OVERVIEW

• Introduction
• Epidemiology
• Aetiopathogenesis
• Psychiatric Disorders and HIV AIDS
• Psychological Problems and HIV AIDS
• Pretest and Post test counselling in HIV AIDS
• Psychopharmacology and Psychotherapy in HIV AIDS
• Global Mental Health in HIV AIDS
• Indian Scenario
• Future clinical, service and research perspectives
SPECIFIC LEARNING OBJECTIVES

• To be able to understand contextual issues in HIV AIDS and Mental health
• To be able to discuss relevant epidemiological and aetiopathological aspects of HIV AIDS
• To understand clinical presentations, and management of neuropsychiatric disorders and HIV AIDS
• To understand context of neuropsychiatric disorders related to drug induced aspects for HIV AIDS
• To understand psychological issues and their management in HIV AIDS
• To comprehend and discuss relevant issues in global mental health
INTRODUCTION

• The HIV/AIDS epidemic remains among the most significant challenges to public healthcare systems worldwide.

• Globally, 36.7 million [34.0–39.8 million] people were living with HIV at the end of 2015.

Global Health Observatory (GHO) data HIV/AIDS (2016)
INTRODUCTION

• HIV epidemic started in the 80’s.
• Neurologists generally dealt with HIV related CNS syndrome
• Until 90’s, psychiatrists were focusing on issues related to grief, loss, support and related therapy for AIDS patients.
• Later, HIV related mood, psychotic disorders, chronic pain syndrome, HAD etc. were identified.
• Antiretroviral drug induced psychiatric symptoms were also covered.
BACKGROUND

• Some of the drugs used in HAART (efavirenz and nevirapine) are known to be associated with psychiatric side effects.

• Although HIV AIDS being a big public health problem worldwide, limited data is available regarding association of HIV and psychiatric co-morbidity from developing countries such as India.

BACKGROUND

• HIV/AIDS is a devastating illness that humans have ever faced, associated psychiatric co-morbidities in HIV/AIDS patients are very common but the factors affecting it are not well studied.

• Literature describes it to be a highly stigmatized, chronic disease with a substantial co-occurrence of

RELEVANCE

• Literature highlights that patients with mental health problems are at increased risk of contracting HIV and HIV-infected patients are at increased risk of developing mental health problems compared with the general population.\textsuperscript{[5]}

• Mental health problems in HIV-infected patients have a negative influence on the overall treatment, adherence to treatment, and prognosis of the HIV-infection
The onset of mental health problems may manifest across a spectrum from the time HIV is diagnosed to starting the treatment and the terminal care phase.

HIV can have direct effects on the brain that may lead to neurocognitive disturbances, mood disorder, psychosis or behavioural changes.

INTERACTIVE AETIOPATHOGENESIS MODEL

- Individual vulnerability
- Human brain and mind
- Social factors
- Human immuno deficiency virus
Psychiatric morbidity parallels the time course of HIV infection
PSYCHIATRIC MORBIDITY PARALLELS THE TIME COURSE OF HIV INFECTION

• Mental health problems are most likely to occur at two stages of the infection:
  • when the person is given the diagnosis of HIV infection
    – Usually self limiting
  • when physical symptoms develop or worsen
    – anticipatory grief
• Compounded by individual vulnerabilities, financial problems, social supports
PSYCHIATRIC MORBIDITY PARALLELS THE TIME COURSE OF HIV INFECTION

• Psychiatric morbidity in HIV:
  – as a result of the interaction between
    • Individual vulnerabilities
    • the stressful situation
    • and the social and emotional supports available.
    • Drug induced

• Neuropsychiatric syndromes such as delirium and dementia
  – direct or indirect effects upon the brain, of the virus
  – from complications resulting from immunosupression, such as opportunistic infection or tumours.
  – Drug induced
MENTAL HEALTH PROBLEMS ASSOCIATED WITH HIV

- Psychological problems
- Psychiatric problems
- Neurological complications
MENTAL HEALTH PROBLEMS IN SYMPTOMATIC PEOPLE WITH HIV INFECTION

• Adjustment disorders
• Anxiety and panic
• Depression
• Grief reactions
• Psychosis
• Substance dependence
• Mania
• Minor cognitive motor deficits
• Delirium
• Dementia
PSYCHOLOGICAL STATES ASSOCIATED WITH KNOWLEDGE OF HIV INFECTION

