Possible links between HIV/AIDS and mental disorders

Due to the virus's tendency to replicate in the central nervous tissue, HIV/AIDS may cause direct physiological injury to brain matter and neurological pathways, thereby leading to neurocognitive disorders. The social and psychological burden of people living with HIV/AIDS may also lead to a variety of mental disorders.

"Untreated mental illness among HIV/AIDS patients may exacerbate viral replication and disease progression, thereby worsening prognosis. It is therefore crucial for them to be aware of their increased risk for certain mental disorders, to recognise the signs and symptoms and to seek help as early as possible. Overcoming stigma is integral to early help seeking and improved outcomes," says Dr Aneshree Moodley, consultant specialist at Akeso Psychiatric Clinics.

HIV-associated neurocognitive disorders

According to Dr Moodley damage caused by the HIV virus to sub-cortical and frontal brain regions leads to a wide spectrum of neurocognitive deficits which are collectively referred to as HIV associated neurocognitive disorders (HANDS), consisting of asymptomatic neurocognitive impairment (ANI), minor motor and neurocognitive disorders (MMND) and HIV-associated dementia (HAD).

"Essentially each of the above disorders can be thought of as a continuum of the same disorder, where there is gradual worsening of clinical features as one progresses from ANI to MMND, to HAD.

Symptoms

"Apathy is a highly common, burdensome and challenging symptom which has become synonymous with HAD. Initially apathy may be subtle and consequently be mistaken for laziness or tiredness.

"However, careful enquiry from a trained specialist will help distinguish apathy from co-occurring physical symptoms or co-occurring depressive symptoms. It is fundamentally different from depression because there is no associated sadness or irritability. In apathy, there is decreased motivation to initiate activities or to participate in activities. The decreased enjoyment of these activities is stressed in depressive disorders but not in apathy.

"Mania is characterised by the same symptoms seen in bipolar mania and is treated in a similar manner as bipolar mania. The prevalence of mania increases from 1%-2% in early HIV to 4%-8% in late HIV. Regarded as a defining illness, it warrants treatment with HAART.

"Psychosis in HAD often occurs in the context of mania. HIV is a biological stress on the body. In addition, the anxiety of having a life threatening disease brings immense psychological stress. It is therefore reasonable that diagnosis of HIV may be sufficiently stressful to precipitate onset of a psychotic illness such as schizophrenia in a genetically vulnerable individual.

"Reversible psychosis, secondary from HAART is also common. Medication such as Nevirapine, Efavirenz, abacavir and gangciclovir are all evidenced to cause hallucinations and paranoia, while psychotic symptoms are often present during a delirium.

"Delirium is a very important and common neurocognitive presentation with a point prevalence of 30%-40% among hospitalised HIV positive patients. The ability to recognise delirium, distinguish it from both HANDS disorders and other mental disorders, will allow correct diagnosis and early commencement of correct treatment. Incorrect diagnosis, on the other hand, may lead to delayed treatment and poorer morbidity and mortality rates.

"It is important for anyone suspected of having a delirium to urgently present themselves to the nearest emergency room where qualified medical personal can complete comprehensive physical evaluation and investigations to distinguish delirium from HANDS, or Schizophrenia and other mental disorders and thereby commence correct treatment.

Depression

"Depression in HIV/AIDS is a complex matter. Psychosocial factors such as adjusting to the diagnosis, making meaning of a positive diagnosis, receiving news of the disease's progression, adapting to life with a chronic life-threatening illness and living through the decompensation and death of family/friends from HIV, contribute immense psychological stress, which increase one's risk of depression.

"In addition, the neurological impact of the virus at a biological level within the brain pathways may also increase risk of depression. A national study completed in 2001 in the US, revealed a 36% one-year prevalence of depression among HIV positive people (Bing et al.) Another US meta-analysis revealed that depression occurs twice as often in HIV positive people than HIV negative people (Ciesla et al.)"

Impact of mental illness on HIV/AIDS

"Mental illness in many ways may increase one's risk for infection with HIV/AIDS. Several severe mental illnesses such as schizophrenia are associated with impaired social skills. The resultant social exclusion may increase likelihood of coercive sexual experiences and/or exchange of money/ goods/shelter for sexual favours. This may contribute to increased risk for infection with HIV/AIDS.

"Manic states may be associated with impulsive decision making, sense of omnipotence and tendency for hedonistic

behaviours. This combination of symptoms may reduce inhibitions around safe sexual practices and increase one's risk for infection with HIV/AIDS. In addition, depression may lead to reduced motivation to negotiate safe sexual practices and increased risk of coercive sexual encounters thereby also increasing risk of HIV/AIDS infection. Several mental disorders are associated with cognitive deficits which may also impair ability to reason around safe sexual practices and thereby increase risk for HIV/AIDS."

Co-morbid mental illness

"Living with co-morbid mental illness, while HIV positive, carries its own set of challenges. The lack of motivation seen in depression, combined with physical symptoms of HIV/AIDS, may reduce help seeking behaviours such as clinic attendance and medication adherence. Self-blame and guilt at contracting a life threatening illness such as HIV/AIDS may retard one's motivation to take medication and get well. Manic and psychotic states are associated with impaired judgment, with reduced medication adherence. The risk of suicide is also higher among those with co-morbid mental illness."

Stigma, suffering, shame and silence in HIV/AIDS

"Despite nationwide anti-stigma campaigns, negative perceptions around HIV/AIDS remain rampant. Stigma is defined as 'a mark of disgrace associated with a particular circumstance, quality or person'. The HIV diagnosis therefore carries a sense of fear, ugliness and rejection. The reaction of families and communities to people with HIV reinforces this sense of ugliness, inadequacy and 'apartness'. It is not uncommon for people to stop shaking the infected person's hand, stop sharing eating utensils, stop sharing food or stop socialising altogether for fear of contracting the disease. This leaves the infected person socially isolated and alone.

"In time, the infected person comes to feel deeply ashamed at having the infection irrespective of his or her role in contracting the illness. Entire families may be ostracised for having an infected member. This may serve to exacerbate the infected person's shame and guilt. As a result, an attitude of denial and silence is fostered. A multitude of HIV infected people live in silence due to fear of physical violence from their partners/families, emotional abuse and/or rejection and ostracisation.

"Worryingly, it is not uncommon for HIV positive people to refuse HAART on the basis of fear of rejection. Social isolation, in turn, increases the risk for depression and other mental illnesses and decreases one's quality of life and overall prognosis. It is therefore imperative that HIV treatment programmes focus on reducing stigma in an effort to improve early testing and treatment adherence."

Life after discharge

Due to the emotional and psychological implications of having HIV, one must be aware of the risk of mental illness and look at strengthening one's social network and support systems.

"There is strong evidence that family support plays a significant protective role for mental illness co-occurring in the context of HIV. It is important to encourage open and honest conversations amongst family members and eradicate the attitude of denial and silence. It is also important to raise awareness of available counselling and support programmes, which may benefit the infected person or their families. Finally, correcting and strengthening coping skills is essential in easing the journey of living with a chronic and serious medical illness," Dr Moodley concludes.

For more information, go to www.akeso.co.za.