good or poor HRQOL can be conceptualized as a predictor of physical and mental health, or as an outcome variable.

The above studies documented the impact of HIV/AIDS on HRQOL, and other studies have validated the high prevalence of depression among persons living with HIV/AIDS (Berg & Ross, 2014; Wong, 2013; Bird & Voisin, 2013; Overstreet et al., 2013; Galvan et al., 2008; Reid et al., 2014). In the current study, the following domains of HRQOL physical functioning, role limitations, social functioning, general health, and energy fatigue were conceptualized to have an impact on depression.

3. Methodology

3.1. Design and sample

Upon receipt of University Institutional Review Board (IRB) approval a descriptive correlational design was used to recruit a non-probabilistic sample of seropositive N = 70 African American men and women. The sample was recruited using project staff, advertisements, news outlets, and infectious disease clinics. The study questionnaires were individually completed in a private area designated to project staff by the HIV clinic. Study personnel were available to clarify questions arising from the questionnaire. The total time to complete the questionnaire was 20 min. The participants were provided an overview of the purpose of the study including: procedures, risks and benefits. Confidentiality was maintained using unique numerical identifiers and each participant was provided informed consent individually in a private room at the clinic before being administered the questionnaire. Additionally, a waiver of signature was requested for the consent form from the IRB as it was determined the participant's signature was not needed. The request was granted. Each participant was provided $10.00 for completing the study questionnaires.

3.2. Study measures

The study participants completed a demographic questionnaire, the Center for Epidemiological Studies Depression Scale (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.

3.3. Center for Epidemiological Studies Depression Scale

The CESD is a 20 item scale that rates depression 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 assesses how an individual has felt or behaved during the past week. Some sample items include: “I felt depressed” or “I enjoyed life”. If a participant scores 16 or higher on the CESD he or she is considered to have depressive symptoms. The scale has established content, construct validity. The reliability of the CESD calculated for this study was 0.93.

3.4. Medical Outcome Study (MOS) Health Survey Questionnaire-SF-36

The MOS- SF-36 is a 36 item scale that measures eight health concepts of HRQOL: 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 using linear transformation so that the highest score captures higher functioning. The MOS SF-36 has well-established construct, content, concurrent and divergent validity. The reliabilities of the MOS-SF36 calculated for this study were: Physical Functioning 0.96, Bodily Pain = 0.85, Role Limitations due to Physical Health = 0.78, Role Limitations due to Emotional Problems = 0.89, Emotional Well-Being = 0.83, Social Functioning = 0.63, Energy/Fatigue = 0.70, and General Health = 0.78 respectively.

4. Study results

4.1. Design & sample

The mean age of the sample was (41 ± 7.56) with a range of (19–54) years of age. Of the sample 69% (n = 48) were male, 31% (n = 22) female, 69% (n = 48) single, 43% (n = 30) heterosexual and the remaining 57% (n = 40) identified as lesbian gay bisexual and transgender. Forty-four percent (n = 31) were Baptist, 63% (n = 44) had an income less than $10,000, and 53% (n = 37) indicated not having enough income to meet their needs. Sixty-three percent (n = 44) lived with someone while 37% (n = 26) lived alone, and 67% (n = 46) resided in a house or apartment.

When asked who was most supportive, a majority 51% (n = 36) indicated their mother, and 56% (n = 39) reported being depressed. Of those reporting having depression 44% (n = 31) indicated they received treatment, and 34% (n = 24) reported being hospitalized for their depression during the past year.

Additionally, 43% (n = 30) reported they were forced to engage in sexual activity on at least one occasion during their lifetime. Of the participants 33% (n = 23) reported currently never using condoms during: