

Case report:

HIV, Homosexuality and Depression – Challenges at Primary Care: A Case Report

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Abstract:

Human Immunodeficiency Virus (HIV) is a chronic lifelong infectious disease that greatly impairs the quality of life. HIV and men who have sex with men (MSM) are seen to be synonyms to each other and both were shown to be the risks for depression. This case report is about a homosexual man who contracted HIV via the MSM activity. Being both homosexual and HIV-infected had given him a lot of negative impacts, stigma and discrimination, which drove him into having major depressive disorder. Having depression with underlying HIV and homosexuality has made this case complicated and challenging, especially when it has to be managed at the primary care level.

Keywords: HIV, homosexuality, men having sex with men, depression.

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Introduction

In 2016, it was reported that 54% of new Human Immunodeficiency Virus (HIV) infections in Malaysia was via sexual transmission in men who have sex with men (MSM) and this proportion has been increasing yearly since 2009.¹ Homosexuality that used to be listed in the Diagnostic and Statistical Manual (DSM) and International Classification of Disease (ICD) before being removed in 1973 and 1990 respectively is currently considered as normal variant to sexual orientation.² Many religions worldwide especially Islam, still believe it as a wrongdoing behavior and do not advocate the acceptance of this. Malaysians are predominantly Muslims, so homosexuality remains a social taboo and forbidden by Sharia Law.³ This gives major impact to the homosexual Muslims where the desire of wanting the same sex could not be fulfilled, as they are obliged to the law. The self-conflicts between religion and homosexuality may result to depression.⁴

Depression is the most common mental disorder among HIV patients and it was shown to be associated with worse clinical outcome

of HIV progression⁵. Having both HIV and homosexuality, would further increase their risk for depression because of the combined stigmas (HIV and MSM). Thus, it is important to integrate the screening of mental illness for the routine HIV care. Recognizing the symptoms earlier allows early interventions to be done, which may help to improve the prognosis of the disease.

Case presentation

A 34 years old man, newly diagnosed with HIV presented at primary care clinic with nausea and abdominal discomfort for a week after initiation of antiretroviral therapy (ART). Further history was non-significant and physical examination was normal. He was given symptomatic relief and was reassured that the symptoms were due to the side effects of ART. He is a homosexual man and was previously exposed to unprotected sexual activities with multiple partners. His baseline CD4 level was 244 and his HIV viral load was 56,646 copies/ml.

During subsequent follow-up, his gastrointestinal symptoms improved but appeared to be low mood and poor eye contact. He revealed that the

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symptoms started four months ago, when he was diagnosed with HIV. His mood worsened with time and started to have significant anhedonia, feeling hopeless, low self-worth and guiltiness. The diagnosis of depression was made at that time. He was offered for antidepressant but refused because of the potential side effects that he might get as how he experienced with the ART. He opted for non-pharmacological treatment. In view of limited resources at the clinic, he was referred to psychiatry for psychotherapeutic interventions. However, he denied the referral because of the potential stigma that he might get at the psychiatry clinic. Thus, frequent follow-up was arranged to monitor his psychological wellbeing closely. Evidence has shown that regular follow up is one of the effective ways to manage depression.⁶ Psychoeducation was given at each of the follow-up. The in-house occupational therapist taught him on relaxation techniques and exercise therapy as part of the interventions.

Unfortunately, his depressive symptoms worsened over time. According to him, HIV status was not the only reason, but being a homosexual man despite his willingness was the one that made him even more depressed. He was aware that his religion and community does not accept homosexuality but his desire towards men is too strong for him to resist. Knowing the limitation in handling this case, the authors decided to consult the psychiatry team for further advice in managing this case. From the discussion, the diagnosis of depression secondary to HIV and ego-dystonic homosexuality was made. Counselling after counselling were given and he finally agreed for psychiatry review. Collaboration between primary care and the specialty unit (psychiatrist and psychotherapist) provides optimum care for the patient. He attended a series of cognitive behavioral therapy (CBT) and some other psychologically oriented interventions. He responded well and his mood improved three months later. For his HIV status, he tolerated well with the ART and has achieved viral suppression after 4 months on ART.

Discussion

The prevalence of depression among HIV patients is high compared to other psychiatric disorders.⁵ The relationship between HIV and depression is

complex. Both can have similar presentations such as loss of weight, fatigue and insomnia. They may have a bidirectional cause effect to each other. Hence, this is why depression is often under-diagnosed and untreated.

