Understanding Depression

Depression can affect a person’s HIV risk behaviors and ability and willingness to change behaviors. It might, for instance, diminish someone’s ability to negotiate safer sex or cause a person to place less value on avoiding HIV infection. The Research Update defines the emotional state of depression, including major depression, dysthymia, and substance-induced depression—and explores the relationship between depression and HIV.

The Implications for Counseling section presents ways that counselors can assess and consider the role that depression might have in a person’s life and risk behaviors, recognizing that it is the role of qualified clinicians to diagnose and treat depression. It is not the role of the HIV test counselor to do this.

Research Update

Depression is a mood disorder that affects a person’s emotional and physical health, and manifests itself in different ways and with differing severity for each person. For one person, the primary aspect of depression may be fatigue, for another it may be overwhelming feelings of hopelessness, and for yet another it may be a persistent loss of appetite. One person may be depressed and remain highly “functional” at work and in social relationships, while someone else may be unable to maintain a job.

Depressive illness is surprisingly common: in any six-month period, approximately 9 million Americans suffer from depression.1 Importantly, people with depressive illness cannot will or wish away their symptoms, and without treatment people may suffer for weeks, months, or years.1

To diagnose depression, clinicians look for the persistent presence of a combination of symptoms over an extended period. These include feelings of sadness, emptiness, or worthlessness; significantly diminished interest or pleasure in all, or almost all, activities; significant weight loss or weight gain; decrease or increase in appetite or sleep; fatigue or loss of energy; anxiety; excessive or inappropriate guilt; diminished ability to think or concentrate; and recurrent thoughts of death.2 Depression is often noted by changes in functioning from a person’s normal patterns. However, for someone who experiences depression over a long period, being depressed may have become “normal” and this person may not recall any other way of living.

There are different categories of depression, including “major depressive episodes” and “dysthymia.” Major depressive episodes are characterized by symptoms that occur nearly every day for a period of at least two weeks.2 In contrast, dysthymia is a more chronic condition characterized by the presence of less intense symptoms for most of the day, more days than not, for at least two years. These categories distinguish depression from passing “blue” moods. Depression is also distinguished from “low spirits” by the severity of certain symp-
Depression is a common mental health disorder characterized by persistent decrease in self-esteem, thoughts of suicide, distinct vegetative symptoms, and disruption of a person's life. Depression is also discrete from grief, which occurs in response to loss or the threat of a loss, but is generally resolved over time. If grief remains unresolved, however, it can lead to depression.

Depression may be diagnosed by a range of health care professionals and is most commonly treated with medication, psychotherapy, or both. Psychiatrists are specially trained to prescribe antidepressants, but other physicians and nurse practitioners can also prescribe these drugs. In some instances, psychiatrists may also use other forms of treatment, such as electroconvulsive (ECT), or “shock” therapy, and light therapy to treat depression. Licensed therapists provide psychotherapy but are not qualified to prescribe medication.

Although advances over the past 15 years have increased medication options and medical providers are quicker than they once were to attend to signs of depression, the condition is often undertreated and undiagnosed by physicians. This may be because providers lack adequate education about depression or are concerned about raising a socially stigmatized subject with their patients. In addition, depression-related behaviors may, themselves, alienate providers. For instance, studies have demonstrated that some symptoms, such as hostile speech, negative self-evaluation, lack of responsiveness, reduced eye contact, negative facial displays, and slowed or monotonic speech tend to repel those in positions to provide help. Primary health care providers may not recognize depression in some cases because their patients often present depression in terms of physical complaints.

There are many reasons people suffering from depression do not actively seek treatment. There are societal stigmas attached to depression that cause many people to try to conceal depression rather than seek help. Some depressed people might not even recognize that they

Related Issue: The Depressed Experience

Clinical descriptions of depression can be useful, but people often describe depression in more tangible terms. The following are ways a person might talk about his or her mood. One of these statements alone does not necessarily indicate a person is depressed. Licensed clinicians diagnose depression in the presence of multiple symptoms that occur continuously.

