UT Health San Antonio

AETC AIDS Education & Training Center Program South Central

Bipolar Disorder and HIV

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Conflict of Interest Disclosure Statement

- The presenter has no conflicts to declare.

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Learning Objectives

- 1.) Learn about Bipolar and its related disorders.
- 2.) Develop an understanding of what risks individuals with both HIV and Bipolar disorder face.
- 3.) Develop an understanding of how to help an individual that has Bipolar disorder with HIV.

Bipolar episodes

- **Manic Episode-** a period of elevated, expansive, or irritable mood that is abnormal to the person it must last at least a week, and present most of the day nearly everyday.
  - Increased energy or activity and include but not limited to decreased sleep, excessive activity that is risky in nature, inflated self-esteem, etc., must cause impairment, not attributed to medication or drug use.
- **Hypomanic Episode-** the same as manic, but only lasts 4 consecutive days. Does not cause severe impairment, but does include a marked change in functioning.
- **Major Depressive Episode-** a period of changed behavior that is present for 2 weeks and must include depressed mood or anhedonia (loss of interest or pleasure).
  - Symptoms may include sleep disturbances, a significant change in weight or appetite, loss of energy, low self esteem, etc. must cause impairment, and is not related to drug abuse or medication.

Bipolar I

- Is characterized by episodes of mania
  - This may lead inpatient hospitalization
  - If you are ever hospitalized/have a manic episode you have Bipolar I
- Prevalence in a 12-month period in the United States is 0.6%
- Lifetime prevalence for men vs women is 1.1 to 1.
- Bipolar I and related disorders have been found to have a high genetic association. If there is a family history, you are 10x more likely to develop this condition.

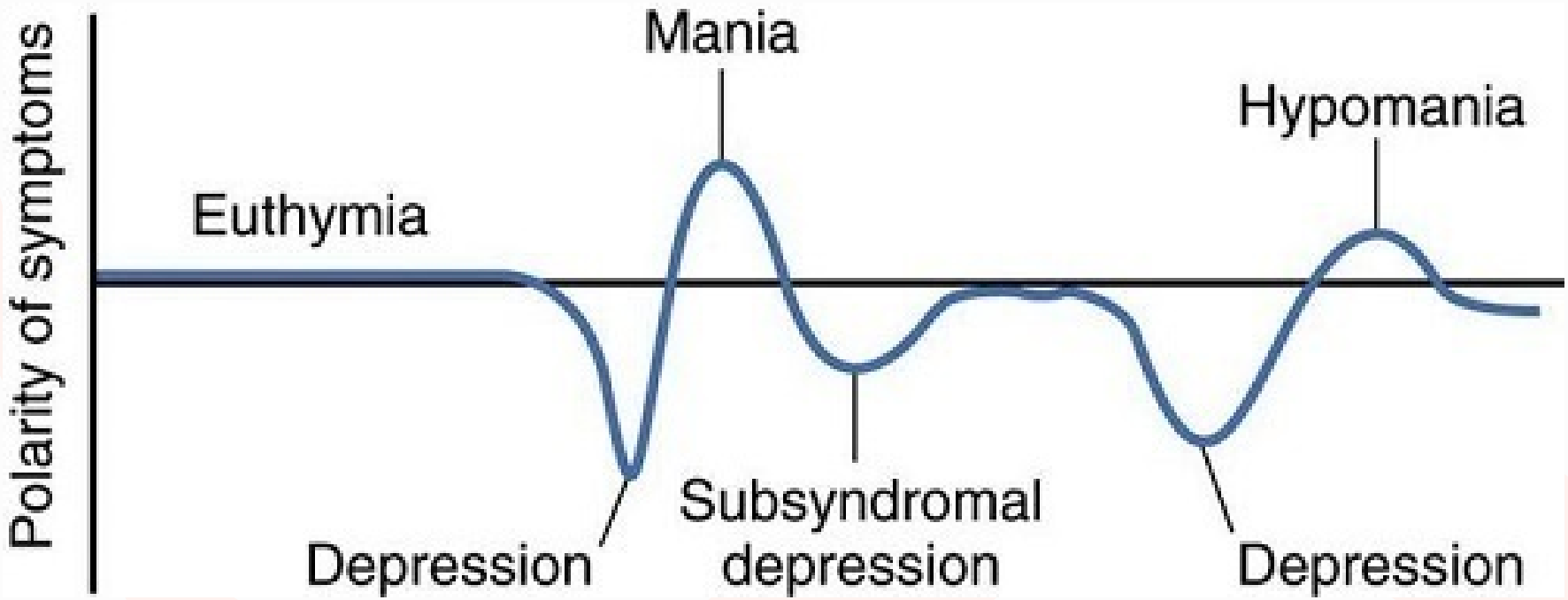
Bipolar II

- A combination of hypomanic and major depressive episodes, must have both.
  - Careful distinction between true hypomania and recovery from depression
- No history of mania
- Is not better explained by other diagnoses like Schizoaffective disorder
- Prevalence in a 12-month period in the United States is 0.8%

Cyclothymia (Bipolar III)

- For at least 2 years there have been multiple periods of hypomanic and depressive episodes that don't meet full criteria for ether.
- These symptoms have been present for half of the 2-year period and there have never been a longer than 2-month break in symptoms.
- Have never met criteria for other bipolar episodes (manic, hypomanic, depressive).
- Prevalence is 0.4%-1% lifetime. Equally common between men and women in the general population.
- A differential diagnosis for all Bipolar disorders is Borderline Personality Disorder.

