# Depression often undertreated in HIV/AIDS patients, psychiatrist warns

*Features*

*Chroniques*

**Ann Silversides**

**Ann Silversides is a freelance writer living in Toronto.**

*Can Med Assoc J* 1998;158:391-2

**In brief**

THE CLINIC FOR HIV-RELATED CONCERNS at Toronto's Mount Sinai Hospital marked its 10th anniversary with the 2nd Dr. Stephen Woo Memorial Lecture, and Cornell University psychiatrist John Markowitz used the opportunity to report that depression tends to be undertreated in patients with HIV/AIDS. However, symptoms often melt away with proper treatment. He said depression used to be considered a logical and inevitable consequence of the virus, but these views have been changing.

**En bref**

LA CLINIQUE DE TRAITEMENT DES PROBLÈMES LIÉS AU VIH de l'Hôpital Mount Sinai à Toronto a souligné son dixième anniversaire par la deuxième conférence commémorative Dr Stephen Woo. John Markowitz, psychiatre à l'Université Cornell, a profité de l'occasion pour signaler que l'on a tendance à ne pas traiter suffisamment la dépression chez les patients infectés par le VIH et atteints du SIDA. Le bon traitement a toutefois tendance à atténuer les symptômes. Il a affirmé que l'on considérait auparavant la dépression comme une conséquence logique et inévitable de l'infection par le virus, mais qu'on change maintenant d'avis.

Physicians' incorrect assumptions about HIV/AIDS patients has meant that depression in these patients is being undertreated, a Cornell University psychiatrist said while presenting the 2nd annual Dr. Stephen Woo Memorial Lecture, held recently in Toronto.

For HIV/AIDS patients who are diagnosed with depression, both medication and short-term interpersonal therapy (IPT) have proved equally effective, said Dr. John Markowitz.

Markowitz said the study of these depressed patients has determined that symptoms like fatigue, inability to concentrate and lack of appetite, which patients attributed to AIDS/HIV, were really symptoms of depression that "melted away" after the depression was treated.

The lecture marked the 10th anniversary of the Clinic for HIV-Related Concerns at Mount Sinai Hospital, which Dr. Woo was instrumental in establishing.

In the early days of AIDS, depression was considered a logical and inevitable consequence of the virus, said Markowitz, who has worked with these patients for more than a decade. "People in the prime of their lives were being cut down by something mysterious and scary and lethal," he said. "Our feeling was, 'Who wouldn't be depressed?' "

At the same time there was concern, which has since proved to be mostly unjustified, that the nature of the illness meant patients would be overly sensitive to antidepressant medication. As a result of both assumptions, said Markowitz, undertreatment of depression was endorsed and continues today. And the attitude that "of course you're depressed, you've got HIV" continues to contribute to the situation, he said in an interview.

Markowitz noted that solid epidemiologic data concerning HIV/AIDS is lacking, with many people being infected without even realizing it. However, small-

scale studies indicate that the rate of depression among HIV/AIDS patients, which stands at about 10% to 15%, is no greater than the rate for patients with other major illnesses, such as cancer.

"That was a surprise and I think many of our intuitions about HIV have been completely wrong," said Markowitz. "We tend to have fears about this illness because it is new and unknown, but the more we find out the more it is like anything else. In fact, most of the people with this virus don't get depressed, and most who do get depressed tend to have prior histories of depression."

Because the efficacy of IPT in treating depression had been established, Markowitz decided to launch a 16-week study of depressed HIV/AIDS patients that compared the use of IPT with the use of the antidepressant drug imipramine and cognitive therapy. Markowitz noted that many patients who are already taking 40 or so pills daily to ward off HIV-related illnesses may be averse to taking even more medication for their depression.

Since IPT is typically limited to 12 to 16 weeks, time is used as leverage. "The time pressure is your ally. If you know the time is limited, and your patient knows, both of you have to work hard and fast. . . . One of the things that has been striking working with HIV patients is how precious time is to them and how they want quick results."

IPT's focuses on the symptoms of depression, not on character change, and it is based on the "simple idea that moods don't appear in a vacuum, but rather in context, so if bad things happen, you feel worse."

The therapy is particularly useful in cases of complicated bereavement, role disputes and major life changes, and the approach emphasizes the exploration of options with the patient.

In IPT, depression is diagnosed as a medical illness, an interpersonal inventory is undertaken and, with the patient's explicit agreement, the problem area is established and becomes the focus of treatment. One key to IPT is that the patient is not blamed for the depression; instead, the blame goes to the life situation. The therapist, who acts as the patient's ally, must maintain a positive and optimistic attitude and be able to instil hope.

Markowitz's study involved 101 clinically depressed patients who were HIV positive but not severely ill at entry; 85% were male, 80% were gay or bisexual, and 58% were white. All 4 treatments worked, but medication and IPT brought the depressed patients into the "normal range" while those in the other treatment groups remained moderately depressed.

Markowitz said the few women who participated did not respond well to IPT. "They were not used to regular attendance, I think, because they tend to be overwhelmed. For infected women, HIV tends to be way down their list of concerns — they're more worried about the next meal, about how to pay the hydro bill, or about their children." ❓