**Significant loss of appetite nearly every day.**
“Nothing tastes good to me.” “I’m not trying to lose weight, but I’ve lost quite a bit in a relatively short period of time.” “I’m just not interested in eating.”

**Significant increase in appetite nearly every day.**
“It seems as if I’m eating all the time. But I don’t feel full for long, so I eat again.” “Often, I’m not hungry, but I keep stuffing myself with food.”

**Sleeping too much almost every day.**
“I’m sleeping much more than usual.” “I’m always tired, but I’m not sick.” “It’s a lot nicer being asleep than awake.” “It feels good to go to bed early and have the day over with.”

**Having trouble sleeping almost every day.**
“Often, I lie awake for a long time when I go to bed at night.”

**Emotional darkness.**
“I feel like I’m isolated in a black hole or the bottom of a well.”

Studies have demonstrated that depressed people are more likely than non-depressed people to engage in behaviors that may put them at risk for HIV.
have a treatable illness. Finally, many people are reluctant to seek care because they do not have insurance to cover the cost of treatment. 

**Depression and HIV**

A few studies of specific populations have found that depressed people are more likely than non-depressed people to engage in behaviors that may put them at risk for HIV. When people are in low spirits, they may look to substance use or sex to feel better. A depressed person exhibiting apathy about his or her life might lack assertiveness and the ability to make clear decisions about negotiating safer sex. A lack of hope and sense of despair among people with depression may impede their adoption of protective behaviors.

Low self-esteem and depression are often correlated, and people with low self-esteem often lack feelings of security, acceptance, competence, and control that might be necessary to reduce HIV risk-taking.

Furthermore, some uninfected gay men who suffer from depression, anxiety, and loneliness, sometimes labeled as “survivor guilt,” may feel that HIV infection is inevitable. This sense of inevitability about becoming infected may cause a person to take a passive role in protecting him or herself from infection. Mental health professionals anecdotally report seeing depressed clients who have engaged in high-risk, unprotected sex because they have sought—consciously or without conscious thought—to become infected. One study of the clinical factors of primary HIV infection reported as an aside that three men asserted they had intentionally acquired HIV because they were experiencing symptoms of depression and a feeling of exclusion from their peer group. While the study did not attempt to prove this connection, it adds to the body of anecdotal evidence for the association between depression and high-risk sex.

As a symptom of depression, a person may actually convince him or herself that he or she has a life-threatening condition such as HIV infection. A recent study suggests that depressed people might actively seek negative feedback and attempt to surround themselves with “gloom;” 82% of depressed people in this study preferred unfavorable feedback to positive reinforcement.

**Epidemiology**

Research has found that members of population groups with high rates of HIV infection, such as gay men and injection drug users, are especially vulnerable to depression. Some researchers speculate that social stigmatization as well as internalized homophobia, lack of role models, familial rejection, and fear and grief about AIDS may contribute to these higher rates of depression.

General population studies find that women experience depression more commonly than men. Studies have demonstrated that reproductive events involving hormonal changes can precipitate depression among women. This is true particularly among women with a personal or family history of mood disorders, which include depression. Women are particularly vulnerable to depression during puberty, some phases of the menstrual cycle, the postpartum period, the time at which a couple recognizes infertility, and the period subsequent to surgically induced menopause.

Studies find that a significant number of women who have a history of premenstrual syndrome also have a history of mood disorders. These studies do not, however, establish a cause-and-effect relationship between these two factors. Researchers have also associated the use of several oral contraceptives with depressive symptoms among some women.