- Shock
- Denial
- Fear
- Guilt
- Anger & Resentment
- Grief & Depression
- Anxiety

- Loss of self esteem
- Loss of control
- Isolation
- Suicidal ideation

“Worried well”

- Relief
- Positive adjustment
PSYCHIATRIC CONDITIONS ASSOCIATED WITH HIV

• The psychiatric sequelae of HIV-1 infection and AIDS are due to
  ☐ Grief response of being diagnosed with a terminal illness
  ☐ Exacerbation of pre-existing psychiatric illness
  ☐ Development of new primary syndromes
PSYCHOSIS AND HIV AIDS

• Navia and Price found that 15% of 46 patients in their study with HAD experienced psychotic symptoms.

• Psychotic symptoms seen in HIV-infected individuals may be primary or secondary.

• Occasionally psychotic symptoms may be the presenting complaints of an HIV illness.


PSYCHOSIS AND HIV AIDS

• Primary psychosis does not yield any signs of HIV cerebral disease
• secondary psychosis often occurs in the context of global (encephalopathy) or localized pathology (most often lesions of the left temporal lobe and diencephalon).
• differential diagnosis include presence of opportunistic infections like tuberculoma, toxoplasmosis and cryptococcal meningitis, which may present as acute psychosis in the initial stages.
• Drugs like INH can also contribute to psychosis and co-occurrence of neurosyphilis may also lead to psychosis.

*Neurosci. 2001 May;26(3):229-34. PubMed PMID: 11394192; PubMed Central*
MENTAL HEALTH & HIV/AIDS
SCHIZOPHRENIA

• Patients with chronic mental illness at increased risk for HIV infection
  – Prevalence rates 2 to 10%
  – Medical providers often do not test for HIV
    • Incorrectly assume pts not sexually active
    • Substance abuse significant co-morbidity
    • Pts do not implement HIV risk behavior knowledge
MENTAL HEALTH & HIV/AIDS
SCHIZOPHRENIA

• Treatment
  – Coordinate between medical & psychiatric providers as much as possible
  – Typical or 1st generation antipsychotics
    • Increase risk of EPS & tardive dyskinesia
  – Atypical or 2nd generation antipsychotics are preferred but risk weight gain:
    - Olanzapine (Zyprexa) > risperidone (Risperdal) & quetiapine (Seroquel) > ziprasidone (Geodon) & aripiprazole (Abilify)

*Note: clozapine (Clozaril) contraindicated for several reasons
DEPRESSION AND HIV AIDS

• Existing studies have shown that emotional problems are among the most common symptoms in HIV patients with up to 98.6% prevalence.

• Depression is a prevalent comorbidity in HIV infection as well as a recognized side-effect of NRTI, Protease inhibitors and NNRTIs.

• HIV infected individuals can be at a high risk of depression and self harm in the period immediately after being diagnosed with a seropositive status, especially if they have a significant past psychiatric history.

  • Chandra PS, Krishna VA, Ravi V, Desai A, Puttaram S. Hiv related admissions in a psychiatric hospital a five year profile. Indian J Psychiatry. 1999
DEPRESSION AND HIV AIDS

• Bhatia et al who found that the prevalence of depression in patients in their study with HIV under ART was 58.75%.
• Mood disorders, depression in particular, are the most frequent psychiatric disorder associated with HIV disease.
• The lifetime prevalence of depressive disorders can range from 22% to 61% in HIV-positive populations in certain studies.
• These rates are significantly higher than estimates of lifetime and current diagnosis of major depression in community samples.
MENTAL HEALTH & HIV/AIDS
DEPRESSION

• Prevalence estimated at twofold higher
  – Meta-analysis 10 studies (Ciesla & Roberts 2001)

• Risk factor for HIV Infection (Regier 1990)

• 2.5 fold increase when CD4 cell <200 cells/mm³ (Lyketsos 1996)
MENTAL HEALTH & HIV/AIDS
DEPRESSION

• Multiple studies indicate almost all antidepressants are effective
  – Concern for P450 interactions with some antiretroviral medications
    • Favor citalopram & sertraline over paroxetine & fluoxetine (2D6)
    • Caution with nefazodone & fluvoxamine (3A4)
  – Side effect profile guides choice of agent
    • Mirtazapine favored for sedation and appetite stimulation
MENTAL HEALTH & HIV/AIDS
DEPRESSION

