HIV and mental health – Theory and practice of interventions

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Disclosures

- None. ☺
- EATG

European AIDS Treatment Group

From Gus Cairns, 2013

Depression in PLHIV

- Estimates vary widely, from 0% to 80%, depending on how it's measured: most estimate 20-30%
- Problems with both measuring instruments and cutoff points: when is it an 'illness'? (Meta-analysis[1] found 21 standardised instruments were used to measure depression in studies of PLHA.)
- Depression is more common among women living with HIV, compared with men living with HIV, according to an international study reported at the 2nd International Workshop on HIV and Women.
- In UK study[2], 26.6% had 'moderate or severe' (severe 6.6%) depression, according to one measure (cf. 7% in general population); 19% according to another measure.
- Social support crucial: see box
- In US HCSUS study, 22% had 'major' depression[3], 48% some depression or anxiety[4].

	Depressive disorder
1: High social support	8.9%
2	16.2%
3	32.1%
4	52.3%
5: Low social support	66.1%

1. Sherr L et al. HIV and depression--a systematic review of interventions. Psychol Health Med. 16(5):493-527. 2011.
2. Lampe F et al. *Depression and virological status among UK HIV outpatients: results from a multi centre study.* 18th Annual Conference of the British HIV Association, Birmingham, abstract O10, 2012.
3. Bing et al. Am J Psych 58:721-8.
4. Orlando et al. Int J Methods Psychiatr Res 11:75-82.

Depression, chronic anxiety

- With older age, there was no clear trend in prevalence of physical symptom distress, but prevalence of depression and anxiety decreased, while prevalence of HrQoL problems increased. This pattern remained after adjustment for gender/sexuality and time diagnosed with HIV. The increase with age in overall prevalence of HrQoL problem was due to increased problems for "mobility," "self-care" and "performing usual activities" domains, not an increase in "depression/anxiety."

1. McGowan J et al. *Journal of the International AIDS Society 2014,* ***17(Suppl 3):19511***

Synergistic epidemics

- Depression: significantly higher rate with gays (Cochran 2009)
- Chronic anxiety: significantly higher rate with gays (Botswick *et al.* 2010)
- Suicide and suicidal ideation: significantly higher risk with MSM, especially the young (Paul *et al.* 2002)
- Substance use, chemsex, novel forms of drug use: ethical issues, however, some new substances more prevalent
- Adherence issues (Yun *et al.*)
- HIV
- HCV
- TB

Depression and chronic illness

- Data primarily from chronic pain fields
- Ample evidence for relationship between chronic illness and depression
- Patients with chronic medical illness and comorbid depression or anxiety compared to those with chronic medical illness alone reported significantly higher numbers of medical symptoms when controlling for severity of medical disorder. Across the four categories of common medical disorders examined (diabetes, pulmonary disease, heart disease, arthritis), somatic symptoms were at least as strongly associated with depression and anxiety as were objective physiologic measures.[1]

1. The association of depression and anxiety with medical symptom burden in patients with chronic medical illnessKaton, Wayne et al.General Hospital Psychiatry , Volume 29 , Issue 2 , 147 - 155

Mental health and outcomes

- After adjustment for socioeconomic factors and health conditions, depression had the largest effect on worsening mean health scores compared with the other chronic conditions. Consistently across countries and different demographic characteristics, respondents with depression comorbid with one or more chronic diseases had the worst health scores of all the disease states.[1]

- The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health. Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis.[2]

1. **Depression, chronic diseases, and decrements in health: results from the World Health SurveysMoussavi, Saba et al.The Lancet , Volume 370 , Issue 9590 , 851 – 858**
2. **No health without mental healthPrince, Martin et al.The Lancet , Volume 370 , Issue 9590 , 859 - 877**

From Gus Cairns, 2013

Depression and self-stigma

Depression

- A physical (= emotional) state that usually leads to negative thoughts
- Foreground emotion: 'brain weather': dominates action and thinking
- Resistant to cognitive change, peer/family influences
- Somewhat susceptible to pharmaceuticals, activity, status change, relational psychotherapy
- Pan-cultural
- Typical Q from screening test: "At least once this week, I have thought my life has been a failure"

Self-stigma

- A set of beliefs and cognitions that can lead to depression
- Background disposition: 'brain climate': influences action and thinking
- Susceptible to cognitive change, peer influences, family acceptance, cognitive psychotherapy
- Resistant to pharmaceuticals, activity, status change; quite resistant to relational therapy
- Consists of specific cultural ideas
- Typical Q from screening test: "It is my own fault that I have HIV" [agree completely/somewhat/don't agree]

Overstreet NM et al. *Internalized stigma and HIV status disclosure among HIV-positive black men who have sex with men.* AIDS Care 25(4):466-71. 2013.