**Substance Use**

There are many connections between depression and the use of alcohol and other drugs, and it is often the substance—rather than depression directly—that impairs a person’s judgment and makes it more likely that he or she will have unsafe sex. In addition, alcohol and

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**Helping Oneself**

Receiving professional treatment for depression is important. In addition to treatment, a person dealing with depression may benefit from some of the following:

1. Do not set difficult goals or take on a great deal of responsibility.
2. Break large tasks into small ones, and do what you can as you can.
3. Try to be with other people; this is usually better than being alone.
4. Participate in activities that make you feel better.
5. Seek to postpone major life decisions until your depression has lifted. If it is not possible to wait, consult with others who know you well and can provide a more objective view of your situation.
6. Do not expect to “snap out” of your depression, and do not get upset if your mood is not greatly improved right away. Feeling better takes time.
other drugs have depressive effects and can induce or exacerbate depression.

Research has documented the correlation between alcohol and depression: untreated depression increases a person’s risk of abusing substances. In addition, having a substance use problem increases a person’s risk of becoming depressed. When people use alcohol for temporary relief of emotional pain, their depressive symptoms might seem relieved for a few hours \(^\text{21}\) by the tranquility or sedation that alcohol can provide, but this leads to a long-term increase in depression.

Some people who suffer from chronic or long-term depression use alcohol and other drugs as a way of “self-medicating.” These people are not necessarily aware that they are experiencing depression or that their drug use is a method of medication. In some cases, people may not have considered other approaches for treating their condition, or they may believe that other approaches are not useful.\(^\text{21}\)

Alcohol and many other drugs cause disinhibition, an aspect of intoxication that often leads to impulsive behavior.\(^\text{21}\) A depressed person, in particular, might find disinhibition to be a pleasant relief.\(^\text{21}\)

Depression is also correlated with cigarette smoking. Because nicotine is a stimulant and also has sedating effects, people often smoke to ease depression. They then find it difficult to quit smoking, in part because doing so causes depressive symptoms to re-emerge.\(^\text{21}\) Some physicians view smoking as a potential sign of depression among patients.\(^\text{21}\)

**Successful Interventions**

Telling a depressed person to cheer up is like telling a person addicted to drugs to “just say no.”\(^\text{21}\) Depression is a physical and emotional illness, and it involves alteration of neurotransmitters, the chemicals that send nerve impulses in the brain. Complete physical and psychological evaluation are the first steps in diagnosing the type of depression from which a person suffers.

Medication or psychotherapy, or a combination of both, are the most common treatments for depression. Psychotherapy can help people uncover sources of depression and give them new strategies for dealing with their feelings. Through psychotherapy, people may learn to anticipate and prevent future depressive episodes. Often, the presence of a psychotherapist as an objective listener can bring tremendous comfort and support to a person dealing with depression.\(^\text{1}\)

Medications that affect neurotransmitters can also be effective in bringing relief to a depressed person. There are five general types of antidepressant medications: tricyclics, monoamine oxidase inhibitors (MAOIs), mood stabilizers, unique antidepressants, and selective serotonin reuptake inhibitors (SSRIs). SSRIs are relatively new, and they include the drugs Prozac, Paxil, and Zoloft. Because of these drugs, more people than ever before are being treated for depression.

SSRIs are used so widely partly because they are not physiologically addictive and because their negative side effects are less pronounced than those of other types of antidepressants.\(^\text{1}\) These drugs can, however, involve side-effects such as headaches, bladder problems, sexual problems, dizziness, drowsiness, and increased anxiety. It is important to note that antidepressants, unlike “street” or recreational drugs, do not radically alter a person’s mood or produce a constant feeling of being “high.” Rather, antidepressants bring mood fluctuations into balance and aid a person’s ability to cope.

**Implications for Counseling**

It is important for test counselors to understand general characteristics of depression, including the fact that depression affects a person’s thoughts, attitudes, and, in turn, HIV risk behaviors.

