HOW TO MANAGE DEPRESSIVE SYMPTOMS IN HIV

Practical recommendations

CONTENTS

1. How common are depressive disorders?
2. What interventions are effective?
3. Practical management
4. Lessening the burden of chronic illness: the patients view

HOW COMMON IS DEPRESSION IN PEOPLE WITH HIV INFECTION?

- Published reports range from 0% to 80%
- Variation depends on many factors, such as instruments, population & stage of illness
- A significant minority experience significant depression

HOW COMMON IS DEPRESSION?

Psychology, Health & Medicine
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HIV and Depression – a systematic review of interventions

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HIV-positive individuals are more likely to be diagnosed with major depressive disorder than HIV-negative individuals. Depression can precede diagnosis and be associated with risk factors for infection. The experience of illness can also exacerbate depressive episodes and depression can be a side effect to treatment. A systematic understanding of which interventions have been tested in and are effective with HIV-seropositive individuals is needed. This review aims to provide a comprehensive understanding of evaluated interventions related to HIV and depression and provide some insight on questions of prevalence and measurement. Standard systematic research methods were used to gather quality published papers on HIV and depression. From the search, 1015 articles were generated and hand searched resulting in 90 studies meeting adequacy inclusion criteria for analysis. Of these, 67 (74.4%) were implemented in North America (the US and Canada) and 14 (15.5%) in Europe, with little representation from Africa, Asia and South America. Sixty-five (65.5%) studies recruited only men or mostly men, of which 31 (35%) recruited gay or bisexual men. Prevalence rates of

HOW COMMON IS DEPRESSION?

- Examples of surveys

Table 2. Prevalence of depression.

Author and date of study	Sample size, *n*	Prevalence of depression	Measure and cut-off point
Avants et al. (1998)	6 in intervention and 8 in control	4 (66.7%) patients in intervention and 4 (50%) patients in control	BDI ≥ 17; range of moderate clinical depression.
Balfour et al. (2006)	63	42.8%	CES-D ≥ 16; clinical levels of depressive symptoms
Gonzáles et al. (1993)	5 HIV positive	4 (80%)	DSM-III-R SCID major depression
Grinspoon et al. (2000)	59	21 (35.6%)	BDI > 18
Heckman and Carlson (2007)	299	71%	BDI ≥ 16; "moderate" or "severe" levels of depressive symptoms
Husbands et al. (2007)	79	40.5% very depressed and 59.5% less depressed	CES-D scores were divided at the mean (≥28) into very and less depressed.
Mulder et al. (1994)	38?	88% in the low to mild range of the BDI. 12% within symptomatic ranges of depression.	BDI ≥ 16; symptomatic range of depression
Neidig et al. (2003)	60	35% according to CES-D, 20% according to BDI	CES-D ≥ 16; high level of depressive symptoms BDI ≥ 15, depression

THE DANGERS OF DIAGNOSIS

ANALYSIS

- Feature: DSM-5: a fatal diagnosis? (*BMJ* 2013;346:f3256)
- Head to Head: Are antidepressants overprescribed? No (*BMJ* 2013;346:f190)
- Head to Head: Are antidepressants overprescribed? Yes (*BMJ* 2013;346:f191)
- Research: Suicides associated with the 2008-10 economic recession in England (*BMJ* 2012;345:e5142)
- Research: Explaining the rise in antidepressant prescribing (*BMJ* 2009;339:b3999)

Medicalising and medicating unhappiness

This article is part of a series on overdiagnosis looking at the risks and harms to patients of expanding definitions of disease and increasing use of new diagnostic technologies

Many patients report sadness or distress during consultations with primary care doctors. Such emotions may be related to grief and other life stresses, including the stress of physical illness. Sometimes sadness appears out of the blue, without obvious relation to external causes. Over recent decades there has been an increasing tendency, especially in primary care, to diagnose depression (commonly major depressive disorder) in patients presenting with sadness or distress and offer them antidepressant medication.[1-3]

In this paper we offer a critical review of the diagnosis of major depressive disorder, show how and why this broad diagnostic label has resulted in overdiagnosis and overtreatment, and suggest how the approach to diagnosis and management of depression should change to reduce stigmatising the sad and provide better help for those who most need vigilant care and medical treatment.