Stigma and depression

- Stigma index
- Internalised stigma
- Self-stigma (Nadine Ferris-France)
- Kalichman (cited by Cairns): "Stigma is resistant to information: it is an overall mindset that may only change slowly – even in response to the shock of finding yourself one of the people you'd previously stigmatised."

1. Gus Cairns: The Diminshed Self – HIV nad Self-Stigma, http://www.aidsmap.com/The-diminished-self-HIV-and-self-stigma/page/2657859/

The lived experience of HIV

- **Embodiment**
  - "This is not my body anymore." "I am changing, my body is changing." "I was so shocked, I didn't know if I was a boy or a girl."
- **Spatiality**
  - "Where do I fit in?" "The world has become a very different place when I was diagnosed."
- **Temporality**
  - "Time has stopped." "I have been living with HIV for 5 years but it seems like forever."
- **Intersubjectivity**
  - "I have lost many friends because of HIV." "How do I find a date now?" [1]

1. Bereczky, 2013

Interventions

- Medicine (antidepressants)
- Psychotherapy
- "Alternative methods"
  - Holistic methods
  - Exercise
  - Nutrition
- Self-awareness

From Gus Cairns, 2013

Treatment for depression

- Review of 90 studies of interventions for depression in people with HIV:
  - "Psychological interventions were particularly effective and in particular interventions that incorporated a cognitive-behavioural component.
  - Psychotropic and HIV-specific health psychology interventions were generally effective.
  - Evidence is not clear-cut regarding the effectiveness of physical therapies.
  - Psychosocial interventions were generally ineffective.
  - Interventions that investigated the effects of treatments for HIV and HIV-associated conditions on depression generally found that these treatments did not increase but often decreased depression.

- Interventions are both effective and available…**Depression needs to be routinely logged** in those with HIV infection during the course of their disease."

1. Sherr L et al. HIV and depression--a systematic review of interventions. Psychol Health Med. 16(5):493-527. 2011.

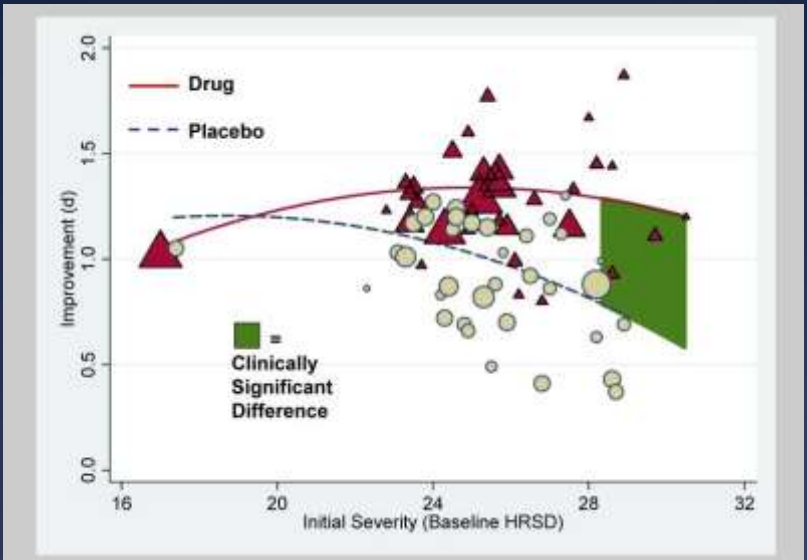
From Gus Cairns, 2013

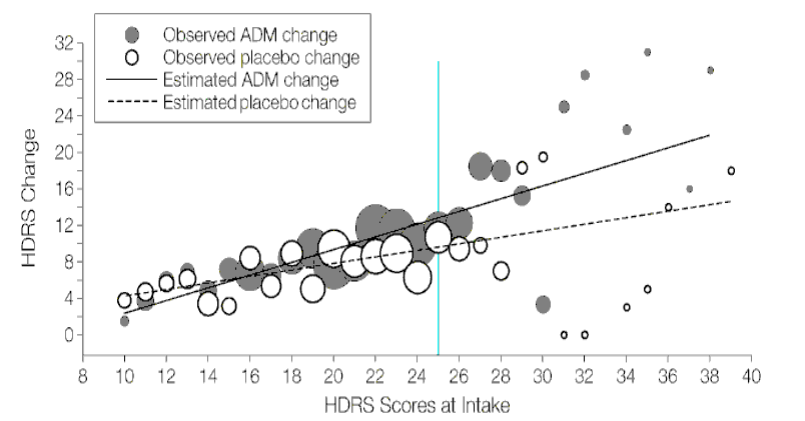
Treatment for depression: antidepressants

