HIV-infected people need all of their coping and adjustment skills to maintain themselves and the quality of their daily lives. Mood disorders—mania and depression—can impair a person's coping skills and judgment, and lead to deleterious behavior, discomfort, and incapacity.

Mood can be defined as a person's ongoing emotional tone, and mood disorders are characterized by abnormal feelings of despondency (depression) and euphoria (mania). This article describes the symptoms of and treatments for the depression and mania that affect HIV-infected people.

Mood disorders can be induced in four ways: organic damage to the brain, side effects of medications, drug abuse, or situational factors. First, depression may be brought on directly by HIV infection or other viral or bacterial infections of the central nervous system (CNS), by CNS tumors or strokes, or by abnormal functioning of the thyroid or adrenal glands. In addition, the early stages of HIV-associated dementia may present as depression.

Second, medical treatments such as cortisone-like hormones, antivirals, antibiotics, analgesics, cancer chemotherapy, and immune modulating agents can cause depression and sometimes mania. Third, the chronic and excessive use of alcohol, sedatives, and opiates may result in depressive symptoms. Such symptoms may also be caused by withdrawal from cocaine, amphetamines, alcohol, and other drugs.

Finally, there are a number of situational factors that may compound a patient's suffering: the experience of living with a life-threatening illness; the stigma associated with HIV infection; the heartache of watching friends become ill and die; the torment of losing physical strength, memory, and vocational and financial capability; and the increasing dependence on others as illness progresses.

Despite these situational factors, it is crucial for clinicians to avoid dismissing depressive symptoms as understandable responses to the stresses their patients endure. Such deemphasis can lead to undertreatment. While symptoms may appear untreatable, aggressive drug intervention and psychotherapy can markedly improve the quality of life for mood-disordered patients with HIV infection.

**Symptoms of Depression**

Depression is manifested not only by sad or irritable mood but also by changes in thoughts, behavior, and bodily functioning. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) recognizes at least four categories of depression: major depression, adjustment disorder with depressed mood, dysthymia, and organic mood syndrome. The symptoms of major depression are characteristic of all of these conditions. In addition to continuous depressed mood and markedly diminished interest in pleasurable activities, major depression is characterized by:

- significant weight or appetite change;
- sleep disturbance;
- observable agitation or marked slowing of movements and thinking;
- fatigue or loss of energy;
- feelings of worthlessness or of excessive and inappropriate guilt;
- decreased ability to think, concentrate, or make decisions;
- recurrent thoughts about death or suicide, or suicide attempts.
Mood disorders, particularly depression—which is perhaps the most frequently diagnosed psychiatric condition—are common in the developed world and, for obvious reasons, these conditions may complicate HIV-related treatment. While mental health practitioners should first explore psychotherapeutic options for responding to these disorders, it is important for them to be aware of the protocols for psychopharmacological assessment and treatment and to know when to refer clients to psychiatrists.

John Baker’s article offers descriptions of depression and mania and examines, in particular, how pharmacological treatment can be used. For counselors, this information is crucial in day-to-day interactions with clients who may confront mood disorders at any point in the progression of their disease. And for therapists who consider psychopharmacology to be a last resort, Baker’s article may offer some insights.

At the other end of the treatment spectrum are conditions that may require greater growth on the part of therapists than on the part of their clients. Since suicidal ideation is a common symptom of depression and because suicide is such an extreme act, it is difficult for many health professionals to accept the possibility that the contemplation of suicide may be rational rather than pathological. James Jones and James Dilley add the perspective of people with HIV disease to the ongoing debate about suicide. Their results suggest that rational suicidal ideation may be common among people with HIV disease, that it may be seen as an acceptable alternative for many of these people, and that rational suicidal ideation is not necessarily related to clinical depression.

For therapists who might perceive all suicide as the failure of therapy, this article suggests that counselors be aware that some clients may approach the idea of taking their own lives as a deliberate and well-informed act.

Adjustment disorder with depressed mood consists of depressive symptoms in response to identifiable psychosocial stresses. Unlike major depression, it lasts only up to six months. Dysthymia is a more chronic and less severe form of major depression. Organic mood syndrome resembles major depression, but is linked to identifiable organic factors such as the side effects of certain medications.

These symptoms can be extremely difficult to evaluate in HIV-infected people because of the contributions and interactions of physical illness and social factors. For instance, many patients with advanced HIV disease exhibit decreased interest or pleasure in previously enjoyable activities. Sleep disorders and fatigue may be caused by fever, night sweats, medications, or chronic physical illness. Appetite and weight loss are commonly associated with intractable diarrhea, wasting syndrome, malignancies, and chemotherapy. Diminished ability to think or concentrate, or indecisiveness may be the result of HIV dementia or medications.

