Sexual Health & HIV Service
Brisbane

- Sexual Health & HIV Service Brisbane
  (nurses, doctors, clinical psychologist 0.5FTE & psychiatrist 0.1FTE)
- Individuals with HIV, or at high risk of HIV
  Predominantly MSM
  Individuals from high risk countries e.g. PNG SE Asia and their partners
  FIFO (mobile workers and travellers)
  Maternal transmission
  Age range 19-50yrs
Common presentations

- Adjustment to (new) HIV diagnoses
- High risk taking behaviour (putting others at risk)
- Drug & alcohol issues
- Adherence
- Shame, stigma, disclosure (isolation)
- Depression, anxiety & stress
Challenges

- HIV population is heterogeneous
- Majority of literature appears to be focused on government target gps: MSM, sex workers, high risk countries, custodial settings
- HIV & HCV landscape is constantly changing – chronic disease management/START/interferon-free HCV Rx
- Very little written on psychological impact of HIV across the lifespan
Diversity of psychosocial difficulties for PLWHIV

- PTSD (diagnosis, AIDS defining illness, severely immune compromised)
- Anxiety disorders, affective disorders (depression, bipolar), psychotic disorders, adjustment disorder
- Cognitive difficulties (HAND)
- Grief over multiple losses – real and anticipated loss
- Tolerating uncertainty (risk for anxiety disorders)
- Adherence
- Stigma, shame, isolation
- Quality of Life – Living the best life you can
- Demoralisation
- Burden of diagnosis, co-morbid difficulties e.g. HCV, complex treatment regimes
- Mistrust of medical/ healthcare professionals
- Family considerations
- Disclosure of status
- Sex and relationships
Psychosocial issues & HIV across the lifespan
Agenda

- Context of ageing, mental health & HIV
  - Prevalence of mental health issues across the lifespan
  - Psychosocial aspects of ageing

- Common psychological issues for PLWHIV across the lifespan:
  - Stress
  - Depression
  - Loss

- What psychology can offer to maintain good mental health across the lifespan

- Q&A
Ageing & mental health

- Between 2015-2050, the proportion of the world’s population over 60 years will nearly double, from 12%-22% (WHO 2015)

- Approximately 15% of adults aged 60+ suffer from a mental disorder (WHO 2015)

- Stigma and discrimination associated with ageing continues
Ageing, HIV & mental health

- No of PLWHIV 65+ grew 10-fold between 1996-2006
  (Kirby Institute)

- By 2020, 50% of all people living with HIV will be 50+ yrs
  (Slavin & Ogier 2011)

- 43% of HIV+ individuals in Australia diagnosed with a mental health condition (depression & anxiety)
  (Grierson, Thorpe & Pitts 2006)

- Poor mental health is not an inevitable part of ageing or HIV
Mental health across the lifespan

- Helpful to consider good mental health alongside personality developmental theories

- Psychosocial personality developmental theories emphasise:
  Stages, criteria or tasks across the lifespan that have to be navigated successfully to ensure optimal personality development = optimal mental health
Psychosocial models of personality

- No of theories of personality development across the lifespan:
  - Erikson’s Theory of Psychosocial Development (1978)
  - Jung’s 4 Stages of Development (60s)
  - Levinson’s Theory (1978)
  - Maslow (1968)

- Childhood, adolescence, adulthood, older adulthood

- Criticisms
  - Simplistic
  - Cultural/society shifts since the 60s
<table>
<thead>
<tr>
<th>Sectors</th>
<th>Major life changes and developmental tasks</th>
<th>Life stages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Being born healthy and normal birthweight</td>
<td>Birth</td>
</tr>
<tr>
<td></td>
<td>Acquiring language skills</td>
<td>Infancy and toddlerhood</td>
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<tr>
<td></td>
<td>Developing impulse control</td>
<td></td>
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<tr>
<td></td>
<td>Entering school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning to read and write</td>
<td>Childhood</td>
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<tr>
<td></td>
<td>Developing social skills</td>
<td></td>
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<tr>
<td></td>
<td>Entering puberty</td>
<td></td>
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<tr>
<td></td>
<td>Dating</td>
<td></td>
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<tr>
<td></td>
<td>Adolescence</td>
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<td></td>
<td>Developing identity and independence</td>
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<tr>
<td></td>
<td>Leaving home</td>
<td></td>
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<tr>
<td></td>
<td>Pursuing higher education</td>
<td>Early adulthood</td>
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<tr>
<td></td>
<td>Choosing a vocation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finding a partner</td>
<td></td>
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<tr>
<td></td>
<td>Having children</td>
<td>Adulthood</td>
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<tr>
<td></td>
<td>Parenting a young child</td>
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<tr>
<td></td>
<td>Parenting a primary-school child</td>
<td></td>
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<tr>
<td></td>
<td>Parenting an adolescent</td>
<td></td>
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<tr>
<td></td>
<td>Achieving vocational success</td>
<td></td>
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<tr>
<td></td>
<td>Parenting a child who is leaving home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parenting adult children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Providing care for an ill parent</td>
<td></td>
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<tr>
<td></td>
<td>Becoming a grandparent</td>
<td></td>
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<tr>
<td></td>
<td>Retiring from a job</td>
<td></td>
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<tr>
<td></td>
<td>Coping with illness or disability</td>
<td>Older adulthood</td>
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<tr>
<td></td>
<td>Providing care for an ill spouse</td>
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<tr>
<td></td>
<td>Coping with the death of a spouse</td>
<td></td>
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<tr>
<td></td>
<td>Coping with the death of peers</td>
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<td></td>
<td>Dying</td>
<td></td>
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</tbody>
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Source: Adapted from Mrazek & Haggerty (1994) p. 224, which was adapted from Kellam SG, Branch JD, Agrawal KC, Ensminger ME 1975, Mental Health and Going to School, University of Chicago Press, Chicago.
Adolescence (12-18 yrs)

