Common Mental Health Issues in HIV-Infected Patients

Mollie Gurley, MSN, APRN, PMHNP-BC
Assistant in Psychiatry, Faculty in the Division of Child of Adolescent Psychiatry
Vanderbilt University Medical Center

Disclaimer

- I have no financial interests that relate to this presentation

Objectives

- How to screen for psychiatric disorders in HIV-infected patients
  - Diagnostic criteria
  - Treatment (medication management, therapy)
- Important and unique implications of mental health treatment in HIV infected patients

Group Discussion

- Why is management of depressive symptoms in HIV-infected patients important?
- What are special considerations when treating this population?
- What are the most common mental health issues/diagnoses you see in practice?

Why is management of co-occurring psychiatric disorders important?

- The prevalence of depression in HIV infected patients is twice as much than in HIV-negative patients (different studies ranges 15% to 40%)
- Risk of depression increases with the progression of HIV infection (2.5 fold increase as it progresses to AIDS)
- Also many medications used in HIV treatment can cause depression, as well as low testosterone

Why is management of co-occurring psychiatric disorders important?

- There are two different likely causes of the increased risk for mental health issues
  - Stigma/isolation, chronic stress
  - The HIV virus and enters and resides in your brain (direct damage to subcortical brain areas and neuroinflammation)

Diagnostic Criteria for Major Depressive Disorder

- **Requires 5 or more in a two week period and one must be depressed mood or anhedonia:**
  - **Depressed or irritable mood most of the day nearly every day**
  - **Decreased interest or pleasure (anhedonia)**
  - **Significant weight change or change in appetite**
  - **Change in sleep (too much or too little sleep)**
  - **Change in activity (psychomotor agitation or retardation)**
  - **Fatigue/loss of energy**
  - **Guilt/worthlessness**
  - **Diminished ability to think/ concentrate**
  - **Suicidal Ideation**

Treatment of Major Depressive Disorder

- Antidepressant medication
  - SSRI's (typically first line)- Prozac, Zoloft, Lexapro, Celexa, Paxil
  - SNRI's- Effexor XR, Pristiq, Cymbalta
  - NDRI's- Wellbutrin (SR, XL)
  - Start low and go slow to improve adherence (reduces initial side effects)
  - Insomnia- responds well to low doses of Trazodone 25 mg-150 mg
- Psychotherapy
  - CBT, DBT

Special Considerations with HIV and Depression treatment

- Depression has been linked to lower ART adherence rates
- In a meta-analysis across 29 studies of 12,243 persons living with HIV/AIDS found that the treatment of depression improved adherence to antiretroviral regimen
- The odds of adherence were 83% better in individuals treated for depression. (Sin & DiMatteo 2013)

Bipolar Disorder

- Due to increased risky behaviors in mania, bipolar disorder has been linked to a higher risk of acquiring HIV infections
  - Bipolar I Disorder
    - Euphoric or irritable mood and increased energy or activity for 1 week
    - 3 of the 7: grandiose, decreased need for sleep, talkative, racing thoughts, distractibility, increased goal directed activity, impulsive
    - Must have social or work impairment

Bipolar Disorder

- Bipolar II Disorder
  - At least one HYPOMANIC episode and one MAJOR DEPRESSIVE episode
  - No full manic episodes
    - HYPOMANIA- the same symptoms of Bipolar I manic episode EXCEPT at least 4 days duration instead of 7 days
    - NO marked impairment in social or occupational functioning
    - Hypomania is typically harder to diagnose

Secondary Mania or AIDs Mania

- Mania 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
  - Later stages of HIV illness
  - Characterized by more irritability (less euphoria), cognitive impairments, talkative, psychomotor slowing
  - FAR more chronic, does not remit if left untreated
  - Less common now due to advent of potent ART

AIDS Mania

- A frequent manifestation is a delusional belief that they have discovered the cure or been cured of HIV
- Dangerous delusion results in high risk behavior and medication nonadherence
- Unfortunately the cognitive impairments also render these patients less likely to pursue treatment independently or consistently

Psychotropic Treatment of Bipolar Disorder

- Lithium
- Depakote (coated tablets better, less GI SE's)
- Atypical Antipsychotics- Risperdal, Zyprexa, Geodon, Seroquel, Latuda, Abilify
- Several considerations of treatment of AIDS Mania:
  - In late stages of the HIV illness doses may be much lower due to greater sensitivity to both therapeutic and toxic effects

What Can I Do?

