Common Mental Health Issues in People Living with HIV

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Disclaimer

- “I have no financial interests that relate to this presentation”

- William Hight, Ph.D.
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Mental Health and Medicine

- We like to diagnose.
- There are 2 sides to the labeling coin:
  - Helpful to communicate with other professionals, to see patterns, to conduct research
  - Stigmatizing and Stereotyping

Working with the PLWH

- Mood Disorders
  - Depression
  - Bipolar Disorder

- Challenging Personalities: Unstable Extroverts

UNDERSTANDING MOOD DISORDERS

Clinical Depression

- Cluster of emotional, physical and behavioral symptoms
- Includes sadness, low self-esteem, loss of pleasure, difficulty functioning
- Overwhelming
- Persistent

Diagnostic Criteria (simplified) for Major Depressive Disorder: One from Column A and Four from Column B

Column A

- Feeling depressed, sad, down, hopeless
- Loss of interest or pleasure in things previously enjoyed

Column B

- Changes in appetite/weight
- Insomnia or too much sleep
- Slowed down physically or mentally
- Agitated
- Fatigue
- Feeling Guilty/Worthless
- Difficulty Concentrating/Making Decisions
- Persistent thoughts of death/suicide

With HIV, Symptoms of Depression can also be caused by

- Low testosterone
- Efavirenz (Sustiva)

Treatment Options

- Psychotherapy
- Antidepressant Medication
- Combination tends to be best

Antidepressants

SSRIs*

- e.g., Prozac, Paxil, Zoloft, Luvox, Celexa, Lexapro

SNRIs*

- e.g.,Effexor, Cymbalta, Pristiq

Others*

- e.g., Remeron
- Wellbutrin (bupropion)

*brand names

Antidepressants and HIV

- Great source of up to date info . . .

www.hivinsite,.ucsf.edu

Antidepressants and HIV

- St. John's Wort – non-prescription homeopathic found in some studies to help with depression.
  - **FDA warning: reduces amount of some Anti-HIV medications in the body to ineffective levels**
    - **PIs**
    - **NNRTIs**

Depression and Recreational Drugs

- Ecstasy – affects serotonin levels
  - Potential long-term effects including depression, anxiety
- Crystal Meth
  - Leads to depression, anxiety
  - May lead to paranoid psychotic symptoms
- Alcohol, Marijuana
  - may cause/increase depressive symptoms

Implications of Depression for Clients Care – Group Discussion

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- .
- .
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BIPOLAR DISORDER

SOME MATERIALS PROVIDED BY CHRISTINA PRICE-EATON, DELTA REGION AIDS EDUCATION AND TRAINING CENTER

Bipolar Disorder

- Psychiatric disorder that causes unusual shifts in
  - Mood
  - Energy
  - Ability to function
- Results in
  - Damaged relationships
  - Poor job/school performance
  - Suicide

Bipolar Disorder: Characteristics

- Extreme, sometimes unpredictable mood
- Periods of highs and lows are called episodes of MANIA and DEPRESSION
- Sever changes in energy and behavior accompany changes in mood
- Periods of normal mood occur in between

Bipolar Disorder

- Affects 5.7 million adults (2.6%) in a given year
- Develops in late adolescence/early adulthood
- Often not recognized
- Long-term illness
- Alcohol and drug abuse very common

Bipolar Disorder: Causes

- Inheritance/Genetics
- Stressful environmental or other negative life events
- Other possible triggers:
  - Antidepressant meds (mania)
  - Sleep deprivation (mania)
  - Hypothyroidism (depression)

Bipolar Disorder: Characteristics

- Symptoms exist on a continuum
  - Severe Mania
  - Hypomania (mild to moderate)
  - Balanced
  - Mild to Moderate Depression
  - Severe Depression

Mania

- Increased energy
- Overly euphoric
- Extremely irritable
- Racing thoughts/speech
- Easily distracted
- Little sleep needed
- Unrealistic beliefs in one's abilities/powers
- Poor judgment
- Spending sprees
- Lasting period of unusual behavior
- Excessive drug use (including sleeping meds)
- Increased sexual drive
- Provocative, intrusive or aggressive behavior
- Denial of problem

Mania and HIV

- Mania in PLWH can either be primary (preexisting bipolar disorder) or secondary (result of HIV disease).
- Secondary mania (AIDS mania) differs from bipolar disorder in later age of onset and lower occurrence of family or personal history of mood disorder. Typically occurs at later stages of HIV illness and characterized by more irritability, more psychomotor slowing and increased talkativeness. May be associated with cognitive impairment/dementia and structural brain abnormalities on CT or MRI.
- ----- from Glen Treisman, M.D., Ph.D; Jeffrey Hsu, M.D, Johns Hopkins Poc-It Guide

Hypomania

- Less destructive state than mania
- Fewer symptoms of mania
- Shorter duration of symptoms
- Often very “artistic” state of the disorder
  - Flights of ideas
  - Extremely clever thinking
  - Increased energy