• Psychotherapy
  – Many studies showing benefit with and without antidepressants
    • Group therapy – prominent modality
    • Cognitive Behavioral Therapy (CBT)
    • Interpersonal
    • Supportive
  – Themes of guilt, shame, anger
MENTAL HEALTH & HIV/AIDS

PTSD

• Greatly increased rates
  – 42% HIV+ women, County Medical Clinics (Cottler 2001)
  – 30% pts develop in reaction to HIV diagnosis (Kelley 1998)
  – Predicts lower CD4 counts (Lutgendorf 1997)
  – Higher levels of pain (Smith 2002)
MENTAL HEALTH & HIV/AIDS
PTSD

• SSRIs show 50% improvement in sx
  – prefer to use sertraline (Zoloft) or citalopram (Celexa)

• Prazosin often used for intrusive nightmares
  – current studies (Raskind SVAMC)

• Psychotherapy effective, using variety of approaches
  (CBT, Abreaction, Supportive)
MENTAL HEALTH & HIV/AIDS
PANIC DISORDER

• Panic Disorder & Generalized Anxiety Disorder > 4 times more prevalent (Bing 2001)

• Affects accessing primary care, adherence to treatment, and quality of life
  – Especially agoraphobic/housebound

• Responds well to treatment
MENTAL HEALTH & HIV/AIDS
PANIC DISORDER

• First line treatment: SSRIs
  – Then consider dual action agents (venlafaxine (Effexor) or duloxetine (Cymbalta)), mirtazepine (Remeron), or tricyclics (TCAs)
  – Wellbutrin of little benefit

• Responds well to psychotherapy: CBT

• Best outcomes = both meds & psychotherapy

• Use benzodiazepines as last resort
  – eg, clonazepam preferred (longer half life)
BEREAVEMENT AND GRIEF

• The severity of HIV and AIDS
• the loss of health
• a decrease in functioning, deterioration of body integrity
• the anticipatory loss of life result in bereavement.
MENTAL HEALTH & HIV/AIDS
BIPOLAR - MANIA

• Prevalence of bipolar disorder in HIV infection is 10 times higher than in general population
  (Lyketsos 1993)

• Stress of HIV infection exacerbates pre-existing bipolar disorder – complicating adherence

• New-onset or secondary mania
  – result of HIV infection, opportunistic infections or due to antiretroviral medications
MENTAL HEALTH & HIV/AIDS
BIPOLAR - MANIA

• Secondary mania
  – Associated with impaired cognition
  – Increased risk of dementia
  – Different clinical features
    • Irritable > elevated mood
    • Psychomotor slowing
    • More chronic than episodic
    • More resistant to treatment
MENTAL HEALTH & HIV/AIDS
BIPOLAR - MANIA

• Treatment
  – Not well studied with mostly anecdotal case reports
  – Depakote (VPA) well tolerated
    • Avoid with impaired hepatic function
    • Risk anemia with AZT
  – Lithium
    • Conflicting reports of good response (increases WBC) versus intolerable side effects
  – Tegretol (carbamazepine)
    • Avoid as risks medication interactions (inducer) & bone marrow suppression
MENTAL HEALTH & HIV/AIDS
BIPOLAR - MANIA

• Treatment
  - Second generation (atypical) antipsychotics all have indication as mood stabilizers, well tolerated and effective for psychotic sx’s
    - Olanzapine (Zyprexa) > risperidone (Risperdal) & quetiapine (Seroquel) > ziprasidone (Geodon) & aripiprazole (Abilify)
  - Risk of metabolic effects: wt gain, DM, hyperlipidemia, etc

*Note: clozapine (Clozaril) contraindicated for several reasons
MANIA AND HIV AIDS

• Lyketsos et al found that in early HIV infection, 1%–2% of patients experience manic episodes.
• However, after the onset of AIDS, 4%–8% of patients appear to experience mania.
• Mania or manic symptoms can be direct effect of the illness, effect of HAART drugs, or as a reaction to disclosure of the diagnosis.


PERSONALITY DISORDERS AND HIV AIDS

• Perkins et al, found a significantly higher prevalence of personality disorder in the HIV-positive (33%) than in the HIV-negative (15%).

• Among HIV-positive subjects, those with a personality disorder compared to those without a personality disorder shows significantly greater mood disturbance, experience greater dysphoria and are more likely to cope with the threat of AIDS in a dysfunctional way.