The counselor’s job is to consider the role of depression in a person’s life and not to diagnose depression. In this process, the counselor can assess the presence of signs of depression, help a client consider the possibility that depression might affect him or her, and explore connections the client makes between HIV risks and depressive symptoms. Consider the range of factors that might affect a client’s risk behaviors or lead a client to be susceptible to future risks. Through the session, provide support and link the client to appropriate referrals to assess and respond more comprehensively to the possibility of depression.

**Assessment**

When discussing HIV risks, be open to whether depression affects a client’s life and risk behaviors. For instance, when clients report that
they are engaging in unsafe sex and lack the desire to do things differently, ask more about this lack of desire. If this arises from hopelessness, for example, or if the client feels that initiating behavior change is pointless, explore these attitudes further. Learn whether the client feels that efforts to protect him or herself from becoming HIV-infected are also pointless. The client’s response to this may reveal that he or she believes that avoiding HIV is a hopeless proposition or that he or she does not hold hope for positive things in life, such as having a long-term relationship.

Be aware of feelings and moods related to depression. When clients express significant fear, such as fear of rejection, loneliness, criticism, disappointment, change, or even of living, recognize that depression can underlie fear. Recognize that anger is also a part of depression. Many clinicians refer to depression as “anger turned inward.” Clients may have unresolved anger toward specific people, places, or things without being consciously aware of this. Or, clients may be aware of being angry but lack the skills or require assistance to deal effectively with these feelings. Recognize the relationship between self-esteem and depression, and the fact that people with low self-esteem may lack the ability to avoid unsafe behaviors.

Some clients may, without being asked, disclose at the outset of a session that they experience depression and need help dealing with it. When this occurs, learn more about what the client means by his or her statement and what depression means to him or her. People use the term depression to refer to many different things, some of which do not fall within the guidelines of “clinical” depression. For example, people often say they are depressed when they are in fact experiencing sadness for a relatively short time.

Conversely, clients may label depression by other names. For instance, they may say, “I’ve got a case of the nerves,” or “My energy isn’t good.” Culture, class, and personal philosophy can all affect the words a person uses to describe feelings or personal states and the views one has toward being depressed or toward people who are depressed. Counselors must probe their clients’ terms what their symptoms mean to them. By doing this, counselors can identify a client’s concerns and motivations for taking action and then shape interventions to the client. Recognize that some people may be experiencing depression but feel prohibited from acknowledging this.

Counselors should assess their own views toward depression or people who are depressed. People in some cultures see depression as a spiritual ailment or punishment that is remedied only through prayer or the healing powers of a spiritual leader. Cultural factors may lead people to see depression as a sign of personal inferiority experienced by those who are weak-hearted. In addition, some people feel relief by viewing depression as a mental illness, others see this as a label or “branding” with negative connotations.

Because depression can impair a person’s decision-making ability, learn the extent to which clients are unable to make clear decisions and effectively negotiate for safer sex. A client’s concentration or ability to thoroughly evaluate acceptable or unacceptable risks may be impaired by unresolved emotions or unattended life events that arise out of depression. Such things can be preoccupying, both consciously and unconsciously.

Partly as a result of depression, a person may become convinced that he or she has a life-threatening condition such as HIV infection. Assess this possibility. In addition, assess the possibility that a depressed person might engage in harmful behaviors because he or she feels HIV infection is inevitable or because he or she seeks to become infected.

Assess relationships between depression and alcohol or other drugs. Learn to what extent clients combine alcohol and other drug use with sex or use substances to relieve or “treat” depression. Point out that while this may provide some short-term relief of depressive symptoms, substance use can actually exacerbate a person’s feelings of depression.

Be aware that clients who have symptoms associated with depression may actually be experiencing something other than depression. A client’s symptoms, for instance, may be temporary, and may result from the testing process itself. Or, a client may experience feelings of grief related to an event such as the death of a friend or partner.