- Adolescence and young adulthood is a critical developmental period:
  - Sexual development, sense of self (self-identity), separation, belonging
    “a reintegrated sense of self, of what one wants to do or be, and of one’s appropriate sex role”. Bee (1992)
  - Potential Stressful Life Events: Anything that differentiates from peers, bullying, exams, introduction to drugs and alcohol (banned from social media & taking selfies!)
  - Health-related behaviours are formed. Become increasingly responsible for their own health actions, choice and initiative
  - The onset of mental illness is typically around mid-to-late adolescence and Australian youth (18-24 years old) have the highest prevalence of mental illness than any other age group (Black Dog Institute 2012)
  - Over one in four (26%) young Australians experience a mental illness every year (Australia Bureau of Statistics 2009)
  - Common mental illnesses in young Australians are: anxiety disorders (14%), depressive disorders (6%) and substance use disorders (5%) (Kitchener & Jorm 2009)
  - Others including schizophrenia, depression & substance abuse can peak in adolescence
Adulthood (18-65 yrs)

- Developing intimate relationships for longer lasting commitment, children (procreation) productivity, career & family orientated

- Potential stressful life events: divorce, procreation, bereavement, unemployment, postnatal depression

- Prevalence of most mental disorders decreases, although suicide is highest in young adulthood

- Mental disorders are usually re-emergence of those experienced in adolescence

- Incidence of “new” disorders also declines

- Mental disorders account for 17% of disease burden in adults 25-64 years old (Mathers, Vos & Stevenson 1999)
Older adults (65+ yrs)

- Productivity slows down (retirement), reflection on the life lived, was it successful?

- Potential stressful life events: Physical health deterioration, cognitive deterioration, bereavement/losses, social isolation, retirement, stigma and discrimination, financial concerns, loss of independent living

- 13% of older adults in Australia reported symptoms consistent with a mental disorder in past month & 16% in last year (Troller et al 2007)

- Women experienced higher rates of anxiety or affective disorders and lower substance abuse compared to men (Troller et al 2007)

- Increasing age was associated with less likelihood of having a mental disorder when cognitive impairment was excluded

- Those with cognitive impairment were more likely to have had symptoms consistent with an affective disorder

- 5% of 65 year olds, 20% of 80 year olds and 30% of 90 year olds have dementia (RANZCP 2010)

- Comorbidity is an issue and risk factor for psychological difficulties
HIV-related psychological distress

- Risk of psychological distress can be increased:
  - Co morbid physical health problems
  - Development of symptoms
  - Illness/Hospitalisation
  - Terminal issues
  - Disclosure
  - Medication/treatment decisions
  - Procreation issues
  - Changing landscape of HIV & HCV

Can happen at any time across the lifespan!
Life is stressful.

Why yes, I'm a bit stressed. Why do you ask?
Stress & HIV

- **Psychological**
  An anxiety state produced when one’s coping abilities are exceeded

- **Physiological**
  The rate of wear and tear on the body

- Research suggests 70-80% of all disease is strongly related to stress (Seaward 2004)
Stress and HIV

- **Acute Stress**
  - Intense, noticeable sudden increase in physiological symptoms, disappears quickly

- **Chronic Stress**
  - Symptoms not as noticeable but last for extended period of time; body continuously aroused
The stress response

- Reptilian brain
  - Primitive/instinctive

- Stage 1
  - The brain identifies a stimulus

- Stage 2
  - Brain interprets stimulus as a threat or non-threat
  - Flight or fight response activated (adrenaline and cortisol released)
  - Physiological changes
The stress response

- **Stage 3**
  - Body remains aroused and on edge until threat disappears

- **Stage 4**
  - Body returns to more relaxed physiological state
chronic stress

- When flight or fight response continues:
  - Adrenal glands continually secrete cortisol (stress hormone) which
    - Inhibits digestion, reproduction, growth, tissue repair, immune system functioning
    - Healthy parts of the body slowly shut
    - Colds, flu, ulcers, chronic diarrhoea, impotency, arthritis, susceptibility to fractures etc
What stress does to your body