Psychotherapy and Depression

Once a clinician has diagnosed significant depression, provider and patient can formulate a treatment plan including psychotherapy, medication, or both. Depressive adjustment disorder usually responds to individual or group psychotherapy and does not require medication. The cornerstone of treatment for dysthymia is psychotherapy, but as is true for organic mood disorder, medication may be necessary to relieve disabling symptoms. The best way to resolve organic mood disorder is to respond, when possible, to its physical cause.

Treatment of depression should begin with an evaluation of the patient’s living situation, financial status, and social support system. Ideally, all depressed patients should have access to individual or group psychotherapy, which, in combination with antidepressant medication, is more effective than either treatment alone. Psychotherapy may aim primarily toward providing emotional support during times of heightened stress and fear and, at other times, at correcting distorted thought patterns that lead to hopelessness, helplessness, and undue negativity about oneself and one’s past and future.

Antidepressant Medications

Antidepressant medications are believed to affect mood by increasing the available amount of certain neurotransmitters, which are the chemical means of communication among neurons (human brain cells). After being sent from one neuron to another, neurotransmitters—such as serotonin and norepi-nephrine—must be removed from the space between neurons to stop their
Antidepressants are often prescribed to take advantage of or avoid specific side effects.

According to several organizations, including the American Psychiatric Association and the National Institute for Mental Health, the popular media has exaggerated the possible connection between fluoxetine and suicidal and violent behavior. All depressed patients should be carefully monitored for the emergence of suicidal feelings or urges to harm others.

References


action. Antidepressants probably slow the process of removal and thus enhance neurotransmitter action.

There are a large number of antidepressant medications—including tricyclic (a designation related to chemical structure) antidepressants; the newer selective serotonergic uptake inhibiting (SSUI) antidepressants; monoamine oxidase (MAO) inhibitors; and psychostimulants—that differ primarily in terms of their side effects and mechanisms of action. Common side effects include dry mouth, constipation, blurred vision, increased heart rate, hand tremors, transient dizziness with changes in body position, urinary retention (anticholinergic side effects), increased sweating, and sedation.

The choice of antidepressant medication should be tailored to the individual, and the full beneficial effect of medication may take as long as four to eight weeks to appear. If a person fails to respond to one agent, then a trial of a different antidepressant is in order. When a patient has an equivocal or minimal response, measurement of the blood level can reveal whether dosage is adequate.

Antidepressants are often prescribed to take advantage of or avoid specific side effects, which as a rule are mild. For example, sedation may be helpful for insomniac or markedly anxious depressed people, while dry mouth may be uncomfortable and lead to an increased tendency to develop thrush. A history of previous good response to a given drug by the patient or by an immediate family member simplifies the choice of antidepressant.

Among the tricyclics, nortriptyline (for example, Pamelor) or desipramine (for example, Norpramin) are agents that provide mild sedation, and relatively mild and few other side effects. By gradually building dosage, patients build tolerance to unwanted side effects and to the transient syndrome of restlessness and agitation that sometimes occurs early in the course of antidepressant treatment.

For depressed patients with pronounced lethargy, slowed motor activity, and excessive sleep, the SSUI antidepressants fluoxetine, sertraline, and paroxetine can produce an excellent response since they rarely cause sedation. Unfortunately, they may contribute to insomnia. Ordinarily, dosage does not have to build gradually. Fluoxetine produces few anticholinergic or cardiac side effects and is considered safer than most antidepressants in cases of overdose. It sometimes results in nausea, insomnia, headaches, and decreased libido. A small number of patients may have to discontinue using fluoxetine because of marked adverse effects such as agitation, physical restlessness, and insomnia.*

MAO inhibitors and psychostimulants are less frequently used than other antidepressants. Because of a long list of foods and medications—including HIV-related medications—that are prohibited during MAO inhibitor use, clinicians should prescribe them only if other treatments fail. The combination of MAO inhibitors and prohibited substances may lead to severe responses. Dietary restrictions are particularly undesirable among patients who may suffer from poor appetite, nausea, and weight loss.

Finally, patients may experience a transient but significant drop in blood pressure and dizziness when they get up from a lying or sitting position. This reaction can be troublesome for people with anemia, adrenal hormone insufficiency, or compromised cardiovascular status.