Evolving views of what constitutes depression

Descriptions of depression can be found in the Bible and Shakespeare, but no formal definition existed until the third version of the American Psychiatric Association's classification systems for mental disorders was published in 1980 (DSM-III). The manual set out clear operational criteria to aid clinicians in diagnosing mental disorders (see box 1) and introduced the term major depressive disorder.

Since then major depressive disorder has received more research attention than any other diagnosis in psychiatry but has created many problems. The criteria, which have not changed since 1980, capture too heterogeneous a population for research studies and are so loose that, in everyday clinical practice, ordinary sadness can be easily confused wit clinical depression.[5]

Unhelpful classifications of mental disorders

Under DSM-III the term major depressiv disorder combined what had formerly bee described as "melancholia"—characterised b severe, disabling, and sometimes life threater ing depression, often coming out of the blu and characterised by marked diurnal variatior suicidal thoughts, and somatic symptoms—wit "reactive depression." Reactive depression cor trasted in almost every way with melancholia with onset closely linked to a definable lif event and with symptoms that were milder an typically including sadness, loss of interest and feelings of guilt and unworthiness. Somati changes, including difficulty sleeping and los of appetite, were less profound and enduring i reactive depression than in melancholia. Thos

DIAGNOSES IN OUR SERVICE

6

PEOPLE WITH HIV REFERRED TO MENTAL HEALTH
Principal Psychiatric Diagnosis (%)

Diagnosis	1990 (n=123)	1995 (n=306)	1999 (n=360)	2005 (n=406)
Depression	21(17)	59(19)	98(27)	162(40)
Anxiety Disorder	6(3)	35(11)	48(13)	50(12)
Adjustment Disorder	33(27)	25(8)	44(12)	53(13)
Sexual Dysfunction	1(1)	5(2)	46(13)	56(14)
Substance misuse	21(17)	22(7)	32(9)	20(5)
Organic (acute)	5(4)	5(2)	14(4)	4(1)
Organic (chronic)	11(9)	18(6)	6(2)	9(2)
Mania	4(3)	7(2)	0(0)	6(1)
Schizophrenia	1(1)	2(1)	4(1)	1(0)
Others	-	-	-	31(8)

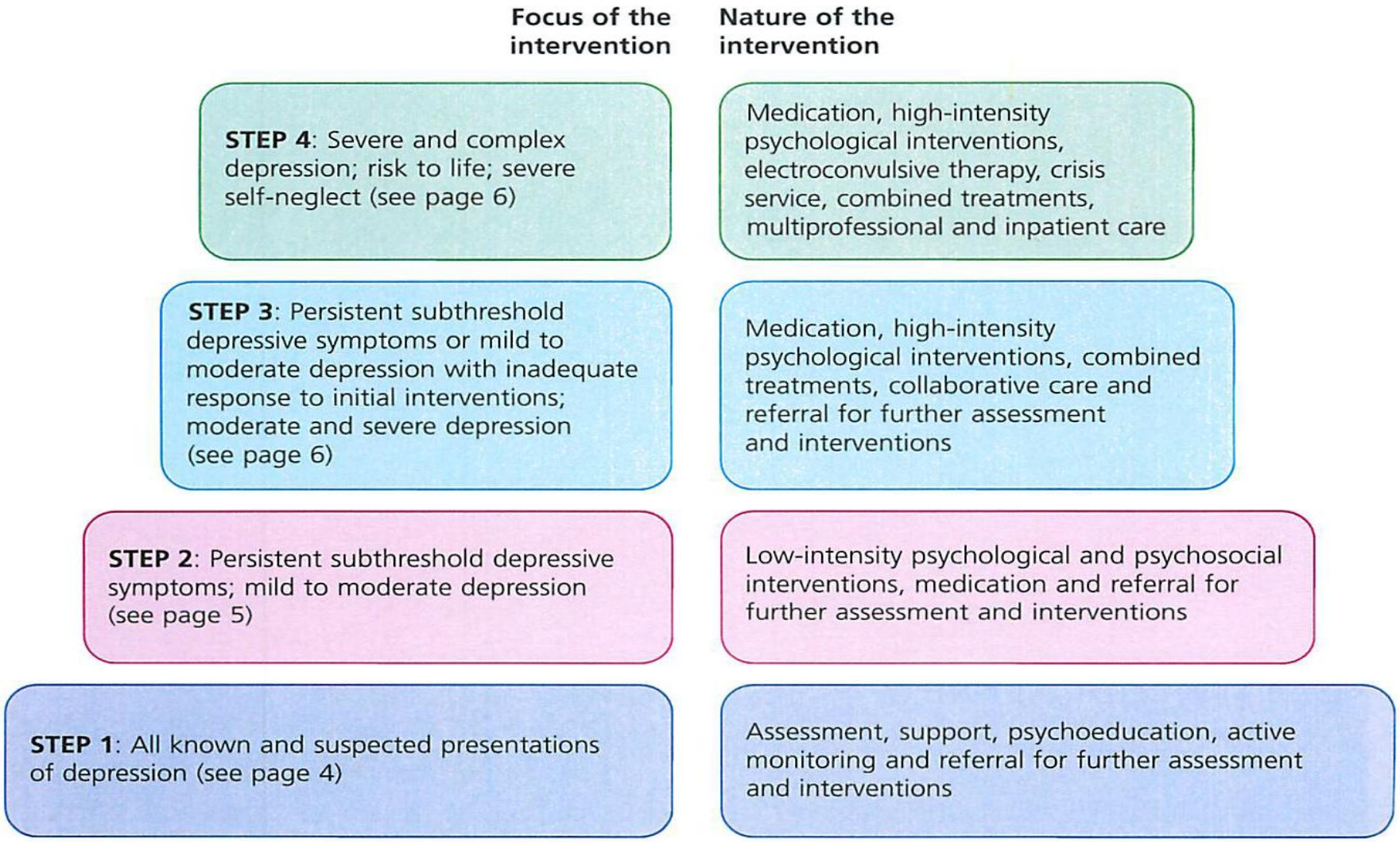
WHAT INTERVENTIONS WORK?

