

Depression and HIV

Acceptance and support keep the blues out of positive life

by Dr. Marie-Josée Brouillette

Depression is different from the periods of melancholy we all experience in our lives. It's a prolonged state of profound sadness, a loss of interest and inability to feel pleasure in situations that should be pleasurable. These traits can be accompanied by other physical and emotional symptoms (see **Criteria for a major depressive episode** on page 15). Symptoms are severe enough to interfere with daily activities, and women are twice as likely to suffer from depression as men. Although many people living with HIV suffer from it, depression is not an inevitable part of life with HIV.

What causes depression?

Depression is linked to changes in neurotransmitters, the chemicals that permit communication between brain cells. The neurotransmitters involved in depression are serotonin, noradrenaline and dopamine, among others.

The chemical changes in the brain that are associated with depression are often brought on by stressful reactions to life events. The likelihood of depression increases with the number of stressful events we live through. Events are especially stressful when they're new, unpredictable, threatening or involve a sense of loss (for example, the loss of a job, or a dream for the future).

Lipodystrophy, for example, can contribute to depression for several reasons. It's accompanied by a sense of loss (the person's appearance), is beyond individual control, and involves the threat of being ostracized.

Why do some people get depressed when others don't?

Many inherited genes influence a person's likelihood of developing depression. For

instance, a "transporter gene" affects the neurotransmitter serotonin's signal to the brain. That transporter is a target for antidepressants, including serotonin reuptake inhibitors (SSRIs). Genetic factors influence the speed at which the "transporter" works. Some people are born with slower

Marc's depression

Marc is HIV positive and his health is generally good. But the lipodystrophy of Marc's face has become noticeable, and his colleagues, who don't know his status, have started asking about his health. Worried his features are revealing his secret, Marc begins to isolate himself, staying home and drinking alone. He has trouble sleeping, is always tired and has no appetite. He can't concentrate and makes mistakes at work. He begins to feel he may be suffering from dementia.

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transporter capacity, leaving them less prone to depression. Antidepressants such as SSRIs essentially restore “normal” function.

Childhood experiences also imprint on the brain. Abuse or neglect make the brain more sensitive to stress, increasing the likelihood of depression. But there again, genetic factors influence the effects the abuse will have.

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How to reduce the chances of depression

Being aware of the symptoms and causes of depression is useful: you can reduce your chances of depression and seek help if symptoms develop. As much as possible, don't stay in situations where you feel victimized or out of control. Look for concrete ways to regain control. Active coping involves facing a situation and searching for solutions rather than ignoring or enduring it.

It isn't always the event that produces negative stress, but how we interpret it according to our

If you're interested in reading more on the impact of childhood experience and genetics on depression, visit:

www.psyoeducation.org

values. Many people who've suffered a serious illness see their priorities change: the earlier we adapt our focus, the better we realize what matters to us.

None of us can eliminate unpleasant situations, but social support can minimize the resultant stress. The best kind of support varies from person to person. Some participate in community groups working with others who are HIV-positive. What's important is to have a place to talk and feel you're being heard and not judged. Seeking out and cultivating these relationships is essential, but can be very difficult for those who have lost many friends or who, for cultural or social reasons, keep their HIV hidden.

Depression in people living with HIV

Depression is more common among people with chronic diseases, and that holds true for HIV as well. That's partly due to the stress of living with a chronic disease, but also to changes in the blood prompted by immune reactions. This stimulation of the immune system (which is linked to viral load) results in a drop in the serotonin available to the brain and an increased risk of depression.

Any diagnosis of depression in an HIV-positive person must consider their complete medical history. Some symptoms of depression, such as insomnia, fatigue or loss of appetite, could be due to other factors, such as HIV itself. Some medications are also associated with depression, particularly efavirenz (Sustiva®) and interferon. Other conditions can contribute to the development of depression or show similar symptoms: hypothyroidism, hypogonadism, and brain infection. AIDS-related dementia often manifests as a lack of interest in one's surroundings, which strongly resembles depression. Any such conditions should be correctly diagnosed and treated.

Treating depression

While depression is linked to chemical changes in the brain, treatment does not always require medications. Psychotherapy and exercise can in some cases alter brain chemistry in the same way as antidepressant medications.



Suzie's predicament

Suzie just tested positive for HIV. She's devastated by the news. She's in love and wants a family. Should she continue her relationship? Can she get pregnant without putting her fiancé at risk? Will she live to see their child grow up? What kind of future will she have if she can't have a family? Suzie's becoming increasingly desperate. She cries all the time, can't sleep, can't eat and sometimes feels suicidal.

Antidepressants in use today are generally safe and well tolerated. A number of antidepressants have been studied specifically in people with HIV. Drugs for which there is double-blind trial evidence in HIV-infected patients include the tricyclic antidepressant imipramine (Tofranil®), the psychostimulant dextroamphetamine (Dexedrine®), and SSRIs fluoxetine (Prozac®), sertraline (Zoloft®) and paroxetine (Paxil®).

Drug interactions are not usually a problem, although doses of bupropion (Wellbutrin®, Zyban®) need to be reduced in the presence of ritonavir (Norvir®). The natural antidepressant St. John's Wort (*Hypericum perforatum*) is not recommended for those taking antiretroviral therapy that includes protease inhibitors (PIs) or non-nucleoside reverse transcriptase inhibitors (NNRTIs): it can reduce blood levels of the ARVs and lead to resistance.

Alcohol and recreational drugs are often sought out to alleviate distress. They can't treat depression, and are likely to aggravate it and complicate treatment.

The belief that things won't get better is part of depression. If a friend appears to be suffering, encourage him or her to see a doctor, even if it means making that first appointment for them and going along for the visit.

Never inevitable, never permanent

Major depression may improve without intervention, but can last several months and may even drive people to suicide. With treatment, it generally lasts only a few weeks. Thoughts of suicide and/or a significant change in attitude indicate a need for help.

Depression is not an inevitable result of HIV infection. If it does develop, it needs to be treated promptly. With attention, the hardships encountered can serve as a catalyst for growth and leave us better equipped to cope with the future. **R**

Criteria for a Major Depressive Episode

Clinical or major depression includes either or both of the following, persisting over a 2-week period:

1. **Depressed mood most of the day, nearly every day**
2. **Greatly lessened pleasure or interest in activities**

Also, at least 4 of the following additional symptoms must be present:

1. **Significant unintended weight loss or weight gain**
2. **Sleeping much more or less than usual**
3. **Thoughts and actions noticeably slowed down or speeded up**
4. **Persistent fatigue and loss of energy**
5. **Feelings of worthlessness, excessive or inappropriate guilt**
6. **Trouble concentrating and/or making decisions**
7. **Recurrent thoughts of death and/or suicide**

- **The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.**
- **The symptoms are not due to the direct physiological effects of a substance (for example, a drug of abuse, a medication) or a general medical condition (for example, hypothyroidism).**
- **The symptoms are not accounted for by bereavement — that is, after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.**