SUBSTANCE USE DISORDERS AND HIV

• VECTOR for HIV
• 44%
• Accumulation of medical sequelae from chronic substance abuse accelerates the process of immunocompromise and amplifies the progressive burdens of the HIV infection itself.
• Injection drug users
NEUROPSYCHIATRIC SYNDROMES ASSOCIATED WITH HIV INFECTION

• HIV infection may be associated with:
  – Mild cognitive-motor disorder (MCMD)
  – Delirium
  – Dementia
  – Organic mood disorders
  – Organic psychoses
MENTAL HEALTH & HIV/AIDS
DEMENTIA

• Neurocognitive problems

  – 30-50% Subclinical
    Neuropsychological testing impaired

  ---------(threshold clinical significance)------------

  – 20% MCMD
    Minor Cognitive Motor Disorder

  – 2-4% HAD
    HIV Associated Dementia
MENTAL HEALTH & HIV/AIDS
DEMENTIA

• Mild Manifestation
  – MCMD
  Minor Cognitive Motor Disorder

• Severe Manifestation*
  – HAD
  HIV Associated Dementia

*functional impairment

• Diagnostic Criteria
  1) At least 2 of: impaired attention, concentration, memory, mental & psychomotor slowing, personality change
  2) Rule out other cause

• Diagnostic Criteria
  1) Acquired cognitive abn*
  2) Acquired motor abn*
  3) No clouded LOC & rule out other cause
MINOR COGNITIVE MOTOR DISORDER

• 22% of asymptomatic, HIV infected individuals, 50% of early symptomatic individuals, and 60% - 90% of late symptomatic individuals have at least MCMD

• Slowness, in-coordination, speed of information processing

• Causes subtle occupational impairment, predicts faster mortality
Mild Neurocognitive Disorder:

- 40-60% have MCMD
- Also known as HIV encephalopathy-is a less severe syndrome

- Ch-by impaired cognitive functioning
  + reduced mental activity+ interference with work ,ADL, social functioning
- No lab abnormalities specify to MCMD(HIV encephalopathy)
NEUROCOGNITIVE DISORDERS AND HIV AIDS

• Neurocognitive deficits are manifestations of both direct and indirect effects of HIV on the CNS.

• HIV/AIDS patients with advanced disease can present with deficits in many cognitive domains.

• As the disease progresses, additional cognitive domains often become impaired. Executive functions such as Attention, concentration and working memory are affected. Learning and memory can also be impaired in HIV/AIDS.


HIV-1 Associated Dementia (HAD)

- More common when CD4 count <200
- The difference between MCMD and HAD lies in the severity of symptoms and interference in daily functioning.
- People with HAD show marked slowing and impairment in attention, concentration and information processing.
- There is also impairment in learning new information, problems in fluency and naming, and motor incoordination.
HIV-1 ASSOCIATED DEMENTIA (HAD): DIFFERENTIAL DIAGNOSIS

- Focal lesions such as cerebral toxoplasmosis, CNS lymphoma, and progressive multifocal leucoencephalopathy.
- CNS infections such as cryptococcus or tuberculous meningitis, cytomegalovirus infection, herpes simplex encephalitis and neurosyphilis
- Depressive pseudo-dementia
MENTAL HEALTH & HIV/AIDS
DEMENTIA

- HIV-infected macrophages directly enter CNS early in HIV infection

- CNS may be sanctuary for HIV replication

- CSF HIV viral load not correlated with plasma viral load when CD4 count <200 cells/mm³

- CSF viral load correlates dementia severity
MENTAL HEALTH & HIV/AIDS
DEMENTIA

• With effective ART, incidence of CNS OIs dropped significantly, since early 1990’s
  – 2/3 decreased incidence HAD
    (Saktor 1999)
  – 75% decrease CMV & lymphoma on autopsy

  – However 60% with some evidence of
    HIV encephalopathy on autopsy*
    (Neuenburg 2002)
MENTAL HEALTH & HIV/AIDS
DEMENTIA

• Risk Factors
  – Seroconversion illness
  – Anemia
  – Vitamin deficiencies (B6, B12)
  – Low CD4 count
  – High CSF HIV viral Load
  – ETOH, cocaine & amphetamine
  – Depression
MENTAL HEALTH & HIV/AIDS
DEMENTIA

• Treatment
  – Most effective treatment is ART
    • Raises question of lumbar puncture to confirm effectiveness on CSF HIV viral load.....
  
