Adventures in Brain Chemistry

A diseased pariah dreams of the bluebird of happiness but wakes up with the chicken of despair

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I'd like to blame it all on the movie *My Own Private Idaho*. There I was, in the theater, in a foul mood. The popcorn machine was out of order, and some stylish clod had stepped on my neuropathy-afflicted toes with his tastefully distressed combat boots. While River Phoenix's fortunes took a turn for the worse, I reflected on the fact that the boy I had a letch on no longer letched back. That I knew this same boy letched after Keanu Reeves, the movie's other main character, didn't help my enjoyment of the flick. I left the theater a bit queasy, and on the way to my car I stepped in dog shit. I got in the car, removed the contaminated footwear, turned on the radio and screamed myself hoarse while pounding the steering wheel. *Aaaaaaaaaaaaaaaah!* Welcome to clinical depression. *Bienvenu*, B-grade mental illness.

Depression is the most common mental problem people get to experience. About one-third to one-half of the general population has an episode sometime in their lives. People at the margins of society are even more likely to be anguished, especially those shell-shocked by the loss of friends and loved ones, be it through disease, natural disaster or war. Unfortunately, the term *depression* is still widely misunderstood, and many people assume that anyone unable to overcome his or her own minor malaise is weak-willed and incompetent. But depression is not just the sadness at the lower half of your natural mood swings. It's much more pernicious, a physical ailment that gnaws at the vitality of body, mind and wallet. Depression can be deadly for people with HIV.

Not surprisingly, depression in HIVers is complicated by the fact that the epidemic is as much a social and psychological concern as a physical one. Having HIV does not necessarily mean you are more likely to have the blues; individuals predisposed to depression prior to dealing with HIV will probably be the ones who get depressed post-diagnosis. But HIV affects you from the outside as well. The constant loss of friends, the constant interruption of the grieving process by yet more lost friends, the fear that this might all be a sneak preview of what's in store for you, and the framing of your love and sex lives in terms of disease take their toll. Thus the likelihood of a related constellation of problems, including substance abuse, sexual dysfunction, hypochondria and writing bad checks. It's important to know the difference between these two seemingly contradictory forces when seeking treatment.

Seeking treatment? Well, it takes some of us longer than others. I was already a little tweaked by several ugly hospital stays, the last one following a nightmarish two weeks of a lockjaw-like

salivary-gland infection that left me unable to eat. I emerged 40 pounds lighter and with some facial paralysis. Then came -- sad violins, please -- the unfortunate romantic interest. But even after all that, it took the *Private Idaho* incident to do what months of unpleasantness hadn't done: Scare me into seeing a shrink.

My California employer's medical coverage was through the health-maintenance organization Kaiser Permenente (pronounced "kills you permanently" -- although they failed to do me in despite having had me helpless in their dungeon so recently). To see an HMO specialist you have to first appease the gatekeeper, who wants to make sure you're not faking illness just so you can brag to friends about glamorous accessories like electroshock or bedpans. Overcoming embarrassment, I made it sound as juicy as possible for the dour little man without straying too far from the truth.

I described my depression as a sticky transparent black gauze draped over my reality. The whole world went a couple of F-stops darker, cutting out just enough light to wipe the sheen off fortunate events and turn the merely inconvenient into the truly devastating. When I'd try to fight back, the gauze would force its way into my mouth, dulling my senses and plugging my nostrils. When I'd lie in bed (I'd be under it if I fit), yard after yard of this clinging apparition would drape itself over my head, smothering and impervious to my attempts to pull it away. Nice, huh? The sorcerer's apprentice thought so too, but doubted my sincerity. I was saying all the right things, you see, but my manner was too calm and collected -- he doubted I was truly troubled. I mentioned that's what friends and family say about some postal workers after they've gone berserk and gunned down co-workers with an AK-47. This turned out to be an appropriate response, since I got an appointment with the shrink of my choice the following day.

Therapists come in several flavors. A social worker is schooled in talk therapy but is not a medical doctor. A psychiatrist is an MD with additional mental-health training; he or she can prescribe drugs as well as do therapy or analysis, which makes him or her more expensive and therefore a health-plan rarity. Finally, there are clinical psychologists, doctors of divinity and other certified mental-health technicians. Don't devalue the lowly social workers, however, since they're the ones you're likely to talk to on short notice. Also, because it's easier for a concerned layperson to get trained in counseling techniques than go to medical school, there's a good chance you'll be able to talk to someone who actually comprehends the source of your distress. It goes without saying that when HIV plays a role in your depression, it helps to have a therapist who knows what a CD4 cell is.

