

Psychological Issues with HIV

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Psychological Needs in HIV



- If psychological needs are not identified and addressed, it can lead to complications such as
 - dropping out of medical treatment
 - poor medication adherence – drug resistance
 - risky activity – onwards transmission
 - poor self care – disease progression
- Higher rates of psychological need reported in PLWH... but also many PLWH cope well.



BHIVA Standard 6, Psychological Care



People living with HIV should receive care and support which promotes their mental, emotional and cognitive well-being and is sensitive to the unique aspects of living with HIV.



British HIV Association
Standards of Care
for People Living with HIV
2013





Case Studies



- **Adjustment:** *Belinda*
- **Sex:** *Marcos*
- **Long-term:** *Richard*
- **Late presenter:** *Susan*
- **Family:** *Maria Louisa*



Belinda



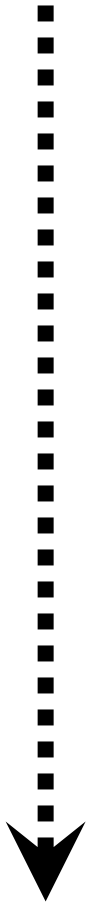
- 24 year old Black British woman, originally from East Midlands
- Last year of university in London, recent relationship breakup
- Received partner notification notice re: chlamydia
- First visit to sexual health clinic for full screening – HIV positive
- In a state of disbelief and shock – not inclined to disclose
- Says she will now have to face life alone, with no partner



Potential psychological issues: *transitions & turning points*



Time in HIV 'journey'



- **Taking the test:** expectations and reality of result
- **Being a "HIV+ patient":** 1st medical appt, 'HIV community'
- **Co-morbid:** *pre-existing* mental and physical health important
- **Telling others:** disclosure in old and new relationships and sex
- **Medication:** starting, changing, adhering, side-effects
- **Major life decisions:** e.g. work, marriage, pregnancy, housing, finances, benefits, immigration, emigration etc.
- **Long-term/'late':** pain, fatigue, illness, hospitalisation, HIV related cognitive impairment, palliative care - the unknown

+ Adjustment to HIV



- Notification of HIV-positive status usually results in a transient adjustment reaction, including despair, shock, grief, guilt, etc.
- Diagnosis is a ***threat to survival***
- Psychological adjustment requires a person to ***make sense*** out of their experience.
- However, there are too many pre-disposing factors and situational variables to predict how an HIV diagnosis is going to impact on psychosocial functioning



Marcos



- 28 year old gay man, originally from Italy, diagnosed 2012
- Open relationship with partner Tony (also HIV+). Both regularly engage in the 'chemsex' scene in London for past 3 years – group sex at people's houses using GBL, Ketamine, Crystal Meth & Mephedrone most weekends, organised via Grindr
- On treatment, but CD4 still low and viral load high. Irregular attendance at clinic and poor adherence suspected.
- At assessment Marcos rates his mood as good, but that he was wanting to change his relationship with sex.



Marcos



- **Chems:** detox (addicted to G), harm minimisation (safer injecting practices, goal setting (abstinence or reduction?))
- **Sex:** group sex without chems? One-to-one sex without chems? 'App addiction'. What doing if not at parties?
- **Adherence:** was assumed this was poor due to chaotic lifestyle – however also has swallowing phobia but was too embarrassed to tell anyone: graded hierarchy.
- **Relationship:** does partner also want to change lifestyle? If not what does this mean for relationship? If so, see jointly?



Richard



- 46 year old gay man, originally from Aberystwyth, diagnosed in 1991
- Started medications in 1996
- Nearly died from pancreatitis in 2001
- Has lost at least 7 friends and lovers to HIV
- Has not worked since 2004
- Family still does not know about HIV status or sexuality
- 8 year relationship recently ended
- Used to volunteer at local HIV charity but this stopped last year



Richard



- Factors commonly mediating depression include:
 - previous history of psychiatric problems
 - substance misuse
 - lack of social contact and support
 - guilt or lack of comfort about sexuality
 - shame about how, when and where HIV was contracted

- Lazarus Effect
 - alive but living?
 - diagnosis before 1996

+ Susan



- 51 year old heterosexual woman, white British. Married.
- Diagnosed 'late' after hospitalisation in 2014. Very unwell at time with pneumonia. Started on ARVs, IRIS initially, then stabilised. Now stable and adherent to medication, CD4 and viral load restored.
- Does not know how acquired HIV or when, no clear 'risk' episodes reported from history. Confused, distressed and depressed since.
- Referred for concerns re: possible *memory difficulties*



Susan



- **Report:** memory difficulties noted by husband. Susan now aware of them and very anxious that she has 'dementia'.
- **Co-morbid:** dyslexia, head injury from cycling accident, previous heavy alcohol intake, current cannabis use.
- **Differential diagnosis:** HAND? Substance use? Anxiety? Depression? ARVs? Menopause? Normal ageing? Head injury? Other?
- **Cognitive assessment:** waited until relative stability in mood and medication. 2hr battery of neuropsychological tests administered.
- **Results:** significant short-term memory difficulties for one-presentation events. Intellectual functioning, processing speed, executive functioning relatively normal – results not consistent with current ADLs – anxiety??
- **Rehab:** reassurance, memory strategies, results as baseline.



