Mental health matters

Use all the social, medical and coping resources you can to combat depression

By Dr. Mark Halman

Depression, anxiety and psychological concerns are common when you're living with HIV. The stress of living with a chronic infectious disease, the stigma associated with HIV infection and the complexity of the care regimen can all contribute to feelings of low mood or worry. Many people are able to use their social support networks, friends, community resources and primary care physicians to find successful strategies for coping and adapting to the stress in their lives. But a substantial number will develop more significant and persistent symptoms of depression and anxiety. These people may benefit from more intensive psychiatric and psychological care.

Major depression

The most common psychiatric problem experienced by people living with HIV is a major depressive episode. Symptoms are a persistently sad or low mood — you feel sad most days for a period lasting at least two weeks and feel sad most of the time. This episode marks a distinct shift from your usual sense of wellness. During this period, you may become less able to function socially or at work and may even become less able to care for yourself.

During a major depressive episode, you may become easily irritated or frustrated. You may feel overly sensitive and/or may easily become tearful. Often you become preoccupied with anxiety and worry, feel strong feelings of shame, guilt and worthlessness and feel like you can't shut off your mind from dwelling on these negative thoughts. A major depressive episode affects more than just your emotional state. You may also have physical symptoms including an overall sense of feeling heavy, fatigued, slow and unwell. You may notice a distinct shift in your ability to sleep, eat and concentrate. A major depressive episode may also bring intrusive thoughts of death and a preoccupation with suicide.

Who's at risk?

It's possible to experience recurrent episodes of major depression throughout your lifetime. The likelihood of developing major depression is shaped by many factors including your biological and genetic vulnerability to depression, your lifetime exposure to stressful life circumstances and traumas, and the availability of social supports you can draw upon to get through tough times.

People with HIV develop major depressive episodes twice as often as the general population. Many people with HIV infection are from groups who have a higher risk for depression even without HIV: gay men, people with substance misuse disorders,

Mark Halman, MD FRCPC, is Director of the HIV Psychiatry Program at St. Michael's Hospital, Assistant Professor at the University of Toronto and Adjunct Scientist at the Centre for Research in Inner City Health, Keenan Research Centre in the Li Ka Shing Knowledge Institute.

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and people who've been exposed to traumatic life events. The higher rate of major depression in people with HIV also likely reflects the burden of living with a chronic disease that's highly stigmatized, experiences of rejection and discrimination, the isolation and loss of social supports that many experience and the biological consequences of living with a chronic infection.

How to get through a major depressive episode

Strategies for managing major depression include self-care, supportive counselling, the use of antidepressant medications and psychotherapy. Self-care involves efforts to maximize your own physical and mental health. You can help maintain your mental health by:

- maintaining a regular sleep schedule
- keeping a structured schedule of activities through the day
- working to connect with friends and support networks
- eliminating the misuse of alcohol and drugs that can worsen isolation and depression.

Several self-help books, based on the principles of cognitive therapy for depression, are very useful, including *Mind over Mood* (Greenberger and Padesky, 1995) and the *Feeling Good Handbook* (Burns, 1999). They provide a helpful starting point for self-care.

Both depression and HIV tend to lead people to isolate themselves from their supports, which makes emotional pain worse since we all rely on others to help us through tough times. People experiencing depression often feel they're a burden on others and are reluctant to reach out. But part of self-care is taking an inventory of those who love you, and reaching out to them for support and care. If you don't have close friends or family, then community supports, support groups, counsellors and psychotherapists can play an important role in helping to overcome depression.

Critical moments

Be on the watch for symptoms of major depression. Times at which people are at greatest risk include:

- the period right after they test positive for HIV
- during progression of symptomatic illness and drops in CD4 count
- when experiencing difficult situations such as discrimination, multiple losses, poverty or homelessness
- when misusing substances, the risk of mood symptoms greatly increases, and ongoing misuse decreases the likelihood that antidepressant medications and psychotherapies will be of benefit
- when taking certain medications for HIV infection (e.g. Sustiva® [efavirenz], also in the combination Atripla®) and hepatitis C co-infection (e.g. interferon). These medications have been associated with depressed mood and neuropsychological symptoms. It's important to monitor for the emergence of major depression, particularly in the first few months of treatment with these drugs.

Treatment

Treatment of major depression is particularly important when you're living with HIV, not only to reduce emotional pain but also to help improve health outcomes related to HIV infection. Depression can make people delay starting antiretroviral therapy and reduce adherence to antiretroviral medications (ARVs), which can lead to treatment failure.

Medications

Antidepressant medications are highly effective in the treatment of major depression, particularly when symptoms are severe. These medications help regulate brain neurotransmitter systems including serotonin, norepinephrine and dopamine, which are related to mood and anxiety symptoms. Some common medications include sertraline (Zoloft®), citalopram (Celexa®), paroxetine (Paxil®), fluoxetine (Prozac®), venlafaxine (Effexor®), buproprion (Wellbutrin®) and mirtazapine (Remeron®). See the sidebar for a list of common drugs.