  – Slows progression of dementia (Ferrando 1998)

  – Reversed periventricular white matter changes seen on MRI scan in some cases
MENTAL HEALTH & HIV/AIDS
DEMENTIA

• Potential neuroprotective agents
  – Most promising are memantine (Namenda) & selegeline (L-Deprenyl)
  – Many adjuvant agents commonly used, with some controversy about use of stimulants
    ● Improved cognitive performance
      (Brown 1995, Hinkin 2001)
    ● Accelerated HAD sx’s
      (Czub 2001, Nath 2001)
MENTAL HEALTH & HIV/AIDS
DEMENTIA

• Adjuvant treatments
  – Selegeline (L-Deprenyl)
  – Bupropion (Wellbutrin)
  – SSRIs (Prozac, Paxil, Celexa, Zoloft, Lexapro)
  – Dual-action antidepressants (Effexor, Cymbalta)
  – Atomoxetine (Strattera)
  – Modafinil (Provigil)
  – Anabolic steroids
  – Atypical or second generation antipsychotics
CHANGES IN THE HIV/AIDS EPIDEMIC

• Medical Treatment Evolution
  – Monotherapy in early 1990s
  – Dual agent approach by mid 1990’s
  – Combination antiretroviral therapy (ART), also called highly active antiretroviral therapy (HAART), since late 1990s: 3 or more agents
CHANGES IN THE HIV/AIDS EPIDEMIC

ART

Has produced dramatic & significant improvement in prognosis for HIV infection

But has also emphasized the importance of:

• Adherence
• Medication Interactions
CHANGES IN THE HIV/AIDS EPIDEMIC
ARV MEDICATIONS

• NRTIs
  Abacavir (Ziagen)
  Didanosine (Videx)
  Emtricitabine (Emtriva)
  Lamivudine (Epivir)
  Stavudine (Zerit)
  Tenofovir (Viread)
  Zalcitabine (Hivid)
  Zidovudine (AZT)

• NNRTIs
  Efavirenz (Sustiva)
  Nevirapine (Viramune)
  Delavirdine (Rescriptor)

• Protease inhibitors
  Amprenavir (Agenerase)
  Atazanavir (Reyataz)
  Darunavir (Prezista)
  Fosamprenavir (Lexiva)
  Indinavir (Crixivan)
  Lopinavir/ritonavir (Kaletra)
  Nelfinavir (Viracept)
  Ritonavir (Norvir)
  Saquinavir (Fortovase)

• Fusion Inhibitor
  T20 (Fuzeon)
HAART AND PSYCHIATRY

• Triple therapy: two reverse transcriptase inhibitors and one PI.

• Two NRTI and a third agent can be NNRTI or a PI or another agent.

• Adherence adherence adherence

• Psychiatric disorders compromise the ability to take treatment, adhere to medications, practice safe sex, and stop using IV drugs.

• Overlooked critical factor in continuing of HIV epidemic.
HIV DRUGS AND PSYCHIATRY

• Abacavir-psychosis and catatonia
  foster et al 2003

• Efavirenz- major depression with psychosis.
  Puzantian 2002

• Psychotropic medications may be reqd to treat psychiatric symptoms resulting either from CNS infection or from HAART.
HIV DRUGS AND PSYCHIATRY

- Zidovudine, a “nucleoside Analogue” that inhibits replication of HIV by interfering with viral reverse transcriptase.
- CNS penetration may also explain confusion, agitation & insomnia in 5%-10% people on Zidovudine.
- Can induce Mania or depression (like INH).
- In recent yrs fewer problems have been reported as lower doses of Zidovudine is used as compared to (2000mg 1day) in the pre-HAART Era.
HIV DRUGS AND PSYCHIATRY

- Zalcitabine, stavudine and didanosine inhibit Nerve Growth factor (NGF) causing peripheral neuropathy

  thus cause headache, malaise, fatigue and pseudodepressive symptoms
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Antiretrovirals
  – 1A2
    • Induction by ritonavir & nelfinavir
  – 2C9
    • Induction by ritonavir & nelfinavir
    • Inhibition by delavirdine
  – 2C19
    • Induction by efavirenz & nelfinavir
    • Inhibition by efavirenz & delavirdine
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Antiretrovirals
  – 2D6
    • Inhibition by ritonavir
  – 3A4
    • Induction by ritonavir, nelfinavir, efavirenz, nevirapine
    • Inhibition by ritonavir, fosamprenavir, indinavir, nelfinavir, saquinavir, tipranavir, delavirdine
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Antidepressants
  – Most metabolized at 2D6
  – Exceptions:
    • Fluvoxamine (Luvox)
      – AVOID
    • Nefazodone (Serzone)
      – AVOID or dose cautiously
    • Bupropion (Wellbutrin, Zyban)
      – @ 400 mg, dose cautiously with ritonavir
MENTAL HEALTH & HIV/AIDS
MEDIATION INTERACTIONS