Psychostimulants, in particular methylphenidate (Ritalin), are probably best reserved for depressed patients who are severely ill and intolerant of the side effects of other antidepressants or who have impaired intellectual functions characteristic of HIV-associated dementia.

While effective, these drugs may lead to tolerance and dependence, particularly among patients with histories of substance abuse. Use of methylphenidate can lead to rapid remission of depressive symptoms as well as to improved appetite, concentration, and attention. Side effects from the drug are generally mild, but clinicians should monitor patients for agitation, the onset of impulsive behavior, or abuse.

Mania

Mania is a continued state of elevated mood, and includes changes in thoughts, speech, behavior, and bodily functioning. As is true of depression, mania occurs in response to HIV infection; medications such as antivirals, antidepressants, or corticosteroids; abused drugs like amphetamines and cocaine; or psychosocial stressors such as loss of a loved one, change in financial status, or threats to health or safety. The criteria for diagnosis of mania include abnormally and persistently elevated or irritable mood and the presence of several of the following symp-
symptoms: inflated self-image; decreased need for sleep; increased or pressured talking; racing thoughts; marked distractibility; or increased activity and excessive indulgence in pleasurable—but possibly harmful—activities such as spending sprees, excessive sexual activity, or foolish business investments.

People with mania generally feel happy and even exuberant. They usually have little desire or ability to comprehend the consequences of their behavior. Manic individuals may deny that they have a problem, offer rationalizations for their behavior, and refuse medication that might bridle their exuberance. Manic patients are impulsive, distractible, and have poor concentration and judgment. While they are not candidates for conventional psychotherapy while acutely ill, they do need help to keep themselves from indulging in potentially harmful erratic and disinhibited behavior.

Lithium works both as an effective treatment for acute episodes of mania and as a prophylaxis for prevention of future episodes. Its typical adverse effects are mild and include increased thirst and urination, gastric discomfort, fine hand tremors, fatigue, and weight gain. Since lithium can be toxic at elevated levels, clinicians must regularly monitor blood lithium levels, and patients must recognize the symptoms of lithium toxicity: vomiting, severe diarrhea, coarse hand tremor, lack of muscular coordination and balance, trouble with speech, and confusion.

Significant vomiting or diarrhea can lead to loss of body fluid and sodium and produce a subsequent elevation of lithium level. As a result, patients must stop lithium therapy while they are experiencing severe body fluid loss. Regular non-steroidal anti-inflammatory drugs such as ibuprofen may also increase blood lithium levels, however, with careful monitoring of lithium levels, these drugs may be taken safely.

As an alternative to lithium, patients may take the anticonvulsants carbamazepine or valproic acid. Carbamazepine, however, may lower white blood cell count, which may already be decreased due to HIV infection or antiviral medications or cancer chemotherapy. Valproic acid may be used in addition to, or in place of, lithium. Its common side effects include mild nausea, sedation, and hand tremor. It may also cause mild abnormalities in liver function among adult patients, but can have more serious effects in children.

Mania medications may take more than two weeks to act, and clinicians may need to use short-term antipsychotic medication in order to achieve rapid symptom control. Since, in my experience antipsychotic medications may lead to abnormal muscular function among HIV-infected patients, I prefer to prescribe antipsychotics such as perphenazine, which is less likely to cause these side effects.

Conclusion

The most important point about mood disorders is that they are easily diagnosed and treated. Do not dismiss them as understandable psychological responses; approach them as HIV-related conditions that can be managed using psychotherapy and medication. In the end, dealing with the symptoms of HIV disease and the psychological challenges of a life-threatening illness is hard enough for clients without adding to the burden treatable conditions.

Clearinghouse: Mood Disorders

References


People with HIV disease, like others with life-threatening illnesses, go through psychological stages as illness progresses.1, 2 These stages are a means of coming to terms with accepting illness and mortality. While progressing through the stages, people with HIV disease continually consider and redefine quality of life issues. It is not uncommon for them to reach a point at which quality of life becomes intolerable, and to respond by making informed and well-planned decisions to end their lives. This is called rational suicide.

Because of the controversial nature of rational suicide and the complicated legal and ethical issues that arise in its wake, there are no data available on the number of suicides that could be considered rational.3 The American Hospital Association has estimated that many of the 6,000 daily deaths in the United States are in some way planned by patients, families, and physicians, many of which go unreported as suicide.4 A public opinion poll conducted by the New York Times and CBS revealed that 53 percent of respondents felt that a physician should be allowed to assist a severely ill person in taking his or her own life.5 Unfortunately, there has been little attention given to the opinions of people with life-threatening illnesses themselves.

