Graying and HIV; The Mental Toll - Depression in Older LGBT Minorities

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Statistics


- Worldwide, more than 80% of all adult infections resulted from heterosexual intercourse.
Since 1981, 60 million people become infected with HIV; 25 million have died (avert.org, 2009) - the death toll is more than all the battle-death of all the wars in the 20th century.


In Sub-Saharan Africa AIDS killed 1.5 million people in 2007, 75 % of total AIDS death (Worldbank, 2008).
- USA-February 19, 2009- AIDS has struck more than 1.1 million Americans (CDC).
- One new infection every 91/2 minutes (Kaiser, 2009).
- About one-fifth do not know they are HIV-positive (Fauci, 2008).
- 51% are African-American, 30% are Caucasian, and 19% Latino (CDC, 2009).
- Women are 25.2% (CDC, 2008).
- More than half (53%) of infections are among men who have sex with men (AFC, 2008).
Impact of HIV among older people of color

Older African-American and Hispanic people deeply affected:

- Older women of color represent 73.9% of this age group.
- Men represent 52.6% of AIDS cases (Emlet, 2004)
AIDS Risks in Older LGBT minorities:

- Lower knowledge of HIV/AIDS.
- Increased stigma.
- Prevention messages are not always age and culture sensitive.
- Poverty, limited access to quality health care, distrust in the care system, afraid of HIV conspiracy.
Elders of color experience greater morbidity and mortality due to chronic conditions (diabetes, cardiovascular disease) which may serve to the overall increase of the functional disability and complicate prognosis for HIV treatment.

Church-important support for aging blacks, but not for HIV/AIDS-related issues.

SEXUAL ORIENTATION very relevant to HIV risk.
Older people suffer the stigma of AIDS, of age, of racism, AND of sexual orientation.

Older adults must confront from society in general, the ageist view of older people as being asexual or exclusively heterosexual.

Older LGBT may be reluctant to disclose sexual orientation, or have decreased sexual communication skills.

Lack of negotiation skills that promote safe sex.
Most of the older gay and bisexual men had to hide their sexual identities throughout their lives to protect themselves from stigma and discrimination.

Older sexual minorities came of age when homophobia and heteroxism remained unchallenged (Grossman, D’Augell i& O’Conell, 2001). Some took refuge in heterosexual marriages (Genke, 2000). They still often refuse to reach out to HIV education and service organizations.
“Psychological Stress can lead to Illness, or even Death”  
(Dr. M. Irwin, UCLA)

- In excess, stress hormones result in suppressed immunity:
  - Release of stress hormones-epinephrine and norepinephrine (adrenaline and noradrenaline)
  - Release of stress hormone cortisol
Older LGBT PWAs Present with High Levels of Stress

As a result they:

- Do not respond well to drugs
- Get sicker and have shorter life spans
- The excess of stress hormones encourages the virus to multiply while suppressing protection
- Have higher levels of the AIDS virus in the blood
Stress, Anxiety, Panic Attacks, and Older PWA

Older PWA experience:

- Higher tension and anxiety
- Greater anger and hostility
- Overwhelming uncertainty: are panic attacks due to patient’s fears, or to changes in the brain structure?
- Decreasing CD4<100 may worsen manic symptoms
• Older PWA might present with:
  - Depression, Suicidal ideation, Anxiety, Stress, Psychotic behavior, Substance Abuse

• Older people may have more problems with thinking and remembering than younger people

• Both age and higher viral load are linked to mental problems (The Body, 2005)
Older PWA experience more depression than younger PWA.

Older depressed PWA tend to have less support and more financial problems, lack HIV-related information, and experience greater stigma than those who are not depressed ((Shippy, 2004)

HIV, associated medical problems, antiretrovirals, and other medications may be the cause of depression/anxiety or worsen your symptoms.

Depression and Anxiety are more common in HIV but the treatments are just as effective and safe in HIV/AIDS.
HIV Depression Mimicking HIV Infection:

- Sleep disturbances
- Loss of appetite
- Fatigue
- Weight loss
- Eventual dramatic weight loss
- Social withdrawal
Depression among older LGBT minorities

Older LGBT with HIV/AIDS have an increased risk of depression due to:

- Severe physical debilitation, the threat to life, central nervous system involvement, disclosure of homosexuality, drug abuse, and guilt.

- Older HIV-positive LGBT are marginalized by ageism and social stigma.
They lack the social support they need and their healthcare providers might be insensitive to their changing needs.