Depression revisited

- Feeling depressed, sad, down, hopeless
- Loss of interest or pleasure in things previously enjoyed
- Changes in appetite/weight
- Insomnia or too much sleep
- Slowed down physically or mentally
- Agitated
- Fatigue
- Feeling Guilty/Worthless
- Difficulty Concentrating/Making Decisions
- Persistent thoughts of death/suicide

Bipolar: Mixed State

- Symptoms of mania and depression occur simultaneously
  - Anxiety, belligerence, confusion, fatigue, insomnia, irritability, paranoia, racing thoughts, restlessness, psychosis and rage
  - Moods easily and quickly shifted
  - Suicide attempts, substance abuse and self-mutilation may occur

Most Common Types of Bipolar Disorder

- Bipolar I
  - One or more manic or mixed episodes. Depression not required for diagnosis, but may occur.
- Bipolar II
  - At least one episode of hypomania and at least one major depressive episode
    - More common
    - More difficult to diagnose
- Cyclothymic Disorder
  - History of hypomania and at least one depressive episode not meeting requirements for major depression. Slow cycling of mood, often seen as personality trait by others.

Treatment for Bipolar Disorder

- Goal is management, not cure
- Timely and competent treatment can be difficult
- Adherence is very important

Optimal Treatment combines medication and psychosocial therapy

Medication

- Mood Stabilizers
  - Lithium prevents and controls manic and depressive episodes
  - Anticonvulsants for difficult to treat episodes (valproate orcarbamazepine)
- Thyroid Supplementation
  - Indicated especially for rapid cycling
  - Lithium treatment may reduce thyroid levels

Bipolar Disorder and HIV

- Both mania and depression occur more often in patients with AIDS diagnosis
- Failure to treat may result in
  - Nonadherence to HIV medications
  - Self-destructive behaviors
  - Unsafe sex !!!

WHAT TO DO?

- Provide support and patience when patient is “testing out” treatments for mood disorders
- Encourage treatment continuation
  - Educate on adherence techniques
  - Facilitate keeping mental health appointments
- Facilitate and encourage support from family/significant other
- Check for decreased need for sleep/increased energy (often first sign of manic episode)

WHAT TO DO?

- Coordinate care with other care providers, therapists, psychiatrists etc.
- Support balanced lifestyle
  - Regulate stress levels
  - Regular exercise
  - Regular sleep and wake times
- Offer referrals to support groups for patient/clients and their families

CHALLENGING PERSONALITIES

Personality Disorders

- **Suspicious**
- **Unforgiving**
- **Eccentric**
- **Peculiar**
- **Deceitful**
- **Irresponsible**
- **Rigid**
- **Stubborn**
- **Arrogant**
- **Manipulative**

“But that sounds like most of my inlaws . . .”

Personality Disorder. . .

- **An enduring pattern of inner experiences and behavior that deviates markedly from the expectations of the individual's culture.**

DSM-V

Personality Disorder. . .

- **Demonstrated in at least 2 areas, including cognition, affectivity, interpersonal functioning and impulse control.**

DSM-V

Personality Disorder. . .

- **Must be inflexible, pervasive, leading to significant distress or impairment, and have an onset in adolescence or early adulthood.**

DSM-V

Personality Disorders and HIV

- General population 10%

  Lezenweger, 2008

- HIV-infected 19-36%

  Jacobsberg, Frances & Perry,1995

Personality Dimensions
Moving away from labels

- Introversion/Extroversion
- Stability/Instability

~60% of people living with HIV/AIDS **seeking psychiatric treatment** have blend of extroversion and emotional instability. **Treisman and Angelino, 2004**

Extroversion

- Focus on immediate experience
- Feelings over thoughts
- Motivated by immediate gratification
- Sociable, impulsive
- Risk-taking

Emotional Instability

- Emotionally labile
- Intense emotional experiences
- Act out in irrational ways
- Impulsive

Working with Unstable extroverts . . .

(adapted from Gibbs and DeWitt)

- Focus on thoughts, not feelings
- Use behavioral contracts
- Emphasize rewards
- Coordinate care between medical and mental health teams

Working with Unstable extroverts . . .

(adapted from Gibbs and DeWitt)

- Avoid being punitive
- Be firm and kind
- Use healthy detachment with anger, anxiety, need to control
- Accept limits of your tolerance for patient's personality

Working with Unstable extroverts . . .

(adapted from Gibbs and DeWitt)

- Avoid battling about unreasonable demands/requests
  - **Time is your friend (24 hour rule)**
  - **Consult with colleagues**
- Don't berate yourself for being "used" or manipulated
- Use case management meetings to staff difficult situations……..

Speaking of difficult situations. . .

It's "Put Bill on the Spot" Time, aka clinical consultation.

THANK YOU AGAIN!