Both HIV and MSM are the risk factors to develop depression.⁶ Homosexuality was previously considered as a pathological condition that required treatment, but later it was regarded as normal variation.² In DSM-II, homosexuality was initially termed sexual orientation disturbance (SOD), which then replaced by Ego-dystonic homosexuality (EDH) before being removed in DSM-III-R. Homosexuality was previously described as an illness to the individual with same sex attractions that found it as disturbing and wanted to change. Even though homosexuality is now considered as normal, however, it is still unacceptable in some countries. Stigma of HIV and MSM were shown to be important factors for developing depression.^{5,6}

Managing depression in HIV patients with homosexuality is challenging. Evidence based guidelines recommend the use of antidepressants as a first line therapy for depression, but some patients may prefer non-pharmacological options because of the risk of harms such as adverse effects and addiction.⁷ Even though most of non-pharmacological interventions (NPI) are not evidence based, however, physician should offer interventions that have been studied directly with antidepressants, such as CBT.⁷ In this case report, the authors had difficulties in managing this case because of the patient preference of NPI, which are very limited at primary care level. There are no trained personnel to provide psychological and behavioral interventions at primary care clinic. Knowing this limitation, authors decided to give combined care with the psychiatry team that would offer better options.

Patient-centeredness is the key in family practice and effective counselling is important at gaining the patient's trust.⁸ Family physicians need to know their limitation in terms of knowledge, competency and available resources at their level. Getting the specialist from the respective specialty

may prevent potential harmful consequences and increases the likelihood of treatment success. Effective management of depression in HIV patients may lead to improvement in health outcomes and their quality of life.⁹

Conclusion

Depression is common in homosexual, HIV patients. It is often under-diagnosed and untreated. Therefore, it is important to incorporate screening for depression as part of the routine HIV care. There is no doubt in having challenges in the management of mental illness among HIV patients. However, such challenges must be approached wisely to achieve positive outcomes and better

prognosis.

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Conflict of Interest

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References:

1. Division of Disease Control M of H. Snapshot of HIV & AIDS in Malaysia 2016, 2017. [Accessed 16.05.2019] <http://www.mac.org.my/v3/snapshot-of-hiv-aids-in-malaysia-2016/>
2. Drescher J. Out of DSM: Depathologizing Homosexuality. *Behav Sci.* 2015;5(4):565-75.
3. Sin How L, Shan-Estelle B, Stacey A. S, Kamarulzaman A, Frederick L. A, Chris C. "You Have to Keep Yourself Hidden": Perspectives From Malaysian Malay-Muslim Men Who Have Sex With Men on Policy, Network, Community, and Individual Influences on HIV Risk. *J Homosex* 2018;1-23.
4. Page MJL, Lindahl KM, Malik NM. The Role of Religion and Stress in Sexual Identity and Mental Health Among LGB Youth. *J Res Adolesc Off J Soc Res Adolesc.* 2013;23(4):665-77.
5. Chaudhury S, Bakhla AK, Saini R. Prevalence, impact, and management of depression and anxiety in patients with HIV: A review. *Neurobehav HIV Med.* 2016;7:15-30.
6. Lee C, Oliffe JL, Kelly MT, Ferlatte O. Depression and Suicidality in Gay Men: Implications for Health Care Providers. *Am J Mens Health.* 2017;11(4):910–9.
7. Gartlehner G, Wagner G, Matyas N, Titscher V, Greimel J, Lux L, et al. Pharmacological and non-pharmacological treatments for major depressive disorder: Review of systematic reviews. *BMJ Open.* 2017;7(6):e014912.
8. Boon How C, Shariff Ghazali S, Ai Theng C. An Introduction to Family Medicine and its Essential Skills in Primary Medical Care. Universiti Putra Malaysia, Serdang: UPM Press; 2015.
9. Sin NL, DiMatteo MR. Depression Treatment Enhances Adherence to Antiretroviral Therapy: A Meta-Analysis. *Ann Behav Med Publ Soc Behav Med.* 2014;47(3):259-69.
10. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D, et al. The CARE guidelines: Consensus-based clinical case report guideline development. *J Clin Epidemiol.* 2014;67(1):46-51.