Studies investigating the prevalence of suicidality associated with HIV infection have produced varied results. While some studies show the suicide risk to be as much as 40 times higher than the general population; others have reported lower risk rates, comparable to those found in samples of seronegative people.6 These discrepancies have been explained by many factors including stage of disease, characteristics of risk group, and sampling errors. This article reports on a small study of people with HIV disease and their attitudes toward rational suicide.

The AIDS Health Project distributed 92

Caregivers to people with terminal illnesses should carefully examine their values regarding rational suicide and give some thought to how they would respond if asked to assist in a plan of self-deliverance.
anonymous questionnaires to Positives Being Positive group facilitators, to be distributed to group participants. Positives Being Positive organizes weekly support groups for HIV-infected people. The questionnaire consisted of 54 items about demographics, quality of life, and emotional and physical health, and included the short form of the Beck Depression Inventory. Eight of the questions dealt with the issues of suicidal ideation and the concept of a rational suicide. A definition of rational suicide preceded questions about it.

**Summary of Questionnaire Responses**

Participants completed and returned 39 questionnaires representing 42 percent of the total sample. Thirty-eight of the respondents were male and one was female; all respondents identified themselves as being gay. Average age was 36 years with the youngest participant being 24 and the oldest being 51 years old. Thirty-two of the participants were White, four were Latino, two were African American, and one was of Chinese descent. Thirty-two of the respondents had known their HIV infection status for a year or more; six had been tested six months to a year before joining the group; and one did not include this information.

**Scoring of the Beck Depression Inventory**

The survey also suggests that support groups, by normalizing feelings about suicide, appear to have a role in helping people to manage suicidal thoughts. The realization that “I’m not the only one,” seems to lead to increased comfort and safety and to willingness to participate in a forum in which group members can explore emotions related to their decisions.

The findings of this preliminary survey indicate that the topic of rational suicide is a relevant one and deserves further investigation and clarification. They also imply that caregivers to people with terminal illnesses should carefully examine their values regarding rational suicide and give some thought to how they would respond if asked to assist in a plan of self-deliverance.

**Conclusion**

Until a cure for AIDS is found, it is likely that people will continue to consider self-deliverance as an alternative to continued pain and suffering. The challenge to clinicians and therapists will be to manage their feelings of counter-transference, remain non-judgmental, and to help provide an environment that will encourage their clients’ exploration of choices. It is crucial for therapists to attempt to understand their clients’ circumstances and to consider a situation in which dying with dignity is more important than prolonging life.

**Comments and Submissions**

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

**Editor, FOCUS**

UCSF AIDS Health Project, Box 0884

San Francisco, CA 94143-0884

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**References**


**Authors**

James R. Jones, MD recently graduated from the psychiatry residency program at the University of California San Francisco. He currently works as a staff psychiatrist at the San Francisco Department of Public Health and as a psychiatric consultant to the Progress Foundation.

James W. Dilley, MD is Associate Clinical Professor of Psychiatry at UCSF, Director of the UCSF AIDS Health Project, and Executive Editor of FOCUS.
Recent Reports

Suicide and HIV Disease

People with HIV disease are at increased risk for suicidal thinking, suicide attempts, and suicide, according to this comprehensive review of the literature on suicide and HIV disease. Nonetheless, the actual number of suicides in this population is very low and key factors, such as social support, meaningful work, and religious beliefs, diminish the chance of suicide.

Suicidal thinking occurs throughout the course of HIV disease, but a critical association exists between increased suicidal ideation and positive results following HIV antibody testing. Some studies show that HIV-infected people without AIDS are more likely to have suicidal thoughts than those with AIDS.

Although studies of attempted suicide are limited, data drawn from a major study of United States Air Force personnel found suicide attempts by seropositive people to be 16 to 24 times higher than that among other Air Force personnel. Similarly, a national study of suicides among people with AIDS during the period 1987 to 1989 found a suicide rate seven times that of the general population. Most of these suicides were among White men, and the median age of the sample was 35. To commit suicide, they used medication overdose (35 percent), firearms (25 percent), suffocation (13 percent) and jumping (9 percent).

Among suicide risk factors are demographic factors, such as being over age 45 and a White male, a family history of suicide, loss of an important relationship, being single or divorced, living alone, and being retired. Other markers for assessing suicide risk include: treatable mental illness, especially depression, alcoholism and injection drug use, serious medical illnesses, hopelessness, and neurobiologic markers.

Clinicians should assess HIV-infected clients in terms of their experience of multiple loss and social isolation, their thoughts and feelings about the disease and its treatments, and their attitudes towards the suicides of others.