The Waves



Risk factors

- If you have a patient that is diagnosed with Bipolar disorder, please assess suicide risk. Individuals with this condition are almost 15x more likely to attempt suicide compared to the general population.
- Family Genetics
- Substance use
- Environmental factors such as income (more common in higher income vs lower income individuals)

What does the research say?

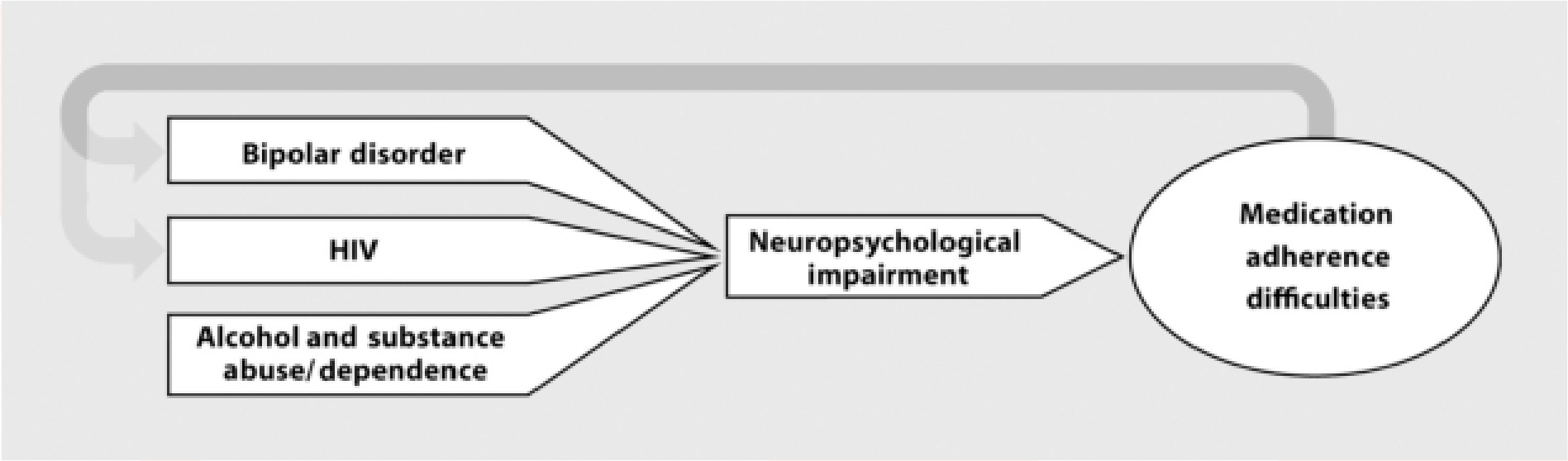
- A recent study found that participants were often diagnosed with Bipolar disorder prior to being diagnosed with HIV. This overlap in diagnosis occurred on average 9.8 years after BD onset. Compared to controls risk factors included MSM and drug use. (European study)

- This study also noted that only 85% of those with BD and HIV were taking ART compared to the general population which is around 98%. This reduced adherence is echoed in many studies looking at BD and HIV+ populations.

- Multiple studies suggest that individuals with HIV and BD are more likely to fill their ART medications compared to their BH medication.

- Those that attended 6 or more BH visits per year were more likely to adhere to ART.

Cycle of non-compliance



Moore et al., (2008)

What can you do?

- Develop mood charting with the patient
- Have daily reminders sent to the patient
- A model of the above suggestions was piloted and found to be effective by Moore et al., (2015).
- Utilize screeners on a regular basis (memory, executive functioning, mood, SUD) (MOOD Questionnaire)
- Encourage collaboration with MH providers
- Utilize reverse integration if possible
  - Add a psychiatrist or psych NP to your team or have an ID physician in an BH practice or clinic

Summary

- HIV and Bipolar disorder can occur together, but often Bipolar disorder precedes HIV and that time might be utilized to help reduce likelihood of HIV infection

- Patients that have HIV and Bipolar disorder should be screened on a regular basis for mood related changes to help with early intervention and prevention.

- Develop a system of collaboration and perhaps a specific clinic flow for patients that have Bipolar disorder and HIV. Co-visits might be helpful for these patients.

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Resources

- Clinical Consultation Center http://nccc.ucsf.edu/
  - HIV Management
  - Perinatal HIV
  - HIV PrEP
  - HIV PEP line
  - HCV Management
  - Substance Use Management
- AETC National HIV Curriculum https://aidsetc.org/nhc
- Core Concepts - Primary Care Management - Basic HIV Primary Care - National HIV Curriculum (uw.edu)
- AETC National Coordinating Resource Center https://targethiv.org/library/aetc-national-coordinating-resource-center-0
- Additional trainings scaetcecho@salud.unm.edu

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