Intervention

Validate the client for his or her willingness to name and discuss concerns. Avoid opening emotional wounds beyond the scope of the counseling session. Be supportive, empathic, and compassionate and avoid criticism while discussing depression. Respect that a client may feel vulnerable discussing this subject.
Explain the ways in which depression might affect a person. For example, if a client describes his or her life as being empty and worthless, reflect these descriptions back to the client. The counselor can then ask questions about the client’s behavior and thoughts, and the client’s answers can guide further intervention.

Validate how difficult it can be to take steps to take care of oneself in the face of depression. Validate even the smallest step a client has taken in this direction—for instance, coming to the test site or speaking with the counselor about depression—in order to demonstrate that he or she has done something.

When a client shows and acknowledges signs of depression, assess whether this client will accept help from the counselor. Learn to what extent a client might be motivated to deal with depression or to pursue a referral. If a client does not want to take a further step such as pursuing a referral, he or she might reveal this through a statement such as, “Yeah, I’m depressed. But there’s nothing I can do about it. And, I don’t want to do anything about it.” When this occurs, assess whether there is something—for instance, isolation or guilt—that the client does wish to “do something about” and explore that area. Follow the client’s lead in dealing with issues of depression at a pace that is comfortable for him or her, and link the client to a referral that is consistent with this pace.

Some clients may confuse feelings of depression with feelings of grief. If clients describe losses they have experienced, help them understand the difference between grief and depression. Explain that grieving after a loss is a normal, albeit painful, response. If a client seems relieved to hear this distinction, ask what he or she is doing in response to feeling grief and what he or she might need during this time. If an explanation of grief does not appear to shift the client’s perspective on this subject, provide a referral to a mental health professional or other resource dealing with grief. Be aware that when unresolved, grief can lead to depression.

Keep discussions of depression centered on the implications of depression on HIV risks. Clarify and redirect sessions as necessary to do this.

**Referrals**

Mental health practitioners are the best referral for further assessment of depression. A mental health professional can assess the roots and depths of an individual’s depression and provide or refer the client to therapy, including individual psychotherapy or antidepressant drug therapy. Counselors often refer clients to HIV support groups, but an HIV-specific group is likely to be of limited use in cases of depression unless the client is also undergoing other interventions to deal with depression.

Explain that some people who are depressed are apprehensive about pursuing referrals. Some people are ashamed about the possibility of being depressed, while others may have little energy to initiate an

**References**

effort to get help. Explain that this process can be difficult to initiate, make clear that providers can help, and refer to examples—such as seeking HIV testing and counseling—by which the client has accessed services. Be sure to connect referrals to outcomes that a client explicitly desires.

There are some cases in which a client may appear to be severely depressed. In such cases, counselors may need to be more directive in guiding clients to referrals and in establishing reasons for clients to pursue follow-up services. This directive stance, which must occur in the context of a compassionate response, can be warranted in such cases because depression can be a life-threatening condition and professional intervention can be life-saving. Remember, however, that counselors are not in a position to force clients to seek referrals.

Case Study

Dawn is a 26-year-old single woman. She has tested for HIV several times and is testing now because she is concerned that she might have been infected through any of several episodes of unprotected vaginal sex with five male partners in the past year. The counselor has explained the window period of infection.

Dawn seems guarded and worried about the outcome of the test. She says she has had several extended periods of feeling especially “down” and “lonely” and has a problem with continued sadness over the past three years. She states that a provider at a women’s clinic suggested two years ago that she seek counseling, but she has had little interest in this.

She says she wants to insist on condom use, but that in the past she has been less likely to use condoms on occasions when she has had a “few drinks” to feel better. It appears that she does not see a connection between her sadness or loneliness and the times that she engages in unprotected sex.

Counseling Intervention

Support Dawn for her decision to seek HIV counseling and testing and for disclosing her experiences and feelings. Empathize with her struggles and concern about the outcome of this test, and the fact that a subsequent test will be necessary. Make sure she understands that her behaviors have placed her at risk for HIV infection.