• Antidepressants
  – SSRIs
    • Fluoxetine (Prozac) & paroxetine (Paxil):
      – some interactions, but not clinically significant for most antiretrovirals
    • Citalopram (Celexa), escitalopram (Lexapro), & sertraline (Zoloft):
      – have fewest interactions
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Antidepressants
  – Tricyclic antidepressants
    • Generally well tolerated with antiretrovirals
    • Nortriptyline & desipramine (secondary amines)
      – Narrow metabolism at 2D6
      – Levels can be elevated by other medications
      – Get a blood level if in doubt
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Antidepressants
  – Dual-action agents:
    • Venlafaxine (Effexor) & duloxetine (Cymbalta)
    • Well tolerated without adjusting dose
  – Mirtazipine (Remeron)
    • Well tolerated
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Anxiolytics
  – Mostly metabolized at 3A4
  – Avoid
    Alprazolam (Xanax)
    Triazolam (Halcion)
    Midazolam (Versed)
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Anxiolytics
  – Safest to use glucuronidated benzodiazepines:
    • Lorazepam (Ativan)
    • Temazepam (Restoril)
    • Oxazepam (Serax)
  – Caution with buspirone (Buspar), and dosing of other benzodiazepines with ART (3A4)
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

Antipsychotics:
for use with ritonavir, start with low dose
1A2 & 2D6

• **Haloperidol (Haldol)** (risk EPS & TD)
  – Avoid chlorpromazine (Thorazine), thioridazine (Mellaril)

• **Olanzapine (Zyprexa)** & **clozapine (Clozaril)**

3A4

• **Aripiprazole (Abilify)** & **clozapine (Clozaril)**
  – Avoid pimozide (Orap)
MENTAL HEALTH & HIV/AIDS
MEDICATION INTERACTIONS

• Stimulants
  – Atomoxetine (Strattera*)  * = nonstimulant
    • Caution with impaired hepatic function
    • Metabolized at 2D6
    • Inhibits at 2D6

  – Modafinil (Provigil) – be cautious
    • Metabolized at 3A4
    • Induces at 1A2 & 3A4
CHILDREN WITH HIV

- No studies addressing the impact of HIV infection on the mental health of children either affected or infected with HIV.
- 6.17 psychiatric cases per 1000 person-years.
- This was significantly higher than the incidence of 1.70 cases per 1000 person-years in the general pediatric population.
- The majority of patients were admitted because of depression or behavioural problems while 47 percent underwent multiple psychiatric hospitalizations.
Suicidal ideation is prevalent in between 50 –70% of HIV positive individuals at various points in the course of their illness.

Suicide accounts for only a small proportion of deaths associated with HIV infection.

Suicidal risk is the highest in the life of a person living with HIV:
  – at the time of diagnosis and
  – later at the onset of AIDS.
RISK FACTORS FOR SUICIDE IN PEOPLE WITH HIV INFECTION

• Historical factors
  – Past psychiatric history, especially depression
  – Past attempts at suicide or deliberate self-harm
  – History of sexual abuse
RISK FACTORS FOR SUICIDE IN PEOPLE WITH HIV INFECTION

• Situational factors
  – Waiting for HIV result if one suspects result may be positive
  – In the immediate aftermath of notification of a positive result (first two to three months)
  – Onset of symptoms, or AIDS related disease
  – Relationship problems or separation from partner
  – Bereavement, especially of a loved one through AIDS
  – Lack of social support
  – Work related problems
  – Multiple psychosocial stressors
  – Multiple physical illness (HIV infection and haemophilia and opportunistic infections)
  – Severe financial distress
  – Severe pain, dysfunction, or disfigurement
ASSESSING SUICIDAL RISK

• Always ask for suicidal ideation
• Assess frequency and severity of suicidal ideas
• Ask for previous suicidal attempts
• Assess if any preparations have been made
• Check for hopelessness, reasons of living
RISK FACTORS FOR SUICIDE IN PEOPLE WITH HIV INFECTION

