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Detection of Psychiatric Disorders by Physicians Attending to People Living with HIV/AIDS (PLWHA) in a Nigeria University Teaching Hospital

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Abstract
People living with HIV/AIDS were found to have high co-morbid psychiatric disorders. These are usually not detected by managing non-psychiatrist physicians. The aim of this study was to determine the rate of detection of psychiatric disorders among People Living with HIV/AIDS attending outpatient clinics by their primary physicians. This study was carried out at the HIV clinics of the University of Ilorin Teaching Hospital, Ilorin among 300 consenting adult HIV positive patients. Physicians attending to these patients were requested to fill a form to indicate if these patients had psychiatric disorders and the types, during their routine review of the patients in the clinic. These patients were also assessed for the presence of psychiatric disorders by the researchers using Mini International Neuropsychiatric Interview (MINI). Diagnoses of psychiatric disorders were based on DSM-IV diagnostic criteria. The psychiatric morbidity rate in the studied population was found to be 38.3% (115 psychiatric cases) using MINI interview and DSM-IV diagnostic criteria. Diagnoses of psychiatric disorders were however correctly made in only 39 (13%) of the patients by the attending physicians (X^2 = 47.96; p-value= < 0.000). Overall, 66.1% of patients with psychiatric disorders were not detected by the managing physicians. None of the cases detected by the attending physicians was offered psychological intervention and no case was referred to the psychiatric unit for management of associated psychiatric disorders. Psychiatric disorders among PLWHA were under-diagnosed by their primary doctors. There is need to improve the ability of the doctors to detect and manage common mental health problems usually found among people living with HIV/AIDS.
Keywords: Psychiatric morbidity; PLWHA; Primary care physician; Nigeria.

1. Introduction

Studies have found significant prevalence rates of psychiatric co-morbidities among people living with HIV/AIDS (PLWHA) (Brian et al. 2006; Komiti et al. 2003; Lyketsos et al. 2000; Abiodun, 1990). Prevalence rates reported vary depending on the location, method of assessment and the type of population studied. The rate of psychiatric co-morbidities in people living with HIV/AIDS has consistently been found to be higher than in those without the disease (Sheu and Muktar 2008; Audu et al. 2007; Adewuya et al. 2007). Mood disorders were the most common form of psychiatric disorders reported among PLWHA in clinical settings (Brian et al. 2006; Myer et al. 2008; Olley et al. 2003; Kimoti et al. 2003). Other psychiatric disorders that are commonly found among them include anxiety disorders, post-traumatic stress disorder, substance use disorders and psychotic disorders (Adewuya et al. 2007; Olley et al. 2005; Kelly et al. 1998).

Different factors have been enumerated to be responsible for the co-morbid state. Many studies reported low socio-economic status, lack of social support, and unemployment to be essential factors (Sheu and Muktar 2008; Adewuya et al. 2007). Other factors were advanced stage of the HIV/AIDS infection and non-tolerance of Highly Active Anti-Retroviral Therapy (HAART).

Despite the recorded high co-morbidity between HIV/AIDS infection and psychiatric disorders, most cases are usually not detected by the attending physicians managing these patients. Petrushkin et al. (2005) reported that less than one-third of these patients with co-morbid conditions were detected at a HIV clinic.

In general, detection of psychiatric disorders in patients with chronic medical conditions by their attending physicians is usually found to be low (Feldman et al. 1995, Moaz et al. 1991). Different reasons have been adduced for this low detection rate which ranges from patients' factors to physicians' factors. Patients may not readily disclose psychological symptoms to their doctors while the physicians on the other hand may not ask for symptoms of psychological distress or view such as integral part of the ongoing physical illness (Gallego et al. 2011).

Low detection of these cases of psychiatric co-morbidities among PLWHA means that majority of them will not receive appropriate treatments for those disorders, resulting in poorer outcome for the patients (DeLorenze et al. 2010). This is because the detection and management of psychiatric disorders among PLWHA will not only reduce morbidity and mortality, but also improve the outcome and the quality of life of this group of patients

(Tostes et al. 2004, Yang et al. 2003).
The aim of this study was to determine the detection rate of psychiatric disorders among people living with HIV/AIDS attending outpatient clinic at the University of Ilorin Teaching Hospital, Ilorin, Nigeria, by the attending physicians.