I know what doctors' visits at Kaiser are like, so the visit to the therapist seemed to me positively luxurious. A whole hour? All to myself? Compare that to a medical emergency, where you can be suffocating from pneumonia, and the doctor still won't give you more than 10 minutes of his or her time. Not only that, but the shrink treated me like a grownup while acting like a helpful big sister. There was a couch and a box of tissues, just like in the movies, but I wasn't obliged to lie down. At the first visit we discussed the various aspects of treatment.

Psychotherapy is the guided exploration of your own mental landscape. In movieland, the skillful therapist tricks and cajoles you into some dark realizations that you always did know but never

wanted to deal with. Needless to say, it's not usually that dramatic. The shrink asks about your background, life history and what's on your mind to find clues that may tie into your current condition and help you navigate around or over the mind's mud puddles.

Advances in understanding the physiology of mental health have led to a powerful class of drugs called psychotropics, which work to restore the balance of your brain chemistry. Both talk therapy and antidepressant meds can be effective, and each has its own highs and lows. For example, opting for therapy can spare you the side effects of adding yet another drug to your pantheon. On the other hand, therapy takes up more of your time and might be inconvenient if you don't get around as easily as you once did.

Being a product of the consumer culture -- and because my HMO pays for only 20 sessions of mental-landscape exploration a year -- I opted for the drugs.

Psychotropic is an ugly word, so let's take a closer look and see what's in the category. An *antidepressant* attempts to affect your mood as a whole; an*antianxiety*, on the other hand, can alleviate the transient symptoms of depression. This distinction is very important, because depression and anxiety are often confused. The nervousness, hypochondria and panic attacks of anxiety are more likely to be the fallout from the post-traumatic stress of life in an HIV war zone. Most antianxiety drugs are diazepines, members of the Valium family, and can be highly addictive. They can cause all sorts of problems if misprescribed to someone needing an antidepressant.

All this tinkering with the brain is what makes antidepressants such powerful drugs, and why you may have to put up with some profound side effects should you decide to take them. Antidepressants tend to leave you with a dry mouth, lack o' libido and constipation (or, as my dad shocked me by observing, a denial of life's most basic pleasures). Paradoxically, impotence may on rare occasions be replaced suddenly by priapism, a pathological erection that won't go away. Should this happen, it is not advisable to run out to the nearest sex club to field-test this new everlasting boner, oh no. You should instead hurry to your favorite emergency room, where the kind doctors and nurses will gently deflate it, lest it turn purple and fall off. Treating impotence may be as easy as adjusting the dose of your drug, or counteracting its side effects with another medication such as bethanocol, testosterone replacement or yohimbine. A dry mouth can make HIVers more vulnerable to gum infections, so pilocarpine might be needed to induce salivation. ("What's that?" you say. "Yet another addition to the pill regimen?" Get over it. Your standing in the HIV community is directly proportional to the size of your pill box. Use your new-found status to commandeer the comfiest seat in your support group.)

Antidepressants may take up to eight weeks to work their magic. However, because of individual variations in chemistry, there's a 30 percent to 50 percent chance that any one drug may have no effect, or only a transient one. In that case, keep trying meds until you find one that works. The first medication I tried was the venerable Prozac, which comes in menacingly pointed little green-and-yellow capsules. For a month and a half I endured tics and twitches and -- the most ironic side effect of all -- an increase in the very anxiety I was hoping to eradicate. Eventually, I gave up. Sorry, Prozac.

Next came Wellbutrin, a friendly sounding pill from good ol' Burroughs-Wellcome. No dry mouth, soft dick or hard stools from this drug, but there was a persistent ringing in my ears (tinitus). This wouldn't have been so bad except that the pitches were different in each ear, and the tones most inharmonious. Then things got really strange. It was fun at first; I'd have wonderfully vivid dreams and my ability to visualize text-book layouts at work took on an incredible photographic clarity. So did the rats that crawled out of my mattress every night and the furniture that danced around the bedroom and walked across the ceiling. Just what I needed, the wee hours of night choreographed by David Lynch. When asked, my shrink sheepishly admitted that all antidepressants have psychoactive effects, but in most people they go unnoticed. My personal light-show was just the price of being such a sensitive young lad, I suppose, but I could have done without this confirmation of my delicate nature. Goodbye, Wellbutrin.