Group Psychotherapy for Depression

A small pilot study of HIV-infected people found decreased levels of clinical depression and anxiety and improved coping abilities following participation in a structured, psychoeducational support group.

The group of six were recruited from several zidovudine studies and consisted of five gay men, one with a history of injection drug use, and a heterosexual woman. All were seropositive and asymptomatic, and reporting psychological distress about their disease state. Prior to HIV antibody testing, none had a psychiatric history; however, within the year prior to the group, all had experienced major depression that had been successfully treated by fluoxetine. Only four completed the 20 one-hour sessions. The organized sessions dealt with HIV education, the emotional and social issues of living with HIV disease, and positive coping mechanisms, such as developing a support system and effective communication.

The key issues that came up during the group sessions were feelings about abandonment, being a social outcast, the stresses of having HIV disease, and the need to establish social support systems. Although group members reported improvement in all psychological areas, the most improvement was in social and work functioning, coping with feelings of abandonment, and using the group to provide social support. The pilot study provides a foundation for further studies into the role of group psychotherapy as an adjunct to antidepressant medication in the treatment of certain atypical depressions among HIV-infected people.

Clinical Assessments of Psychopathology

A study of psychopathology in gay men found low rates of depressive and anxiety disorders, but extremely high lifetime rates of major depression and alcohol and other psychoactive substance use disorders.
There was no difference in study results between seropositive and seronegative men in this self-recruited sample.

Researchers clinically assessed current and lifetime psychopathology in a group of 208 gay men, 124 of whom were HIV-infected and 84 of whom were not. Subjects were well-educated, financially secure, middle-class gay men with a mean age of 38 years. A full-day of comprehensive assessments included neurologic and medical examinations, blood work, psychiatric, psychosocial and psychosexual interviews, and neuropsychology tests.

The most common current mental disorders were depressive disorders (4 percent) and psychoactive substance use disorders (3 to 7 percent). Anxiety disorders were virtually nonexistent. Severity levels were low, indicating a lack of clinically significant depressive symptoms. Neither stage of illness nor immune status—based on T-helper cell, T-suppressor cell, and helper/suppressor ratios—were associated with any measure of depressive or anxiety symptoms.

The current psychopathology rate for the general population (15.4 percent) was comparable to the rate for gay men (16.0 percent). However, lifetime rates were markedly different: of the general population, 5 percent experienced a major depression, 14 percent alcohol abuse/dependence, and 6 percent other drug abuse/dependence, compared to gay men among whom 32 percent of HIV positives and 33 percent of HIV negatives experienced a major depression, 41 and 30 percent alcohol abuse/dependence, and 56 and 38 percent other drug abuse/dependence.

**Diagnosing Psychological Disorders**

Bialer PA, Wallack JJ, Snyder SL. Psychiatric diagnosis in HIV-spectrum disorders. Psychiatric Medicine. 1991; 9(3): 361-375. (Beth Israel Medical Center and Mount Sinai School of Medicine.)

The prevalence of psychiatric disorders among individuals with HIV disease is not known, and a comprehensive review of the published research found no consistent pattern of diagnosis nor a typical diagnosis in this population. In all studies, clinicians found it difficult to accurately distinguish organic disorders from non-organic disorders, which can also be confounded by physical symptoms that mimic psychiatric symptoms. For making appropriate diagnoses, the reviewers used the definitions provided in the DSM-III-R.

HIV infection itself, opportunistic infections, neoplasms and the side effects of medications may cause organic mental disorders. AIDS Dementia Complex, with incidence estimates ranging from 14 to 66 percent, requires both clinical and neuropsychological testing for accurate diagnosis. Delirium, already a common organic disorder in hospitalized HIV-infected patients, may increase in prevalence as the proportion of drug users with HIV disease and withdrawal delirium increases.

The evidence for the prevalence of major depressive syndrome among HIV-infected people is limited and variable. In patients with advanced AIDS, depressive symptoms may have an organic cause, and their response to antidepressant medication may be poor. However, asymptomatic seropositives generally respond well to antidepressant therapy. Even when the diagnosis of major depressive episode is made, a number of processes—such as adjustment to illness, loss and pain, or subclinical encephalopathies—may treat decisions in this group of patients more complex.

Adjustment disorders, defined as maladaptive reactions to stress, may be particularly common in HIV-infected people because of the rapid number of stresses and losses that occur in succession. Anxiety disorders, however, are relatively uncommon, although anxiety functions at all stages of HIV disease, often as a symptom of other psychiatric disorders.
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