- Psychological therapies
  - CBT and related therapies
  - Long term therapies
  - Group therapies
- Physical method
  - Medication
  - ECT and other

NICE GUIDELINES FOR THE TREATMENT OF DEPRESSION IN PEOPLE WITH PHYSICAL DISORDERS

The stepped-care model

This model provides a framework for organising the provision of services, and helps patients, carers and practitioners to identify and access the most effective interventions. The least intrusive, most effective intervention is provided first. If a person does not benefit from that intervention, or declines an intervention, they should be offered an appropriate intervention from the next step.



Step 1

Identifying depression

Ask a patient who may have depression:

- During the last month, have you often been bothered by:
  - feeling down, depressed or hopeless?
  - having little interest or pleasure in doing things? ***KPI***

If the patient answers 'yes' to either question

A practitioner who is not competent in mental health assessment should:

- refer the patient to an appropriate professional – if this is not the patient's GP, inform the GP.

A practitioner who is competent in mental health assessment should:

- Ask three further questions to improve the accuracy of the assessment:
  - During the last month, have you often been bothered by:
    - feelings of worthlessness?
    - poor concentration?
    - thoughts of death?
- Conduct a comprehensive assessment that does not rely simply on a symptom count, taking into account:
  - the degree of associated functional impairment and/or disability
  - the duration of the episode. ***KPI***
- Consider the role of the physical health problem and any prescribed medication in the depression.
- Check that optimal treatment for the physical health problem is being provided, seeking specialist advice if necessary.
- Explore how the following may have affected the development, course and severity of depression:
  - any history of depression (including previous treatments), comorbid mental health or physical disorders, and mood elevation
  - interpersonal relationships, living conditions and social isolation.
- For patients with language or communication difficulties, consider using the Distress Thermometer and/or asking a family member or carer about symptoms; if significant distress is identified, investigate further.

Severities of depression[1]

Subthreshold depressive symptoms: Fewer than 5 symptoms.

Mild depression: Few, if any, symptoms in excess of the 5 required to make the diagnosis, and symptoms result in only minor functional impairment.

Moderate depression: Symptoms or functional impairment are between 'mild' and 'severe'.

Severe depression: Most symptoms, and the symptoms markedly interfere with functioning. Can occur with or without psychotic symptoms.

[1] Taken from DSM-IV (see www.nice.org.uk/CG91niceguideline for further details).