* Most modern antidepressants are SSRIs – selective serotonin re-uptake inhibitors. First licensed: Prozac (fluoxetine) in 1987: off-patent 2001.
* Prevent serotonin from being reabsorbed by neurons so it stays around longer
* Take several weeks to reach full effects
* Common side-effects: dreams, headache, weight gain or loss, suicidal ideation, sexual dysfunction (anorgasmia, low libido), bruxism (teeth grinding), akathisia ('speed gurns')
* Withdrawal symptoms: sometimes, rapid recurrence of initial depression unless doses tailed off
* Complex relationship with suicidal action: increased risk of suicides compared to placebo in RCTs, but considerable fall in suicides in population level among patients using SSRIs , especially in women,
* Some studies report suicidal effects heightened in children/adolescents
* Sometimes given for anxiety disorders too but review found no evidence of efficacy in people with HIV

From Gus Cairns, 2013

Efficacy of antidepressants





- Two FDA reviews in 2008 and 2010 concluded that overall effect size of SSRIs was **0.31**[1] or **0.36**[2]
- i.e. 31%-36% more people experienced an improvement than experienced an improvement on placebo
- Effect size only reached NICE efficacy threshold of 0.5 in patients with high baseline depression scores
- Some criticism of calculation of effect sizes, and of HRSD as instrument, but *no evidence* SSRIs work with other than severe depression
- Now recommended by NICE for severe depression or moderate depression that has not responded to psychotherapy

1 Kirsch I et al. Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration. PLoS Medicine 5(2): 2008

2. Fournier JC et al. Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-analysis. *JAMA* 303(1):47-53. 2010.

Treatment for depression: psychotherapy

From Gus Cairns, 2013

- Here defined as one-to-one 'talking therapy' of any modality, delivered by an accredited/qualified counsellor/psychotherapist
- Issue: definition of overall activity
- Issue: definition of specific techniques ('black box' problem)
- Issue: definition of control group (usually: GP/clinic waiting list – but that may involve some care)
- Issue: definition of improvement – 'loyalty to therapist' issue
- Standardisation of treatment: how long for? How many sessions? How often?
- Given all these constraints, how efficacious is psychotherapy?

From Gus Cairns, 2013

Efficacy of psychotherapy

- Considered as one activity, in studies with a well-defined control group, the effect size of 'n' sessions of any counselling and psychotherapy is **0.79**[1], **p**eople who receive counselling and therapy have a 79% greater improvement in psychological distress scores (NB not just depression) than people in control groups.
- Cf. overall effect size of medical procedures taken as a whole = c. **0.5**
- About 60% of patients/clients experience a clinically significant improvement from baseline in both controlled and population-level studies
- NB Between 5% and 10% of people get worse in psychotherapy, possibly as a 'side effect'
- *However* only 18% more people, compared with people given normal GP care, achieve a complete resolution, i.e. from high psychological distress to none.
- This is because of reversion to the mean, i.e. people refer themselves at times of peak distress and tend to get better naturally

Lambert MJ and Ogles BM. The efficacy and effectiveness of psychotherapy. In Begin and Garfield's Handbook of Psychotherapy and Behavior change, 5th Edition. Chicago: John Wiley and Sons. 2004.

From Gus Cairns, 2013

What works in psychotherapy?

- Countless schools and theoretical models of psychotherapy
- Three or four very broad schools: cognitive-behavioural, psychodynamic, humanistic &, emerging now, **holistic/somatic**
- 'Caucus race' issue: "all have won and all must have prizes": when individual orientations studied, they *all* tend to work
- CBT has most positive results: but probably only because it has been studied the most in the UK
- CBT definitely has an edge in anxiety disorders but somatic psychodynamic therapy may work better for severe trauma/PTSD
- In depression, at least eight different types have been shown to work in RCTs

From Gus Cairns, 2013

What works in psychotherapy 2

- 'Lambert's pie': what is the relative effect of different factors to the efficacy of psychotherapy?
- 1-3% of variance in outcomes due to therapists' particular orientation/ techniques
- About 5-10% due to therapist factors such as similarity (or difference!) to client, age, gender, supervision, experience etc
- About 30% due to characteristics of the therapeutic relationship such as consensus/collaboration on goals, trust, empathy
- That leaves about 60-70% due to characteristics of client: whether they want to change, innate skills they can capitalise on, capacity to engage, realistic expectations
- Therapy that helps people build existing strengths usually works better than therapy that aims to change weaknesses
- "The lightbulb has to want to change"

Asay TP and Lambert MJ. 'The empirical case for the common factors in therapy: quantitative finds. In Hubble, Duncan and Miller eds), *The Heart and Soul of Change: What Works in Therapy.* Washington DC, American Psychological Association. 1999.

