EUROPEAN HIV NURSING CONFERENCE

19-20 October 2014 • Barcelona, Spain

HIV & Mental Health

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HIV

Depression & Anxiety

ARV related issues

Bipolar Disorders

Personality Disorders

Dementia

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HIV & Mental Health

- **HIV infection is higher among certain at-risk groups, such as injecting drug users and patients with severe mental illness (Beyer, 2007)**
- **Neurologic complications associated with HIV were recognized very early in the epidemic (Dube, 2005)**
- **Some HIV treatments can produce psychiatric side-effects (Treisman & Kaplin, 2002)**

HIV, Depression & Anxiety

- It may be difficult to distinguish between a ‘natural reaction’ to HIV diagnosis & psychiatric disorder.
- History taking may be difficult…what do you call it, low mood? Depression? mental health disorder?
- And if diagnosed it it seldom treated (Rodkjaer, 2010)
- Depression is high in HIV and has a negative impact such as poor adherence (Mayston, 2012)

HIV, Depression & Anxiety

- Depression maybe made worse by insomnia, fatigue etc.
- Suicide still a risk (3 times higher than the general population) (Keiser, 2010)
- Anxiety disorders noted such as social phobia, agoraphobia, panic & post traumatic stress disorder.

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Diagnostic Criteria of Major Depressive Disorder (MDD)

- Depressed mood
- Loss of interest or pleasure
- Decrease in appetite
- Insomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of excessive guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death, recurrent suicidal thoughts.

HIV-related Medications that may induce mood disorder symptoms

- **Steroids**: depression or euphoria
- **Interferon**: neurasthenia, fatigue syndrome, depression
- **NRTI**: depression or euphoria
- **NNRTI**: decreased concentration, depression nervousness, nightmares

Case Study - Tony

- 32, gay man. Diagnosed positive 2010 after a routine screen (negative test 2009)
- Accepting of diagnosis, not unduly anxious or distressed
- CD4 426 VL 59, 545
- Lived with negative partner. Smokes and drinks socially, past use of recreational drugs but not since diagnosis
- Working full time some stress “small things” requested counselling

Tony 4 & 6 months later

- Appeared well, had a cold. CD4 316, VL 17,358
- Stopped work due to stress, still seeing health advisors.
- 6 months after diagnosis - Commenced ARV's (kivexa/Efavirenz)
- Admitted voluntarily to mental health unit (MHU) via A&E with acute anxiety state, thoughts of self-harm and suicide. Diagnosed withAdjustment Disorder – had left partner, moved to parents (unaware of his status). To remain on ARV's
- Disclosed that he had started ARV's the day before admission to MHU and had self harmed and felt depressed since diagnosis.

One month after discharge from MHU

- Reported mood swings, felt ‘crazy’ felt pressure to continue taking ARV’s
- Diagnosed as ‘bipolar’ (labelled as difficult to manage, excitable, tearful, aggressive at times)
- Switched to Kivexa/ Etravirive
- Reported feeling “back to normal” but still remained anxious and stressed

All's well that ends well!

- **One month later – arrested for attacking his sister and damaging property, admitted to MHU voluntarily but sectioned after attempting to hang himself. Diagnosed with severe depression & adjustment disorder. Commenced Mirtazepine**
- **Today – mood improved, discharged from MH services**
- **CD4 627 VL undetectable**

Case Study - John

- John, 49, HIV positive since 1995.
- Extensive ARV history has tried numerous regimen's with moderate to severe side-effects.
- Severe peripheral neuropathy and all over pain – taking morphine
- Cared for by ex-partner who is newly diagnosed and easily stressed.
- Decided not to have anymore treatment and requested Palliative support. Referred to CNS for support.

John - On Assessment

- Thin, poor appetite, Poor mobility walks with a stick,
- CD4 47, VL 14,345. Feels lethargic, sleeps a lot during the day. Night sweats, frequent infections, insomnia.
- Advised to go on ARV's Ritonavir, Darunavir, Truvada (refuses Truvada due to side-effects)
- Referral to local hospice for symptom control but refused as he requests CPR & active treatment.
- Issues with carer discuss looking for new carer or respite care to give him a break.

What are the issues?

- Stops treatment as tired/fatigued and wants to die
- Wants active treatment so he doesn't die
- Refuses counseling or psychological support
- Some manipulation of carer (carer now seeing psychologist)
- Depressed at times, tearful but at times happy to talk around funeral arrangements and end of life issues

What can I do?

- **Be prepared and know your limits -** avoid situations that make you wary or anxious, as this may be obvious to the patient.
- **Treat everyone as a person -** holistically with respect, with appropriate boundaries, and with an understanding of that person's life
- **Don’t jump to conclusions –** don’t put every incident down to mental illness, there may be other causes drug or alcohol use, blood toxicities, infection, double dosing.
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What can I do?

- **Be open, honest & non-judgmental –** we may have fears that effect we work. Being honest may mean admitting that you are unsure what to do next and need to seek advice; or that you are anxious or worried about a patient/situation.
- **Take HIV out of it –** mental health issues may have been around long before the HIV diagnosis, get to know their history and what has worked and not worked before is useful.
- **Seek help, education & know the law** – get to know your local MH service, laws that support you and the patient.