



Medical Management of People with HIV Psychiatric Conditions

This fact sheet is to assist services working with ADAHPT to understand case management and the ADAHPT model of Co-case Management.

There are two groups of people who develop psychiatric illness and HIV infection.

- Those with pre-existing mental illnesses who become secondarily infected with HIV.
- Those who are HIV positive and present with or develop psychiatric disorders (either directly or indirectly).

Mental disorders in patients who are HIV positive are always diagnosed through a process of exclusion. For example, many conditions such as opportunistic infections, metabolic changes and substance abuse produce symptoms similar to AIDS dementia complex (ADC) and other psychiatric conditions and these conditions need to be ruled out.

There are four major groups of psychiatric conditions:

- Organic Disorders (i.e., delirium and ADC)
- Mood Disorders (depression and mania)
- Anxiety Disorders
- Psychotic Disorders

Organic Disorders

People with delirium and/or ADC can present with psychiatric symptoms. Although confusion and/or disorientation are both signs of delirium and dementia, they are different. **Delirium is an acute confusional state** that is potentially reversible.

Delirium usually occurs over a period of days to months. Dementia is much slower and thus develops over a period of time. Common causes of delirium include medication side effects, metabolic and cardiopulmonary problems and acute systemic illness (including some opportunistic infections).

Assessment of organic disorders is by history gathering, assessment of opportunistic infections, MRI scans, and perhaps lumbar puncture.

Treatment:

Treatment includes specific sedation measures for agitated delirium, a stable environment, maximum support, minimal sleep disruption and the discontinuation of any suspected toxic medications. AIDS Dementia Complex may present with some apparent psychiatric symptoms such as agitation, hallucinations or paranoid thoughts.

Mood Disorders

Mania:

As with major depression, mania can occur early or late in the course of HIV infection. Clients with mania usually fit into two categories:

- Those clients with pre-existing bipolar disorder (manic depressive disorder)
- Those clients with mania as a consequence of HIV involvement.

In addition, mania in advanced disease can be associated with cognitive changes or AIDS Dementia Complex.

Common symptoms of HIV related mania include the following:

- Decreased sleep, increased activity (although often replaced by psychomotor slowing)
- Elevated mood (sustained for days or weeks and usually irritable)
- Overly talkative (and cannot be interrupted)
- Inventing "grand schemes"
- Attention to unimportant or irrelevant activities
- Sometimes a grandiose belief that they have been "cured"



Medical Management of People with HIV Psychiatric Conditions

This fact sheet is to assist services working with ADAHPT to understand case management and the ADAHPT model of Co-case Management.

- “Racing” thoughts
- Cognitive slowing despite elevated mood

HIV related mania can differ clinically from the true mania of bipolar disorder in that irritability, rather than true grandiose euphoria, is the core symptom.

Clients with late onset mania (where first manic episode comes in the late stages of HIV infection) are less likely to have a personal or family history of mania. They are also more likely to have cognitive impairment. Clients with a pre-existing bipolar disorder can develop mania at any time in the course of their HIV infection. Prescribed (including Gancyclovir and Dapsone) and non prescribed drugs and steroids can cloud and exacerbate the condition.

Treatment:

In early stage HIV infection (seroconversion), the treatment of mania is the standard treatment (ie: benzodiazepines and low doses of neuroleptic drugs). In the “middle” stages of HIV progression the treatment is the same for manic clients without HIV infection (mood stabilisers, Neuroleptic drugs, and benzodiazepines).

In the late stages of HIV infection, treatment has to be closely monitored owing to the client's physiological vulnerability (usually a single neuroleptic is most effective)

At this stage of the infection, clients are extremely sensitive to the side effects of neuroleptic medication. Doses much lower than is the custom are sufficient. Mania responds well to treatment in HIV clients including those clients with advanced AIDS, however, the treatment period may well be longer than it is for people without HIV.

Depression:

Studies show that depressive disorders are very common but underdiagnosed and undertreated in HIV infection. Depressive symptoms may increase over the course of HIV illness, especially after the onset of AIDS. Major depression is never a “normal” response to a particular situation. It should be approached with the same rigour as any other medical illness.

Presenting symptoms:

- Can be of a physical nature ie; low energy, loss of appetite, insomnia, early morning waking and constipation.
- Cognitive changes that may include loss of memory and poor concentration
- Affective changes that may include low mood, hopelessness, worthlessness, nihilism, suicidal ideation, guilt and anhedonia.

Treatment:

Medical treatment of depressive disorders is dependent on the severity of the depression. The more severe the depression, the more likely antidepressants need to be administered. Clinically depressed clients with HIV have been shown to benefit from a therapeutic relationship and medications to alleviate depressive symptoms.

Generally, a Selective Serotonin Reuptake Inhibitor (SSRI) or tricyclic antidepressant is the treatment of first choice. To commence with, antidepressants are prescribed at a low dose and are gradually increased while the client is carefully monitored for side effects. For mild to moderate depression, or as an adjunct to pharmacological therapy, therapeutic interventions such as cognitive behavioural therapy have proven effective.



Medical Management of People with HIV Psychiatric Conditions

This fact sheet is to assist services working with ADAHPT to understand case management and the ADAHPT model of Co-case Management.

Anxiety Disorders

- Fairly common, up to 20% to 40% prevalence
 - Often coexists with depression and substance abuse
 - May be related to HIV related stressors including HAART
 - Diagnosis of anxiety is important as it can affect the capacity of the client to take in information, plan ahead, or adhere to a treatment plan
- Anxiety responds well to relaxation, cognitive behavioural treatment and supportive counselling
- Treatment:**
Treatment infrequently requires the use of medication – sometimes small doses of sedating antidepressants (tricyclics) or short acting benzodiazepines may be prescribed (there is some risk here of abuse and dependence).

Psychotic Disorders

- May be caused by an infection
- Prevalence is unknown but probably uncommon
- Presenting symptoms include delusions (paranoid, grandiose and somatic) and auditory hallucinations

Treatment :

Antipsychotics such as Olanzapine, Risperidone and Quetiapine are used in the treatment of HIV and psychotic disorders. Small doses initially should assist in reducing the high risk of side effects, especially Parkinsonian type symptoms.

Benzodiazepines are used for sedation and should be used in combination with antipsychotics.

Acknowledgement

ADAHPT would like to acknowledge the assistance of Dr Laurie Power, Consultant Psychiatrist, Department of Psychiatric Services, St Vincent's Hospital, Sydney in helping to prepare this fact sheet.