Step 2

Sleep hygiene

- Offer advice on sleep hygiene, including:
  - establishing regular sleep and wake times
  - avoiding excess eating, smoking or drinking alcohol before sleep
  - creating a proper environment for sleep
  - taking regular physical exercise if possible.

Active monitoring

- For patients who may recover with no formal intervention, have mild depression and do not want an intervention, or have subthreshold depressive symptoms and request an intervention:
  - discuss the presenting problem(s) and any concerns
  - provide information about depression
  - arrange a further assessment, normally within 2 weeks
  - make contact if the patient does not attend appointments.

Low-intensity psychosocial interventions

- Consider offering one or more of the following to patients with persistent subthreshold depressive symptoms or mild to moderate depression, and to patients with subthreshold depressive symptoms that complicate the care of their chronic physical health problem:
  - a physical activity programme (modified for the particular physical health problem)
  - a peer support programme in a group of patients with a shared physical health problem
  - individual guided self-help based on cognitive behavioural therapy (CBT) principles
  - computerised CBT (CCBT)[2]. ***KPI***
- For details of delivery of interventions, see section 1.4.2 of the NICE guideline (www.nice.org.uk/CG91niceguideline).

Drug treatment

- Do not use antidepressants routinely to treat subthreshold depressive symptoms or mild depression, but consider them for patients with:
  - a past history of moderate or severe depression **or**
  - mild depression that complicates the care of the physical health problem **or**
  - initial presentation of subthreshold depressive symptoms present for at least 2 years **or**
  - subthreshold depressive symptoms or mild depression persisting after other interventions. ***KPI***
- Do not prescribe or advise use of St John's wort. Explain about the different potencies of the preparations available and potential serious interactions with other drugs.

Step 3

Treatment options

Target population	Treatment options
• Patients with persistent subthreshold depressive symptoms or mild to moderate depression who have not benefited from a low-intensity psychosocial intervention	• An antidepressant (see pages 8–9) **or** • A high-intensity psychological intervention (group CBT, individual CBT or behavioural couples therapy)[3].
• Patients who present initially with moderate depression	• A high-intensity psychological intervention (group CBT, individual CBT or behavioural couples therapy)[3]. ***KPI***
• Patients who present initially with severe depression	• Consider offering both individual CBT[3] and an antidepressant (see pages 8–9).

[3] For details of delivery, see section 1.5.3 of the NICE guideline (www.nice.org.uk/CG91niceguideline).

- When choosing an intervention, take into account:
  - duration of episode and trajectory of symptoms
  - previous course of depression and response to treatment
  - likelihood of adherence to treatment and potential adverse effects
  - course and treatment of the chronic physical health problem
  - patient's treatment preference.

Patients with moderate or severe depression who have not responded to initial interventions

- Consider collaborative care for patients whose depression has not responded to initial high-intensity psychological interventions, pharmacological treatment or a combination of psychological and pharmacological interventions. ***KPI***
- Collaborative care should include case management supervised by a senior mental health professional, close collaboration between physical health services and specialist mental health services, interventions as described above, and long-term coordination of care and follow-up.
- For details of treatment options, see www.nice.org.uk/CG90quickrefguide

Step 4

- Interventions may include medication, high-intensity psychological interventions, electroconvulsive therapy and other physical treatments, combined treatments, crisis resolution and home treatment teams, and inpatient care (for further details, see www.nice.org.uk/CG90niceguideline).
- If treatment is provided by specialist mental health services for patients with complex and severe depression, there should be close collaboration with services treating the physical health problem.