**Head**
- issues with mood, anger, depression, irritability, sadness and a lack of energy, swings in appetite, concentration problems, sleeping issues, headaches and pain, mental health issues, like anxiety disorders and panic attacks

**Skin**
- skin problems like acne

**Joints and Muscles**
- aches and pains, tension, lowered bone density

**Heart**
- increased blood pressure, increased heart beat, higher cholesterol and instances of heart attack

**Stomach**
- stomach cramps, reflux, and nausea and weight fluctuations

**Pancreas**
- diabetes

**Intestines**
- digestive issues like irritable bowel syndrome, diarrhoea and constipation

**Reproductive System**
- reduced sex drive, lower sperm production (for men) and increased pain during periods (for women)

**Immune system**
- reduced ability to battle and recover from illness
Is stress related to HIV disease progression?

- Almost all studies say YES (Leserman 2002; Leserman et al., 2002)

- Stress is also related to a host of other physical diseases: Cardiovascular conditions, cancer etc

- Chronic stress can exacerbate physical health conditions
Many aspects of HIV are potentially stressful (Moskowitz & Wrubel, 2005).

- Initial anxiety over diagnosis
- Anxiety over poor test results
- Financial Worries due to unemployment
- Worry about Infecting others
- Worry about the future
- Worry about Disclosing to Partner or family
- Deteriorating health
- Stress = Increased Cortisol = Decreased immune functioning
- Body Image worries
- Worry about Medication effectiveness
Depression

- By 2020 depression is expected to be second only to heart disease as a source of the overall mortality and disability burden of disease worldwide (Chapman, Perry & Strine 2005)

- Depression predicted shorter survival time \((after\) controlling for HIV-associated symptoms and CD4 count; \(^{1}\) (Patterson et al. 1996)

- Stress + depression = faster progression to AIDS defining illnesses (Burack et al, 1993; Leserman et al, 1997)

- Hopelessness, denial/avoidant coping is related to reduced CD4 and increased VL \(^{2}\) (Ironson et al, 2005b)

- Psychosocial implications of depression & HIV
Depression in PLWHIV
-Possible Pathways-

Withdrawal

Difficulty making Friends or Maintaining Existing r’ships

Isolation

Lowered self-esteem

Increased negativity Or stress

- Just don’t care
  - Anymore = hopelessness, fatigue

Drug and Alcohol Use

Unsafe Sex

Contract other Conditions

Additional health Problems

Non-attendance at Medical Appts

Poor nutrition, No Exercise

Poor Medication adherence

Health problems

Decreased immune functioning
Loss

- PLWHIV are faced with a profound sense of loss on many levels and often experience multiple losses.
- If loss is not addressed, it can lead to a host of psychosocial difficulties including:
  - Depression
  - Anxiety
  - Risky behaviour
  - Non-adherence
- Successive health crises can plunge people into a loss/grief adjustment cycle.
Potential losses over a lifetime

- Friends/loved ones/parents
- Freedom of health
- Travel
- Failed treatment e.g. HCV
- Loss of work /financial independence
- Social groups
- Intimate relationships
- Children
Grief/Loss/Adjustment

Kübler-Ross Grief Cycle

Denial
- Avoidance
- Confusion
- Elation
- Shock
- Fear

Anger
- Frustration
- Irritation
- Anxiety

Depression
- Overwhelmed
- Helplessness
- Hostility
- Flight

Bargaining
- Struggling to find meaning
- Reaching out to others
- Telling one’s story

Acceptance
- Exploring options
- New plan in place
- Moving on

Information and Communication

Emotional Support

Guidance and Direction
Good QoL

- With multiple losses, stress and the burden of complex chronic disease management...

How can you find meaning and mediate successful adaptation to a life with multiple chronic illnesses and associated psychosocial sequelae?

Integrate the disease(s) into the sense of self?

How can you live the best life possible with what life throws at you?
Psychology

- Recognise psychological issues

- Broader conception of mental health (mental disorder vs not)

- Optimal mental health encompasses key components of positive emotional experiences, life satisfaction, personal growth or interpersonal flourishing (Ryff, 1995)

- Shift from “problem focused” to strengths based and acceptance focus

- Assisting person to recognise the unpleasant reality of the disease while keeping hope and goals in life
Psychology

Multiple approaches:

- Psychoeducation
- Cognitive Behavioural Therapy (CBT) (PTSD, depression, anxiety, stress management)
- Motivational Interviewing Techniques (MIT) (adherence issues, depression, addiction issues)
- Psychodynamic Psychotherapy (complex trauma, risky behaviour)
- Acceptance and Commitment Therapy (grief/loss/adjustment, depression, anxiety, stress)
Acceptance and Commitment Therapy (ACT)

- Accept the difficulties and challenges life delivers
- Applicable to family/carers/colleagues
- Learn to tolerate the whole spectrum of human emotions including the unpleasant ones
- Move forward and life the best life (QoL)
- Reconnecting with our values
- Principles include:
  - Mindfulness
  - Cognitive defusion
  - Compassion focused work
  - Problem solving
  - Values and goals based work
Questions?

What has helped you live the best life possible?