Maria Louisa



- 40 year old, Portuguese, HIV/HCV
- Son (11) HIV+ & daughter (9) is HIV-
- Husband died of HIV related causes six years ago
- Both had been IVDU a lifetime ago in Lisbon
- Stopped pegylated interferon treatment for hepatitis 4 years ago because she could not tolerate side effects
- She stopped working last year because of chronic low back pain



Maria Louisa



- Attendance at HIV clinic is inconsistent, but she takes son to clinic regularly
- Her son still does not know about his HIV status
- Appears ‘down’ and ‘unresponsive’ to reassurance and support
- Daily activities have dwindled due to pain and mobility problems
- GP offered opiate pain medication but refuses for fears of ‘addiction’



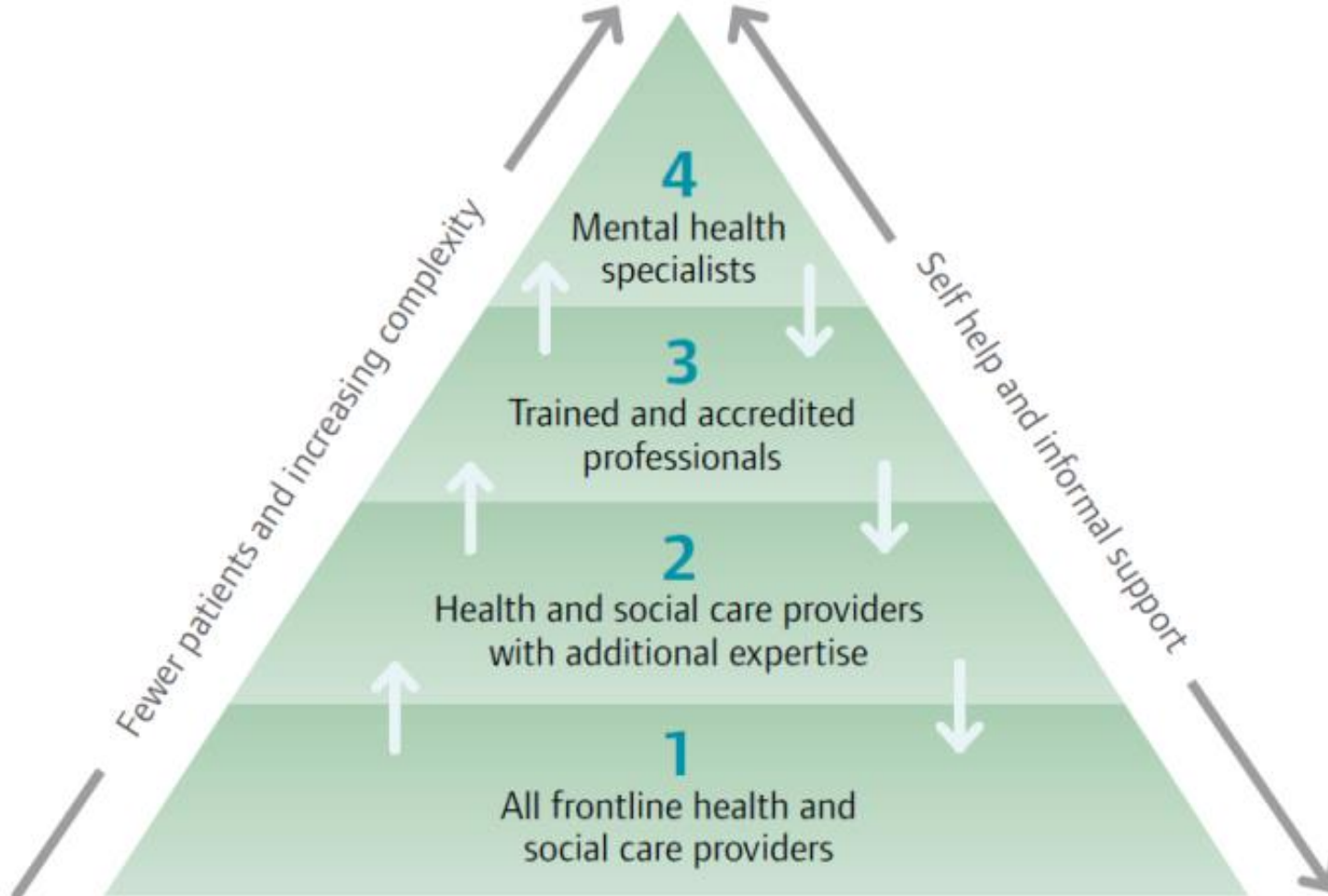
Maria Louisa



Issues:

- Difficult to engage – lost to follow up
- Co-infection with HCV – previous treatment failure
- Secrecy and silence about ‘previous life’
- Facing disclosure issues with son
- Other complicating health problems
- and ???

+ Range of Psychological Interventions





The image shows the cover of a report titled "Standards for psychological support for adults living with HIV". The cover has a green background with a pattern of overlapping circles. At the top, there are logos for the British HIV Association (BHIVA), The British Psychological Society, and the Medical Foundation for AIDS & Sexual Health. Below these logos, the text reads: "British Psychological Society", "British HIV Association", and "Medical Foundation for AIDS & Sexual Health". The main title "Standards for psychological support for adults living with HIV" is written in large white letters. Below the title, it says "NOVEMBER 2011". At the bottom of the cover, there are logos for several professional organizations: baop (British Association for Counselling & Psychotherapy), BASHH (British Association for Sexual Health and HIV), NAT (National Aids Trust), research - culture (National HIV Nurses Association), RCGP (Royal College of General Practitioners), Royal College of Nursing, RCPSYCH (Royal College of Psychiatrists), and SSHA (Society of Sexual Health Advisers).

Eight auditable standards:

1. Promotion of mental health & wellbeing
2. Comprehensive psychological support services
3. Engagement of people living with HIV
4. Support at time of diagnosis
5. Identifying psychological support needs
6. Competence to provide psychological support
7. Co-ordination of psychological support
8. Evidence-based practice