- Encourage treatment continuation and provide support when patient is “trying out” new medication
- Educate on adherence techniques
- Facilitate keeping mental health appointments
- Facilitate and encourage family/social support (isolation is a barrier to adherence)
- Check for decreased need for sleep as this can be a first sign of a hypomanic/manic episode

What Can I 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

Schizophrenia

- No evidence suggests that HIV causes schizophrenia, but data does suggest schizophrenia's HIGH RISK behavior contributes to risk/prevalence of HIV infection
- Diagnostic Criteria:
  - Must have 1 positive symptom (hallucinations, delusions, disorganization) for one 1 month
  - 2 of the following: hallucinations, delusions, disorganized speech/behavior, or negative symptoms (low emotion, low motivation)
  - Prior or residual poor functioning for at least 6 months
  - Social or work impairment

Treatment of Schizophrenia

- Antipsychotic medications are first line treatment:
  - Atypical Antipsychotics- Risperdal, Abilify, Seroquel, Geodon, Zyprexa, Invega, Latuda, Saphris, Clozaril, etc. (more metabolic SE's)
  - Typical Antipsychotics-Haldol, Prolixin, etc. (more extrapyramidal SE's)
  - LAI (long acting injectables) can improve adherence, IM injection every 2-4 weeks

PTSD

-Exacerbates HIV risk behaviors and worsens health outcomes

- PTSD and early trauma make patients more high risk for engaging in behaviors that increase risk of HIV
- Often co-exists with substance abuse

PTSD Symptoms

- Intrusive thoughts, nightmares and flashbacks of past traumatic events (re-experiencing symptoms)
- Avoidance of reminders of trauma, hypervigilance, and sleep disturbance
- Lead to dysfunction in these areas:
  - social
  - occupational
  - interpersonal

PTSD

- Just because someone experiences a traumatic event (or multiple) does NOT mean they have PTSD
- Most experience onset within a few months of the traumatic event, although there can be delayed onset (>6 months)

Helpful Questions for PTSD Assessment

- How do you feel when you recall the event?
- Do you experience dreams or flashbacks about it?
- Do you find yourself avoiding people, things, or activities you associate with the event?
- Do you find yourself forgetting occurrences from that period?
- Do you find yourself looking carefully around when you are in a public place?

PTSD

Treatment

- Anxiety Disorders treated with therapy (TF-CBT, CBT, DBT, EMDR, etc.)
- CBT has the most evidence
- SSRI's are first line
- CBT and SSRI's = best outcome

Group Discussion: Personality Disorders and HIV

- What are some of the most common challenging personality disorders or characteristics that you experience in this population?
- What have you found helpful when increasing therapeutic alliance and rapport with these patients?

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

Treisman and Angelino, 2004

Personality Disorders and HIV-infected Patients

- More prevalent among HIV-infected individuals (19-36%) than the general population (10%) Johnson JG, Williams JB, Rabkin JG, et al. 1995
- Cluster B Disorders are most common (antisocial, borderline, narcissistic, and histrionic) and are present in up to 49% of substance abusers
- Antisocial Personality Disorder is the most common PD among HIV infected individuals
  - Additionally, has been shown to increase the risk for of HIV infection Weissman, 1993

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

Following approaches for PD's and treatment adherence:

- Describe behaviors in terms of rewards
  - Reframe from "consequence avoidance" to describe the benefits, ex. "If you don't stop using drugs, you'll get sicker" vs. "If you stop using drugs, you'll feel better"
- Help patient recognize their vulnerabilities
- Focus on THOUGHTS not FEELINGS
- Describe the treatment plan clearly and with firm limits (unified set of goals and expectations)

Substance Use Disorders

- Substance dependence can be a primary vector for transmission of HIV and complicate HIV treatment
- Numerous co-morbidities with previously discussed psychiatric disorders
- Often difficult to distinguish one from the other
- The most significant co-morbidity with HIV and substance abuse is DEPRESSION

Simplified Steps for Substance Abuse

- Acceptance as a role of a patient
- Detoxification
- Rehabilitation
- Treatment of co-morbid conditions
- Maintenance treatment and relapse prevention

- Referral to addiction medicine and specialists

Conclusions

- Co-morbid psychiatric disorders are of increased prevalence among HIV seropositive individuals and represent unique challenges
- The identification and effective management of co-morbid psychiatric disorders can improve adherence, treatment outcomes, and quality of life for those living with HIV/AIDS.