ANTIDEPRESSANTS and ARV

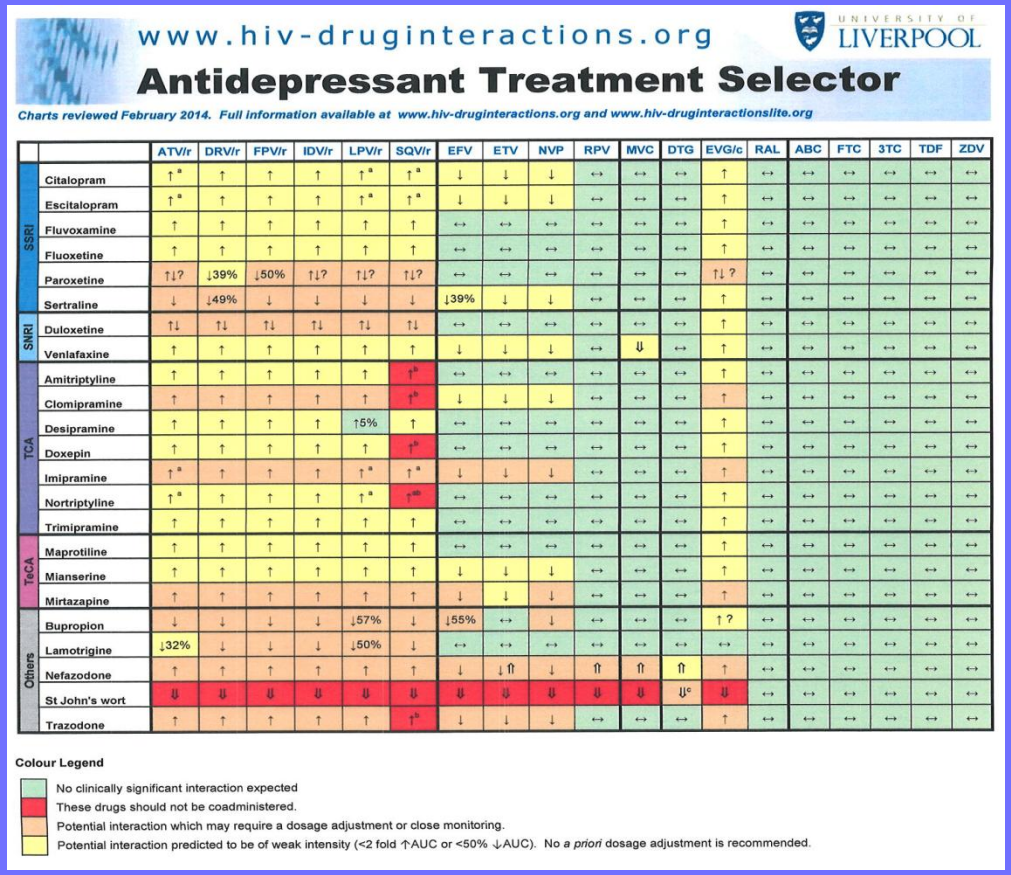
There are potential interactions, but in most cases they lead to increased levels of antidepressant (SSRIs & venlafaxine), rather than lowering of ARV levels

PI are the most likely to increase antidepressant levels

Mirtazapine has no known interactions

St John's wort can reduce levels of PI & nevirapine

Searching for possible interactions http://www.hiv-druginteractions.org



www.hiv-druginteractions.org

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Antidepressant Treatment Selector

Charts reviewed February 2014. Full information available at www.hiv-druginteractions.org and www.hiv-druginteractionslite.org

		ATV/r	DRV/r	FPV/r	IDV/r	LPV/r	SQV/r	EFV	ETV	NVP	RPV	MVC	DTG	EVG/c	RAL	ABC	FTC	3TC	TDF	ZDV
SSRI	Citalopram	↑[a]	↑	↑	↑	↑[a]	↑[a]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Escitalopram	↑[a]	↑	↑	↑	↑[a]	↑[a]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Fluvoxamine	↑	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Fluoxetine	↑	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Paroxetine	↑↓?	↓39%	↓50%	↑↓?	↑↓?	↑↓?	↔	↔	↔	↔	↔	↔	↑↓ ?	↔	↔	↔	↔	↔	↔
	Sertraline	↓	↓49%	↓	↓	↓	↓	↓39%	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
SNRI	Duloxetine	↑↓	↑↓	↑↓	↑↓	↑↓	↑↓	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Venlafaxine	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	⇓	↔	↑	↔	↔	↔	↔	↔	↔
TCA	Amitriptyline	↑	↑	↑	↑	↑	↑[b]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Clomipramine	↑	↑	↑	↑	↑	↑[b]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Desipramine	↑	↑	↑	↑	↑5%	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Doxepin	↑	↑	↑	↑	↑	↑[b]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Imipramine	↑[a]	↑	↑	↑	↑[a]	↑[a]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Nortriptyline	↑[a]	↑	↑	↑	↑[a]	↑[ab]	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Trimipramine	↑	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
TeCA	Maprotiline	↑	↑	↑	↑	↑	↑	↔	↔	↔	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Mianserine	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
	Mirtazapine	↑	↑	↑	↑	↑	↑	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔
Others	Bupropion	↓	↓	↓	↓	↓57%	↓	↓55%	↔	↓	↔	↔	↔	↑ ?	↔	↔	↔	↔	↔	↔
	Lamotrigine	↓32%	↓	↓	↓	↓50%	↓	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Nefazodone	↑	↑	↑	↑	↑	↑	↓	↓⇑	↓	⇑	⇑	⇑	↑	↔	↔	↔	↔	↔	↔
	St John's wort	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓[c]	⇓	↔	↔	↔	↔	↔	↔
	Trazodone	↑	↑	↑	↑	↑	↑[b]	↓	↓	↓	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔

Colour Legend

- No clinically significant interaction expected
- These drugs should not be coadministered.
- Potential interaction which may require a dosage adjustment or close monitoring.
- Potential interaction predicted to be of weak intensity (<2 fold ↑AUC or <50% ↓AUC). No *a priori* dosage adjustment is recommended.

Lessening the burden

Patient Preference and Adherence

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ORIGINAL RESEARCH

Factors that lessen the burden of treatment in complex patients with chronic conditions: a qualitative study

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Purpose: Patients with multiple chronic conditions (multimorbidity) often require ongoing treatment and complex self-care. This workload and its impact on patient functioning and well-being are, together, known as treatment burden. This study reports on factors that patients with multimorbidity draw on to lessen perceptions of treatment burden.

Patients and methods: Interviews (n=50) and focus groups (n=4 groups, five to eight participants per group) were conducted with patients receiving care in a large academic medical center or an urban safety-net hospital. Interview data were analyzed using qualitative framework analysis methods, and themes and subthemes were used to identify factors that mitigate burden. Focus groups were held to confirm these findings and clarify any new issues. This study was part of a larger program to develop a patient-reported measure of treatment burden.

Results: Five major themes emerged from the interview data. These included: 1) problem-focused strategies, like routinizing self-care, enlisting support of others, planning for the future, and using technology; 2) emotion-focused coping strategies, like maintaining a positive attitude, focusing on other life priorities, and spirituality/faith; 3) questioning the notion of treatment burden as a function of adapting to self-care and comparing oneself to others; 4) social support (informational, tangible, and emotional assistance); and 5) positive aspects of health care, like coordination of care and beneficial relationships with providers. Additional subthemes arising from focus groups included preserving autonomy/independence and being proactive with providers.

Conclusion: Patients attempt to lessen the experience of treatment burden using a variety of personal, social, and health care resources. Assessing these factors in tandem with patient perceptions of treatment burden can provide a more complete picture of how patients fit complex self-care into their daily lives.

Resources for easing treatment burden diagram

Table 2 Resources for easing treatment burden by data collection method

Themes and subthemes	Interviews	Focus groups
Theme 1		
Problem-focused strategies	×	×
Routinizing self-care	×	×
Enlisting support from others	×	×
Planning for the future	×	×
Using technology	×	×
Preserving autonomy/independence		×
Being proactive with providers		×
Theme 2		
Emotion-focused coping	×	×
Maintaining positive attitude	×	×
Focusing on other life priorities	×	×
Spirituality and faith	×	×
Theme 3		
Questioning the notion of burden	×	×
Adaptation/normalizing self-care	×	×
Social comparison with others	×	×
Theme 4		
Receiving support from others	×	×
Informational	×	×
Instrumental	×	×
Emotional/companionship	×	×
Theme 5		
Positive aspects of health care	×	×
Systemic aspects	×	×
Individual-provider aspects	×	×

1.PROBLEM FOCUSED STRATEGIES

- Routinizing self-care
- Enlisting support from others
- Planning for the future
- Using technology
- Preserving autonomy
- Being proactive with providers

2.EMOTION FOCUSED COPING

- Maintaining positive attitude
- Focusing on other life priorities
- Spirituality and faith

3. QUESTIONING THE NOTION OF BURDEN

- Adaptation/normalizing self-care
- Social comparison with others

4. RECEIVING SUPPORT FROM OTHERS

- Information
- Instrumental
- Emotional/companionship

5. POSITIVE ASPECTS OF HEALTH CARE

- Systemic aspects
- Person-provider aspects

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