Older African-Americans with HIV/AIDS may face rejection from friends, family, and religious congregations because of the socially stigmatizing behaviors typically associated with HIV/AIDS condition (Emlet, 2004).

Shame leads them to isolation and apprehension about seeking the care needed (Karpiak, 2007).
Older African-Americans might not seek treatment for HIV and depression due to the perceived stigma of using services, the fear of health-care system due to historic acts of racism, and real and perceived discrimination (Emlet, 2004).

In addition, older survivors “are bombarded with…insults… which complicate their medical regime and have the potential of being life threatening. That undermines their sense of stability and make it much more difficult to adjust “(Emlet, 2006).
Comorbid depression common in those with HIV disease

People with major depression are at increased risk for depression and mortality.

HIV increases the risk of developing depression through direct damage to subcortical brain areas, chronic stress, increased social isolation, and sadness brought by the condition.
Depression in older LGBT persons with AIDS is associated with unsupportive social interactions, such as: insensitivity, disconnecting, forced optimism, and blaming.
Suicide

- History of marked depression
- Previous suicidal attempts unrelated to HIV status
- Desire to escape an “unbearable” situation
- Older adults with HIV who attempt suicide experience social isolation, stigma, loss of independence, discrimination, rejection, drug abuse, and lack social support.
- Desperation and fear when diagnosed
- Knowing someone who just died, death of partner
- Observing others decline physically, emotionally, and cognitively
- Fear of becoming dependent on others
- Those people are likely to use avoidance and escape to cope with their HIV status
- Are less likely to receive social support from their families after disclosing their HIV status
- Their disclosures are met with stigma and rejection
Stressors Increasing HIV Depression:

- New HIV symptoms
- Negative laboratory tests findings
- Changes in physical appearance
- Multiple diagnosis of pathology
- Medication no longer working
- Financial problems
- Loss of social support
- Loss of health insurance
Treating Depression and HIV

- Role of Psychotherapy and Medication combined

- Almost all antidepressants are safe with antiretrovirals--‘Start low and go slow’

- Therapeutic Doses of Medications during acute, continuation, and maintenance phases
Psychological Treatment of Depression:

- Clinicians need to be aware of their own ageist beliefs and biases related to aging, sexuality, cultural differences, and sexual orientation.

- Anderson (1998) believes that the biggest barrier to success in treating this population is clinicians’ unwillingness to overcome ageism. Older HIV-positive people need an encouraging environment in their fight with the disease.
Specific Strategies:

- Enlightened Reassurance
- Cognitive Reframing
- Appropriate Humor
- Tasks Setting and Structure
  Providing
Enlightened Reassurance:

- Making person aware that Depression might mimic HIV disease
- Depression is time limited
- Information about long term survivors
- Side effects of medication expected to be time limited
Cognitive Reframing:

- Challenging morbid thoughts
- Assessing realistically social support
- Assessing the treatments available now vs 25 years ago
- Looking in perspective at new developments in treating it
Using Humor:

- Appropriate humor to understand a chronic illness and counter stigmatization

Tasks Setting and Structure

Providing to:

- Increase responsibility
- Focus on accomplishments
- Improve the mood
- Reduce fear about the future
In Addition, the Plan of Action Might Include:

- Selecting a physician
- Making decisions about new medications
- Attending support groups
- Working part time
- Taking classes in an area of interest
- Look at options not recognized as available before the onset of illness
Older PWA who are depressed and present risk of suicide need comprehensive mental services:

- counseling
- case management
- enhancing perceived support
- increase in their coping resources
- specific psychosocial interventions
Treatment News:

- New hope: Marrow transplant. Dr. Fauci said it was costly and dangerous, but an inspiration for gene therapy as a means to block or suppress HIV (2008).

- The first one-in-one, once-a-day drug to treat HIV was approved and on sale in July 2006 (The Body, 2006). Atriva, the combination pill includes Sustiva (attacks the virus later in the cycle), and Truvada (block copying of the AIDS virus at two different points).
- Some studies show that older age does not seem to significantly affect the long-term virological outcome of HAART treated PWA, compared to younger age HIV-infected persons.

- For the first time ever, investigational vaccine regimen has shown some efficacy: a combination of ALVAC-HIV and AIDSVAX B/E (The New England Journal of Medicine, Sept 2009).
Brief Behavioral Skills for Older LGBT-positive Minorities

- Risk related behavioral self-management
- Risk reduction intervention programs in inpatient, outpatient, and community settings
- People on HAART should treat other presenting problems such as anxiety, depression, or drug addiction
- Teaching prevention (such as condom use), not only medication compliance

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