AIMS Medical Science

AIMS Medical Science, 9(3): 447–449.
DOI: 10.3934/medsci.2022023
Received: 05 September 2022
Revised: 08 September 2022
Accepted: 08 September 2022
Published: 14 September 2022

http://www.aimspress.com/journal/medicalScience

Editorial

Series introduction: HIV/AIDS and mental health

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Keywords: biosocial; burden of illness; HIV/AIDS; mental health; PLWHA; syndemic(s); substance use

As we enter the fifth decade of the human immunodeficiency virus (HIV) pandemic, HIV continues to cause substantial morbidity, particularly in populations with disproportionate and sustained exposure to structural inequities. This is repeatedly observed when the interplay between HIV infection and psychiatric illness is examined, particularly in the context of noxious social conditions. However, when the HIV epidemic evolved in the 1980s, it was largely recognized as an isolated disease and psychiatric features were largely relegated to the psychological impacts of the adjustment reaction to a positive diagnosis and the stigma of living with HIV. It has since become evident that HIV infection has notable neuropsychiatric sequelae throughout the course of illness, is transmitted through complex biosocial interactions which play an instrumental role in shaping the course of illness, and effective management requires integrated and intersectional approaches to care [1–6].

Although the high case fatality rate that initially characterized the illness has since plummeted, there are still 1.5 million new cases a year globally (UNAIDS), with a disproportionate number of the cases occurring amongst marginalized and stigmatized populations [7]. This is further exacerbated by COVID-19 pandemic related health service reductions and delays, redirected public health foci, increased social isolation and deepening fractures in public infrastructure in the context of the ongoing COVID-19 Pandemic. The unique impact of the COVID-19 Pandemic on people living with HIV/AIDS (PLWHA) is further explored in this Series.

The advent of highly active antiretroviral therapy (HAART) has resulted in the transformation from acute infectious illness to a post-acute era in which HIV infection is a chronic disease that faces a new challenge: ageing with HIV. This Series explores ageing with HIV and elucidates the unique

needs of PLWHA as they age with a chronic disease. Ageing with HIV is associated with increased risks of neurocognitive impairment which is heightened by treatment non-adherence [8,9], yet psychiatric care is still a lagging component of HIV care. Care should ideally be delivered through an integrated multispecialty care model in order to optimize patient outcomes, particularly as multisystem morbidity is the norm rather than the exception with chronic HIV infection.

Despite the longevity conferred by treatment, PLWHA continue to experience significantly increased rates of psychiatric illness, which is not well accounted for by the traditional biomedical model. Rather, the elevated rates of psychiatric illness amongst other adverse health conditions observed in the most vulnerable populations of PLWHA reflect a dynamic state of synergistic epidemics, or syndemics [1–6]. The process of syndemogenesis is characterized by distinct synergistic biosocial processes in which adverse environmental contexts interact with the biopsychosocial disease process to yield a multiplicative effect of excess disease burden clustered in vulnerable populations [1,2,5,10].

The complex biosocial environment, pervasive stigma of HIV, and the transmutation of these factors at the biologic level drive an excess burden of addictions and other psychiatric comorbidity in PLWHA. Conversely, people with persistent psychiatric illness are at increased risk of HIV infection. People with HIV and/or AIDS are uniquely vulnerable to psychiatric conditions both as a result of the pathophysiology of the infection itself, the experience of illness and the neuropsychiatric sequelae of antiretroviral medication [5,11–14]. The experience of illness encompasses significant adjustment reactions associated with a new HIV diagnosis, anxiety and depressive disorders associated with living with HIV/AIDS, neuropsychiatric sequelae of HAART, substance use disorders as a maladaptive means of coping with the diagnosis as well as the role of substance use as a syndemic generator in the acquisition and clustering of HIV with other conditions.

The complex psychiatric synergies associated with HIV/AIDS constitute a core component of the burden of living with HIV/AIDS, with considerable impact on transmission, disease progression and severity, treatment costs, adherence to treatment, and prognosis [2,5,8,9,11–14]. As such, the interaction of HIV/AIDS and psychiatric disorders constitutes an essential area in which further momentum is required. This special issue will focus on the complexities of HIV infection and mental health, explored through the following topics in the Series:

1. HIV Psychiatry—the missing link to HIV prevention and comprehensive care
2. Syndemogenesis: a dash of exclusion, a pinch of inequity and a heaping spoon of synergistic interactions: exclusion, inequity and syndemogenesis
3. HIV, multisystem morbidity and mental health
4. Ageing with HIV: neurocognitive impacts
5. Neuropsychiatric sequelae of medication non-adherence
6. Compounding Impacts: the interplay between the COVID-19 pandemic and people living with HIV/AIDS
7. Substance use disorders and HIV/AIDS

Conflict of interest

The author declares no conflicts of interest in this paper.

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