2. Research Methods

Study setting: The study was carried out at the University of Ilorin Teaching Hospital, Ilorin, is a tertiary health facility in the North-Central geopolitical zone of Nigeria. The HIV clinics at the hospital are run by the Departments of Family Medicine, Internal Medicine, Microbiology and Heamatology on different days of the week.
Patients can be refereed to any of the clinics from within and outside the hospital. However, patients seen at the hospital General Out-Patient Department are usually referred to Family Medicine unit HIV clinic while those that come through the Accident and Emergency unit or found to be positive for HIV infection while on admission are usually referred to the Internal Medicine HIV clinic. This makes these two clinics the most patronized in terms of patient load. Hence these two HIV clinics were used for this study.
2.1 Subjects: Three hundred consenting adult HIV positive patients (required sample size was calculated) were seen during the study period of four months (January – April, 2010). Twelve physicians from the two departments participated in this study. These doctors attended to the HIV/AIDS patients that came for routine follow-up clinics after which they filled a slip which was prepared following the format used in a previous WHO study (Harding et al. 1980) on which each doctor running the clinic indicated each patient's hospital number, sex and also responded whether or not he/she thought the patient had a psychiatric disorder. A doctor responding positively (yes response) also specified the type of psychiatric disorder.
After this, the patients were each assessed by one of the research psychiatrists (DS) using Mini International Neuropsychiatric Interview (MINI) (Sheehan et al. 1998). Diagnoses of psychiatric disorders were made in accordance with the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association 1994).
2.2 Ethical Consideration
Approval for the study was obtained from the Ethics and Research Committee (ERC) of University of Ilorin Teaching Hospital (UITH). Permission to study the patients was also obtained from the consultants' in-charge of the clinics. The informed consent of each respondent was sought and only those whose consents were obtained were recruited into the study.

3. Results

The attending physicians made diagnoses of psychiatric disorders in 47 (15.7%) out of 300 patients assessed. The types of diagnosis made by the attending physicians were depressive illness 21 (44.7%), anxiety disorders 13 (27.7%), neurosis 12 (25.5%), and psychosis 1 (2.1%).

Table 1 Diagnostic rating by attending physicians

Diagnosis by the physicians'	Number (%)
Physical problem only	253 (84.3)
Physical and mental problems	47 (15.7)
Specific Diagnosis	
Depression	21
Anxiety disorders	13
Neurosis	12
Psychosis	1
Grand total	300 (100)

However, using MINI, the research team were able to confirm 115 (38.3%) cases of psychiatric disorders among the patients. The breakdown of the cases showed that; 60 (52.2%) had depression; 30 (26.1%) had dysthymia; 7 (6.1%) had panic disorder; 6 (5.2%) had schizophrenia-like psychotic disorder; 6 (5.2%) had post-traumatic

stress disorder; 5 (4.3%) had social phobia and 1 (0.9%) participant had diagnosis of alcohol dependence syndrome.

Out of a total 115 cases of patients living HIV/AIDS with psychiatric co-morbidities detected in the studied population by the psychiatrists, only 39 (33.9%) were correctly identified as having mental health problem by the attending physicians. Thus the attending physicians were significantly less likely to detect psychiatric disorders in the study population compared to the researchers diagnoses, (X^2= 47.96, p< 0.000).

Out of 47 cases diagnosed as having psychiatric morbidities by the attending physicians, 8 were non-cases as identified by the psychiatrists using MINI and DSM-IV criteria. This gives the diagnostic sensitivity as 33.9% and diagnostic specificity as 95.6%.