Engage Dawn in a discussion about the relationships among her mood, alcohol consumption, and unprotected sex to see what, if any, connections she recognizes. If she does not see a connection, suggest the possibility. In this discussion, validate her desire for safer sex. Explain to her that alcohol use can affect a person’s decisions to engage in unsafe sex.

Beyond this, explain that when people experience difficult feelings, such as sadness, they may be less interested in taking care of themselves and insisting on condom use. Discuss the idea that feelings such as sadness can prompt people to consume alcohol and that this may lead a person to be even more vulnerable to engaging in unprotected sex. Help her see that alcohol itself can depress a person’s mood. Ask Dawn how she feels about this description and its relevance, if any, to her own experience.

If Dawn does not see a connection and expresses agitation in this discussion, try to discover whether she is willing to discuss any of this further. She may be willing to discuss her sadness, for instance, but not her alcohol use. If she is not willing to discuss either of these, recognize that it may not be possible to explore this subject any further for now. Suggest that if or when she wants to look at the issues that have been raised, help is available and she can contact an HIV services agency or get a referral by calling an AIDS hotline. Express concern to Dawn about her sadness and other feelings, and then focus on other ways she might avoid unprotected sex in the future.

During this discussion, consider and explore Dawn’s earlier exchange with a provider who suggested that she receive counseling. Discover the nature of the discussion that preceded this, any reasons Dawn did not pursue this suggestion then, and any reasons she may not pursue help now. Be respectful of reasons Dawn might state. Explore her motivations for testing and avoiding unsafe sex as reasons she might now be willing to seek support. Provide referrals and explore her willingness to pursue these, and what might help her to do so. Emphasize the immediate importance of seeking help in order to avoid unprotected sex.

In the event that Dawn does see a connection among her feelings, alcohol use, and unsafe sex, pursue this. State that acknowledging this is a significant step toward making future changes. Explain that adequately addressing these subjects is beyond the scope of the test counseling session, but that she can be referred to a professional who can assess more clearly her feelings, and respond supportively.
Test Yourself

Review Questions
1. True or False: Most people who are depressed readily recognize their symptoms and seek help.
2. Depression can last for: a) weeks; b) months; c) years; d) all of the above.
3. The following, when they occur persistently, are symptoms of depression: a) changes in sleep patterns; b) changes in eating patterns; c) fatigue; d) all of the above.
4. True or False: People at high risk for HIV are especially unlikely to be people experiencing depression.
5. True or False: Depression affects a person’s emotional state, but does not have physical effects.
6. Antidepressant treatments: a) make people feel perpetually happy; b) are usually addictive; c) have become much more effective and practical in recent years; d) almost always produce severe side effects.
7. True or False: Someone who is depressed would never be functional enough to seek HIV testing and counseling.
8. According to estimates, how many Americans suffer from depression during a typical six-month period? a) less than 25,000; b) 100,000; c) 9 million; d) 230 million.

Discussion Questions
1. What questions is it important for a counselor to ask a client to determine whether depression might be an issue in this person’s life?
2. What are some appropriate referrals for a depressed client? How might a counselor approach a client who is suspicious or defensive at the mention of a psychiatrist?
3. How can counselors consider the role of depression in a person’s life and avoid seeking to diagnose depression? How can counselors communicate to clients that the role of the counselor is not to diagnose depression?
4. How can counselors discuss the subject of depression with clients without seeking to “label” a client as being depressed.
5. How can counselors respond to their own fears or other feelings about not being able to respond adequately to a client who might be dealing with depression?

Answers
1. False. For many reasons, people who are depressed often do not recognize this fact or seek help.
2. d.
3. d.
4. False. Populations at high risk for HIV are also at high risk for depression.
5. False. Depression has physical effects as well, including fatigue, appetite changes, and sometimes headaches or stomach aches.
6. c.
7. False. While depression can lead a person to be immobilized or dysfunctional, many people who are depressed are functional.
8. c.
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