



HIV and Clinical Depression

Why is clinical depression a concern for people with HIV?

Mood disorders – depression in particular -- are the most frequent psychiatric complication associated with HIV disease. In fact, one study estimates lifetime prevalence of depressive disorders to range from 22.1-61.0% in HIV-positive populations. These rates are significantly higher than estimates of lifetime (5% and 17%) and current (3% and 10%) diagnoses of major depression in community samples. (1)

Who is at risk for depression?

Individuals with who HIV have not disclosed their seropositive status, have lost loved ones to HIV, or are themselves in an advancing stage of the illness are at serious risk. Treatment failure, and even treatment success should also be considered risk factors for depression. People who have a current or past history of alcohol use or drug use need to be screened for depression, and patients who have poor social support are especially at risk. A history of mood disorders, suicide, or anxiety disorders– either in the patient or the patient’s family – are serious risk factors for depression.

Does HIV cause depression?

A common belief among health care professionals is that an HIV-positive diagnosis will naturally result in depression. While the diagnosis will certainly trigger anxiety and distress – sometimes so severe that it impairs functioning and may even lead to suicide – this kind of situation-specific emotional response is not the same as depression. A person experiencing the distress of being diagnosed with HIV may indeed need treatment, most likely for an adjustment reaction, but the distress will respond to supportive and other types of psychotherapy rather than medications.

HIV-related damage to subcortical areas of the brain can produce HIV dementia, resulting in states that are mistaken for clinical depression. In addition to dementia, there are other medical and endocrine abnormalities experienced in patients with HIV which can create mood disturbances. Systemic illnesses secondary to HIV infection, like hepatitis, PCP, endocrinopathes can all look like depression. Malnourishment, specifically with defi-

ciencies in vitamins B6 and B12 also mimics depression.

What’s more, a number of medications used to treat HIV have side effects that can cause depression and other psychological symptoms, as outlined in the table below.

HIV Medication	May Trigger
Interleukin	Depression, disorientation, confusion and coma
Steroids	Mania or depression
Efavirenz (Sustiva)	Decreased concentration, depression, nervousness, nightmares
Stavudine (Zerit, d4T)	Depression or mania, asthenia
Zidovudine (Retrovir, AZT)	Mania, depression
Interferon	Neurasthenia fatigue syndrome, depression
Zalcitabine (Hivid)	Depression, cognitive impairment
Vinblastine	Depression, cognitive impairment

How can a clinician differentiate depression from other complications of HIV?

Symptoms of true clinical depression come in two categories, affective and somatic. Affective symptoms include depressed mood, loss of interest in normally pleasurable activities, feelings of guilt or worthlessness, hopelessness or suicidal ideation. Somatic symptoms include loss of weight/appetite, sleep disturbances, agitation/retardation, fatigue and loss of concentration. Some of these symptoms of clinical depression (e.g. fatigue) can masquerade as effects of HIV and its treatment. But the fatigue that accompanies depression will include a true loss of interest (as opposed to simply loss of ability) in formerly enjoyable activities. (2)

Because the effects of HIV and its treatment, and other physical illnesses can affect mood, differentiating these things from clinical depression is a challenge– but the key to seeing the difference is in depression treatment response. Conditions that are not actually depression will respond poorly to antidepressant treatment.



What kind of treatment is appropriate for a person with HIV who is suffering from clinical depression?

The same treatments used with depression in the general population are effective in treating depression in people with HIV (see table below). All of the treatment options listed below should be considered with the patient's stage of illness and his particular treatment plan for HIV in mind. In particular, psychopharmacology must include monitoring for drug-drug interactions. Some drug-drug interactions to be especially alert to include potential change in absorption of depression medications (because of the actions of HIV medications), competition for protein binding affects, and in-

Depression therapy	Advantages	Drawbacks
SSRIs (Prozac, Paxil, Zoloft)	Relatively easy to use and are well tolerated by most patients.	Increased GI activity, anorgasmia, akathisia, apathy, anxiety, and when toxic, a serotonin syndrome.
Bupropion (Wellbutrin)	Rarely causes sexual dysfunction.	Contraindicated in patients with unstable seizure disorder; multiple divided dosings
Venlafaxine (Effexor)	Raises CNS levels of both serotonin and norepinephrine; well-tolerated as first-line agent or in patients refractory to other antidepressants.	Initial stimulant side effects may disturb some patients, may increase blood pressure in hypertensives; GI side effects (also common with antiretrovirals)
Trazodone (Desyrel)	Can be used as sedative at low doses.	May cause sedation in a.m. at 50-100 mg when taken at night; 1/7000 incidence of priapism
Tricyclics	Weight gain and constipation can be helpful with marked weight loss or diarrhea. Sedation is useful with insomnia. Marked benefit on neuropathic pain, common in late HIV and AIDS.	Weight gain, constipation, orthostatic hypotension, dry mouth, sedation. Can be lethal in overdose.
Hormones (testosterone, DHEA)	Can be very helpful in alleviating fatigue, anorexia, and diminished libido, particularly in patients with hypogonadism.	Off label for treating depression, side effects with hormone treatment impact biological functions
Electroconvulsive Therapy	May be especially useful for patients too medically ill to tolerate antidepressants or in severely suicidal, psychotic, or treatment resistant patients. May play a role in pregnant depressed patients.	Electroconvulsive therapy is associated with confusion just after the treatment is administered, and there is a greater likelihood of confusion in cases where a patient has a coexisting CNS disease
Psychotherapies	Can effectively address quality of life issues, other emotional issues related to HIV	May need to be used in combination with psychopharmacology for optimal effectiveness

duction/inhibition of CP450, which may alter drug levels.

Once clinical depression has been diagnosed in a person with HIV, the clinician should be mindful that the risk of suicide is higher than in the general population – and this is true at all stages of HIV. Finally, clinicians should be aware that with pharmacology the approach should be to “start low and go slow” with dosage, particularly in patients with an advanced case of HIV,

How important is it for people with HIV to get needed treatment for depression?

HIV-positive patients who have depressive symptoms will benefit from treatment beyond getting relief from the depression. In fact, a recent study suggests that depressed patients with HIV who are given treatment may be more likely to receive appropriate care for their HIV disease. Antidepressant therapy for treatment of depression is actually associated with a significantly lower monthly cost of medical care services (3).

A physician treating any patient for HIV who is depressed must weigh the benefits of treatment – and the potential to relieve symptoms of depression – against the side effects of the chosen treatment and the likelihood of adverse drug-drug interactions. Each patient, and each case, is individual, and must be approached as such. Treatment for depression can make a significant difference in treatment for HIV in both the physical and emotional well-being of individuals living with the disease.

References

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About this Fact Sheet

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