• Psychological factors
  – Perceived social isolation and loneliness
  – Reliance on denial as the central defence mechanism; lack of the ‘fighting spirit’
  – Perception of self as a victim or as a burden on others
  – Hopelessness; lack of any ‘reasons for living’
  – Fear of complications of AIDS
STIGMA AND HIV

• HIV/AIDS as punishment (e.g. for immoral behaviour)
• HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims)
• HIV/AIDS as war (e.g. in relation to a virus which must be fought)
• HIV/AIDS as horror (e.g. in which infected people are demonized and feared)
STIGMA AND HIV

• Stigma complicates the treatment of HIV worldwide
• vicarious stigma influenced felt normative stigma creates discrimination (enacted stigma)
• internalized stigma were associated with higher levels of depression

• HIV-related stigma: Adapting a theoretical framework for use in India, TISS, NIMHANS social science and medicine 2008
COUNSELLING IN HIV INFECTION

- Preventive counselling
- Preparing for an HIV test
- Coping with a positive test result
- Ongoing supportive counselling
- Problem solving
- Crisis intervention
- Grief & bereavement
PREVENTIVE COUNSELLING

PREVENTIVE EDUCATION
- safe sex
- proper use of condoms
- clean needle use
- reconsider life style
- spread HIV/AIDS prevention message
PRETEST COUNSELLING

• EMPHASISE CONFIDENTIALITY

• EXPLORE HIGH RISK BEHAVIOUR
  – Unsafe sex practices (consider spouse’s behaviour)
  – I.V. Drug use (shared needles/Sex with user)
  – Blood/Blood products received

• EXPLORE HIV/AIDS KNOWLEDGE
  – Clarify misconceptions
PRETEST COUNSELLING

• EXPLORE TEST IMPLICATION: in relation to patient’s life situation (eg: marriage, pregnancy ..)
• Explain test:- is for antibodies to HIV not an AIDS test
• Meaning of negative result & need for follow Up test
• Meaning of positive result
• Allow patient time to ask question
• Document in the chart (not in front of patient)
POST-TEST: TEST NEGATIVE

• explain negative result
• check back to confirm understanding
• clarify doubts/misconception
• need for retest or follow up test
• repeat preventive education
POST-TEST: TEST POSITIVE

• follow patients lead when to disclose
• state result clearly
• wait – give time to absorb information
• give time for expression of feelings
• Listen and be empathetic
POST-TEST: TEST POSITIVE

• Behavioural
  – assess commitment & understanding to risk reduction
  – explore factors related to general health and immune functioning

• Interpersonal
  – impact on partner, family, friends, employer
  – how to break news (offer help & support)
  – plan to maximize support & minimize stress

• Medical
  – Plan health/early intervention. Avoid quacks
  – Adherence issues

• life style issues
  – stress nutrition, exercise, no to substance, strategies to prevent re-exposure to virus.
WHO SHOULD KNOW RESULT?

- Discuss implications/discrimination
- Partner notification/testing
- Practicalities of test: sample collection, getting result, give appointment.
- Assess strategies for coping
- Evaluate past handling of stressful situations
- Evaluate patient’s social support network
GLOBAL MENTAL HEALTH

• Several correlates were associated with ADHD: Mpango RS, et al. BMC Psychiatry. 2017.
• Smokers less likely to have low CD4 count at baseline and 6-month follow-up, but more likely to have low CD4 count at 12-month follow-up. Winhusen T, et al. AIDS Behav. 2017.
GLOBAL MENTAL HEALTH

• Postnatal depression predicted cognitive delay; decreased prenatal male involvement predicted delayed gross motor development ($ps < 0.05$). Rodriguez VJ, et al. AIDS Behav. 2017.


GLOBAL MENTAL HEALTH


• Increased partnerships between policy-makers, practitioners and researchers in order to design evaluation studies and can feed into the growing evidence base. Skeen S, et al. Vulnerable Child Youth Stud. 2017.
IMPLICATIONS

• Further research can be directed towards assessing service and development related to factors in HIV AIDS and mental health.
• Factors such as stigma, culture, misconceptions, attitudes towards psychiatric consultation in HIV/AIDS can be studied further.
IMPLICATIONS

• From a clinical point of view, focus on consultation liaison psychiatry and mental health services for patients with HIV/AIDS are recommended.

• Community based mental health care models for HIV/AIDS can be considered for further clinical research.