These medications are generally well tolerated but can cause side effects and need to be taken under your doctor's supervision. Suicidal thoughts and feelings are common in major depression and may paradoxically become worse with antidepressant treatment, particularly in people under the age of 25. People starting on antidepressants should be monitored closely by their health care team and support networks.

Starting medication

Antidepressant medications are generally started at a low dose to make sure they're well tolerated and then increased over one or two weeks. Depressive symptoms don't usually improve immediately — most people will feel their symptoms improve after four to six weeks of treatment. The goal of treatment is full remission of the symptoms of major depression and a return to feeling well. In general, if symptoms persist, it's advisable to increase the dose of the antidepressant medication in consultation with your

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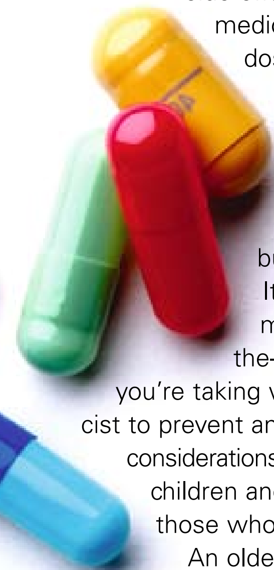
health care provider, so that the maximum dose is reached by week 12 of treatment.

If symptoms aren't improving with maximum dosing, it may be reasonable to add a second antidepressant or switch to a different class of medication. Once a helpful medication or combination of medications is found, treatment is continued, at the same dose, for a period of nine to 12 months to consolidate the effect. Many antidepressant medications have withdrawal-related side effects, so when it's time for the medication to be discontinued, the dose should be decreased gradually under medical supervision.



Drug interactions

Drug interactions with antiretroviral medications can occur but these are not often serious. It's important to review all the medications (prescription, over-the-counter and natural remedies) you're taking with your physician and pharmacist to prevent any harmful interactions. Special considerations are needed for pregnant women, children and adolescents, the elderly and those who are very medically ill.

An older class of medications called the tricyclic antidepressants (e.g. amitriptyline [Elavil®] and imipramine [Tofranil®]) are as effective as the newer agents in treating depression, but generally cause more side effects and drug interactions. Therefore, they're considered second-line choices for treating depression in people living with HIV. St. John's wort, an herbal product used for depression, has severe interactions with protease inhibitors (PIs).

Talk therapy

All antidepressant medications are more effective when used in combination with some form of counselling or psychotherapy. When symptoms of major depression are mild to moderate, treatment with psychotherapy alone may be sufficient. However, when major depression is severe, antidepressant medications are essential.

In its most basic form, psychotherapy involves talking about your experience with a trained counsellor or therapist. Integral elements of all talk therapies include the support you get from sharing your experience with another person and the opportunity to reflect on your emotions and experiences, in the hopes of coming to know yourself more honestly and openly.

Talk therapies aim to help you create room for compassion in your life, both for yourself and others, so that you can more effectively use your natural support systems. Cognitive behavioural therapy (CBT) and interpersonal therapy (IPT), are short-term psychotherapies that are very effective in treating depression, either alone or when combined with antidepressant medication. Cognitive therapy helps you look at how your thinking may be distorted by depression and how this distorted thinking can limit recovery from depression. Interpersonal therapy helps you look at key relationships in your life, and focuses on particular areas such as loss and bereavement, role transitions, and interpersonal disputes.

While depression is more common among people living with HIV, this doesn't mean it's inevitable or should be accepted as part and parcel of living with HIV. Keep on the lookout for changes in mood, maintain a strong social support network and seek help quickly if you need it.

Antidepressant drugs

CLASS Monoamine oxidase inhibitors (MAOIs)
TARGET Inhibit metabolism of excess serotonin and epinephrine
DRUG NAMES Marplan® (isocarboxazid), Aurorix®, Manerix®, Moclodura® (moclobemide), Nardil® (phenelzine), Parnate® (tranylcypromine), Selegiline®, Eldepryl® (levo-deprenyl)

CLASS Tricyclic Antidepressants (TCAs)
TARGET Inhibit reuptake of norepinephrine and serotonin
DRUG NAMES Elavil®, Endep®, Tryptanol® (amitriptyline), Asendin®, Asendis®, Defanyl®, Demolox®, Moxadil® (amoxapine), Anafranil® (clomipramine), Tofranil® (imipamine), and others

CLASS Selective serotonin reuptake inhibitors (SSRIs)
TARGET Inhibit serotonin reuptake
DRUG NAMES Celexa® (citalopram), Lexapro® (escitalopram oxalate), Prozac® (fluoxetine), Luvox® (fluvoxamine), Paxil® (paroxetine), Zolof® (sertraline)

CLASS Serotonin-norepinephrine reuptake inhibitors (SNRIs)
TARGET Keep both serotonin and norepinephrine at the right level
DRUG NAMES Effexor® (venlafaxine)

CLASS Novel antidepressants
TARGET Inhibit reuptake of dopamine, serotonin and norepinephrine
DRUG NAMES Wellbutrin® (bupropion)

CLASS Tetracyclic antidepressants
TARGET Increase amount of noradrenaline and serotonin
DRUG NAMES Ludiomil® (maprotiline) and Remeron® (mirtazapine)

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