Table 2 Diagnosis of primary physicians compared with case detection by psychiatrists using MINI and DSM-IV criteria

	Diagnosis by Primary Physicians		
Presence of DSM-IV diagnosis (psychiatrist)	Mental disorder present	Mental disorder absent	Total
Cases	39	76	115
None cases	8	177	185
Total	47	253	300

Diagnostic sensitivity: 33.9%
Diagnostic specificity: 95.6%

When those that had psychiatric disorders were compared with the ability of the physicians attending to these patients to detect if they had psychological problems at all or not, the followings were observed: Out of the 30 cases of dysthymia, 22 (73.3%) were considered as non- cases by the attending physicians. Thirty-nine (65%) cases of depression were also missed. Half (50.0%) of the cases of schizophrenia-like psychotic disorder and PTSD were considered as non-cases by their primary doctors. Four (57.1%) out of the 7 participants with panic disorder were considered as non-cases and the only case of alcohol dependence was also missed.

On the other hand, when specific diagnoses made by the primary physicians were compared with the research diagnoses using MINI, the followings were obtained: Out of the 13 cases identified by the primary physicians as anxiety disorder, only 6 (46.2%) had diagnosis of anxiety disorders. Four (30.7%) of them had depressive disorder, 1 (7.7%) had psychotic disorder and the remaining 2 (15.4%) were non-cases. They also made diagnosis of depressive disorder in 21 participants. Breakdown of this showed that 19 (90.4%) had depressive disorder, 1 (4.8%) had schizophrenia-like psychotic disorder and the remaining 1 (4.8%) was a non-case. Diagnosis of neurosis was made in 12 participants out of whom 6 (50%) were cases of depressive disorders, one (8.3%) of them had diagnosis of anxiety disorder, and the remaining 5 (41.1%) were non-cases. Diagnosis of psychotic disorder was made in only one participant and the final diagnosis using MINI was also a psychotic disorder (schizophrenia-like).

None of these few patients living with HIV/AIDS detected by the attending physicians to have psychiatric disorders were offered any psychological intervention and none of them were referred to the psychiatric unit for management of their psychiatric disorders.

4. Discussion

It has been established that there are increased prevalence rates of psychiatric disorders among people leaving with HIV/AIDS (Adewuya et al. 2007; Olley et al. 2005; Ciesla and Roberts 2001). This has also been confirmed in the present study where a prevalent rate of 38.3% was found for psychiatric morbidity among PLWHA.

This study also showed that most of the psychiatric cases were not detected by the attending physicians with only about one-third being identified. When symptoms were recognized, diagnoses were also often missed in many of the patients. However, the attending physicians were more likely to make diagnosis of depressive disorder correctly than any other type of psychiatric disorder. It was observed that cases where the primary physicians had difficulty making a specific diagnosis were labeled simply as neurosis.

Earlier studies had found detection rate of psychiatric disorders among PLWHA by the healthcare providers to be less than or equal to 33% (Petrushkin et al. 2005). This was however done among counselors attached to the clinic. Findings from various studies among chronically ill patients in non-psychiatric settings have shown that the rate of detection of psychiatric disorders by non-psychiatric physicians to be low (Maguire et al. 198;

Abiodun and Ogunremi 1990; Fallowfield 2001). Feldman et al (1995) observed that non-psychiatric physicians were able to recognized 35% of patients with psychological distress among patients attending secondary health facility in Israel. The reasons adduced for this reduced ability to detect psychiatric problems among medically ill patients by their primary physicians included patients' factors of non-disclosure of psychological symptoms to their doctors and failure of the physicians on their part to ask specifically for symptoms of psychological distress in their patients (Gallego et al. 2011). However, studies have demonstrated that psychiatric disorders in PLWHA are treatable and results into improvement in the quality of life of the patients and also better compliance to treatment (Hartzell et al. 2008; Tostes et al. 2004; Yang et al. 2003). It is therefore essential that doctors managing PLWHA are trained to detect and manage common mental health problems found among this group of patients in order to ensure an improved outcome in the patients

5. Conclusion

Psychiatric disorders in PLWHA are common and most of these cases remain undetected by physicians attending to them. Mental health professionals therefore need to collaborate with the physicians. This may be inform of conducting training programmes/ workshops on the detection and management of common mental health problems among PLWHA, including training on the use of valid and reliable short screening instruments to improve detection rate. Psychiatrists should also be involved in the provision of liaison services with the physicians taking care of PLWHA in order to improve the overall quality of care of these patients. This will help guarantee a holistic approach (biopsychosocial model of care) to the care of patients living with HIV/AIDS.

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