Finally, there was Zoloft. Sweet Zoloft. Gentle Zoloft. Three's the charm for Zoloft, three cheers for Zoloft. I've been on it ever since.

While you're waiting to see if the first round of antidepressants works, you, your therapist and your doctor should go over your medical records and get inside your head. Think of depression and HIV as a big tangle of string. You're not going to undo it by yanking from any one direction, but thoughtful problem solving from several different angles might work. Here are some things worth talking about:

- HIV attacks in the prime of life. Young and middle-aged people aren't supposed to become decrepit. While oldsters can usually get away with whining about hair loss, lack of libido, stiff joints and adult diapers in public, HIVers may not be accorded the same courtesy. Don't take your health problems as a personal insult.
- Uncertainty about the future can be a source of chronic worry. You may become so wrapped up in thoughts of death that you may not know what to do with your life two or three years after diagnosis. You may have to pay that credit-card debt after all. Don't burn any bridges unless you're absolutely sure you won't need to cross back.
- If it hasn't already happened, anticipate that the second major bout of an opportunistic infection may depress you much more than the first. After having fought one health crisis, it's as though your hard-won normalcy has been snatched away.
- For a variety of reasons, attending physicians may take hospitalized patients off antidepressants during their stay. If hospitalization is a likely possibility, an antidepressant with a long half-life (Prozac or Zoloft, for example) is less likely to cause withdrawal effects in the short term.

- Nutrition deficiencies can cause or abet depression. Talk to a dietitian or doctor about B vitamins, iron and zinc. People dealing with chronic illness may need extra protein and fats, so eat a nutritious, high-energy diet. Take an active role in your health, both in and outside the doctor's office. Friends, teasing about your life of leisure, don't realize that treating the condition that put you on disability is at least a part-time job.
- Our moods ebb and flow throughout the day. Try to work with the current instead of against it. When a wave of anxiety, panic or despondency hits, don't resist it rigidly. Rather, bend with it, let it wash around you, and you may be surprised to find yourself still standing after it has passed.

As you can see, depression is not a stand-alone affliction, to be treated without regard to an HIVer's other health problems. Your mental problems are your physical problems. This is especially true for pain, whether it's the Polynesian fire walk of peripheral neuropathy or more mundane aches. It's no surprise that chronic pain can worsen depression, but depression can exacerbate the effects of neuropathy and other discomforts as well. Yet many doctors are afraid to treat pain aggressively for fear of addiction to narcotics. According to recent studies, however, the likelihood of someone being treated for long-term pain getting hooked on painkillers is small. Given the extent to which pain can sap your body's energy and healing ability, the risk might be worth it. (Oh hell, just ask for Demerol and enjoy the ride.) In addition, neuropathy responds well to Elavil, a non-narcotic analgesic that was an early antidepressant. It's rarely prescribed for depression anymore, but it can raise one's pain threshold, lessening the amount of numbing painkillers one needs to function.

Depression may even make you question your sanity. Focusing all that attention on your own psychic misery can make you spacey about the surrounding world. It's not uncommon for people distracted by their depression to complain about objects slipping from their grasp or seeming to fall off the shelf when they walk by. (Piles of cantaloupes seem to have a personal vendetta against me.) One can lose track of time, leading to missed appointments or rotting leftovers in the refrigerator. Don't clam up for fear of dementia; talk to your physician and therapist about any weird experiences you're having. Although HIV may show up in the brain early in infection, most people who get demented don't do so until fairly late in the course of the disease.

Fear of pain and dementia leads some people to thoughts of killing themselves. All suicidal thoughts are not the same, however. Feeling like you don't deserve or desire to live is very different from thoughts of "rational" suicide to avoid unbearable pain or becoming an invalid. Given the variable nature of mood, you might not feel as bad in an hour or a day, so please try to stick it out. Rational suicide, on the other hand, can actually be an effective coping mechanism; this option has given me a sense of control over the quality of my own life. And after reaching the milestone I had previously set as the point where I'd check out, I found that I had the strength of

will to hold out a little longer.

But self-deliverance is so...*depressing*. We'll save that for a rainy day. Meantime, how am I doing? Am I cured? For the most part, yes, thank you. It's a matter of constant maintenance, like the rest of my HIV-influenced health. I still won't watch that damn movie, *Private Idaho*, but I enjoy most everything else.

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