

## \*Anxiety Disorders in HIV and Aging

- Many anxiety disorders can be addressed with SSRIs rather than benzodiazepines with fewer adverse consequences.
- If pharmacotherapy is indicated for acute control of anxiety, the short- to intermediate-acting benzodiazepines with no active metabolites are preferred.
- Non-benzodiazepine agents are preferred for longer-term anxiety control, when longer-term pharmacotherapy is judged to be warranted.

Anxiety disorders have not been studied as well as HAND or depressive spectrum disorders in HIV infection but would seem to be fourth in frequency amongst HIV infected patients – behind HAND, depressive spectrum disorders, and alcohol/substance use disorders and have been shown to be increased in likelihood with HIV infection (Lopes et al., 2012). Adjustment disorder is frequently noted after initial notification of HIV infected serostatus and may be the most common psychiatric disorder manifesting primarily with anxious mood. General medical causes of anxiety must be considered, including the early stages of pneumonia. Generalized anxiety disorder and panic disorder have been documented in 15.8% and 10.5% of HIV seropositive persons versus 2.1% and 2.5% of the general population, respectively (Bing 2001). Post-traumatic stress disorder has also been reported at a higher rate among the HIV infected (Israelski et al. 2007). This is particularly true for women, in whom a history of trauma could, in turn, relate to a decreased sense of empowerment and a decreased likelihood of negotiating HIV precautions with sexual partners. In a study examining age differences, the rate of anxiety disorders (panic disorder and generalized anxiety disorder) and PTSD were found to be somewhat more frequent

in younger patients (at 22.5% and 16.1%) vs. older patients (at 17.7% and 6.6%, respectively (Zanjani et al. 2007). Anxiety symptoms have been specifically noted to threaten adherence measured by missed ARV doses, although older age was associated independently with a greater likelihood of maintaining the schedule of taking ARVs (Schönnesson et al. 2007).

In one recent study, 47% of patients demonstrated significant anxiety symptoms, Patients showing such anxiety symptoms had a high number of ARV switches (i.e., were at the fourth line or more) (Celesia et al, 2013). Psychopharmacotherapy for the anxiety disorders in HIV infected persons should be avoided whenever possible, particularly for older patients. Cognitive behavioral stress management, guided imagery, progressive muscular relaxation training, self-hypnosis, biofeedback, and other such behavioral techniques are preferred. However it may be useful to employ psychopharmacotherapy in low doses to support the older patient's sense of control and autonomy.

The most common anxiolytic therapies used – the benzodiazepines – are sedating, interact with alcohol, foster dependence, and are associated with drug

interactions on the cytochrome P450 (CYP450) 3A4 isoenzyme system (strongly inhibited by the protease inhibitors). If needed, on an ongoing basis, the SSRIs are generally preferred to the benzodiazepines. For short-term treatment, short- to intermediate-acting benzodiazepines with no active metabolites, such as lorazepam and oxazepam, may be employed. Buspirone is an option to consider that is non-sedating, safe in overdose, and has no abuse potential, although it does suffer from a delay in onset of action. Other options with no abuse potential include hydroxyzine, diphenhydramine, pregabalin and the nutritional supplement, valerian.

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