Body and mind

- **Holistic/somatic therapy methods**
- "Body-oriented psychotherapy interventions" is an umbrella term for all psychotherapies "that explicitly use body techniques to strengthen the developing dialogue between patient and psycho-therapist about what is being experienced and perceived ... In most schools of body psychotherapy, the body is considered a means of communication and exploration" (Heller, 2012, p. 1) "Body-oriented or somatic psychotherapy is a very diverse field (Röhricht, 2009; Young, 2011). The common theme is the connection between body and mind and the underlying premise that our relationship to ourselves, others and the world is not only rooted in our mind and thoughts but also in our bodies."

Bloch-Atefi, A. and Smith, J.(2014), The effectiveness of body-oriented psychotherapy: A review of the literature. Melbourne: PACFA.

Is that a… thing?

- Although these empirical studies indicate that body-orientated therapy interventions are effective for treating somatization, anxiety symptoms, PTSD and schizophrenia, there is a need for further rigorous research to increase the generalisability of results on body-oriented interventions with larger sample sizes and controlled conditions.
- A considerable body of research has validated acupoint simulation as an efficacious or probably efficacious treatment for several conditions according to APA standards.
- While there is evidence that touch therapies may be effective in decreasing heart rate, respiratory rate, blood pressure, pain, and total mood disturbances, there is a need for more high quality studies in this area. - Very vague evidence.

Bloch-Atefi, A. and Smith, J.(2014), The effectiveness of body-oriented psychotherapy: A review of the literature. Melbourne: PACFA.

Exercise

- …exercise might have a moderate-sized effect on depression, but because of the risks of bias in many of the trials, the effect of exercise may only be small. We cannot be certain what type and intensity of exercise may be effective, and the optimum duration and frequency of a programme of exercise. There are few data on whether any benefits persist after exercise has stopped.

- The evidence also suggests that exercise may be as effective as psychological or pharmacological treatments, but the number of trials reporting these comparisons and the number of participants randomised, were both small.[1]

- It seems particularly useful, in order to support the prevention and the fight against depression through sport, that the practice of moderate physical activity should be as diversified as possible. The ideal seems to be to exercise an endurance sport, alternating with a team sport or a martial sport. [2]

1. Cooney GM, Dwan K, Greig CA, Lawlor DA, Rimer J, Greig CA et al. Exercise for depression. Cochrane Database Sys Rev 2013; (9): CD004366.
2. Marilisa Amorosi: CORRELATION BETWEEN SPORT AND DEPRESSION Psychiatria Danubina, 2014; Vol. 26, Suppl. 1, pp 208-210

Groups

* Huge but not very systematic body of practical, anecdotal evidence
* […] the *combination* of these three features—homogeneity, outpatient composition, and behavioral orientation—is as- sociated with overall greater client improve- ment in treatment groups.[1]
* The results of this study suggest that group psychotherapy is efficacious in reducing depressive symptoms among, HIV-infected individuals. Of note, women were nearly absent from all studies. Future studies should be directed at addressing this disparity.

1. Burlingame, G. M. F. The differential effectiveness of group psychotherapy: A meta-analytic perspective. Group Dynamics, 2003:7(1), pp.3-12.
2. Seth Himelhoch, Deborah R. Medoff, and Gloria Oyeniyi. AIDS Patient Care and STDs. October 2007, 21(10): 732-739. doi:10.1089/apc.2007.0012.

A holistic approach

- Tie the person back into society
- Offer interfaces to reintegrate
- Reduce stigma through acceptance
- Allow binding
- Facilitate therapeutic processes
- Facilitate unity of body and mind – The person lives in a body, the two are inseparable

Don't leave the person alone.
As simple as that!

EATG European AIDS Treatment Group

Resource poor settings

* What do you think?
* How can all (or any) of this be implemented in resource poor settings?
* What is (can be) the role of the community of PLHIV in interventions?

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