Psychiatric Challenges Related to HIV for Patients and Carers

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DISCLAIMER

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HIV in Psychiatric Illness

Mental Disorders in People Living with HIV/AIDS (PLWHA)

- Mental disorders are highly prevalent in PLWHA, with **depression occurring nearly twice as often** as in the general population.
- Common mental disorders (CMDs) include **depression, anxiety, and substance use disorders**.
- In South Africa, **26–38%** of PLWHA have a CMD compared with **12.6%** of the general population.
- Overall, **20–60%** of PLWHA experience a psychiatric disorder, with depression being the most common.
- HIV and mental illness have a **bidirectional relationship**: mental illness may increase HIV risk, while HIV-related CNS effects, psychosocial stressors, stigma, and ART side effects may contribute to mental illness.
- CMDs are associated with **poor ART adherence**, **higher viral loads (>200 copies/mL)**, and poorer treatment outcomes.
- Despite the high burden of co-morbidity, access to HIV treatment may be limited due to concerns about adherence and medication-related neuropsychiatric effects.

Mental Health and HIV

Why Are Mental Illness Rates Higher in People Living with HIV?

- **Bidirectional relationship:** Mental illness increases HIV risk, and HIV increases the risk of mental illness.
- **Mental illness as a risk factor for HIV:**
  - Increased sexual risk-taking behaviours
  - Higher rates of substance use
  - Impaired judgment and decision-making
  - Greater exposure to high-risk social networks
- **HIV as a cause of mental illness:**
  - Direct neurological effects causing cognitive and behavioural changes
  - Psychological impact of living with a chronic illness
  - Stigma, discrimination, and social isolation
- **Common predisposing mental disorders:**
  - Cognitive disorders (intellectual disability, dementia, brain injury)
  - Mood disorders (depression, bipolar disorder)
  - Psychotic disorders (e.g., schizophrenia)
  - Personality disorders (especially borderline and antisocial)
- **Consequences of untreated mental illness:**
  - Poor adherence to HIV treatment
  - Reduced self-care and functioning
  - Difficulties maintaining employment, housing, and relationships
- **Clinical importance:** Early detection and treatment of mental illness may reduce HIV risk behaviours and improve overall HIV outcomes.

Neurobiology

- HIV enters the CNS early and infects **microglia and macrophages**.
- Infected cells release **inflammatory cytokines** and neurotoxic substances, causing **neuroinflammation**, neuronal damage, and white matter injury.
- Damage is most evident in **subcortical and fronto-striatal brain regions**, resulting in cognitive, behavioural, and emotional disturbances.
- Shared mechanisms underlying psychiatric and neurological disorders include:
  - Neuroinflammation
  - Immune dysregulation
  - Microglial activation
  - White matter compromise
- HIV can worsen psychiatric symptoms and cognitive impairment, while pre-existing psychiatric disorders increase vulnerability to HIV.
- Clinical manifestations include:
  - HIV-Associated Neurocognitive Disorders (HAND)
  - Depression and other psychiatric disorders
  - Cognitive decline resembling Alzheimer's disease
  - Parkinsonian features (bradykinesia, rigidity, gait disturbance)

Management of Psychiatric Conditions in HIV

- Engagement and therapeutic rapport
- Identify and contain risks and consider need for involuntary treatment.
- Obtain further history from family or partner, as indicated.
- Notify child protection agencies, if indicated.
- Consider need for referral to specialist care.
- Exclusion of organic illness
- Further physical examination and investigations, as indicated

Approach to Management of Psychiatric Conditions

Biological

- Identify and treat underlying psychiatric illness e.g. antidepressants, mood stabilisers, antipsychotics, as indicated.
- Consider use of short-term anxiolytic or hypnotic drug to contain symptoms and aid engagement.
- Consider need for drug or alcohol withdrawal regimen, if indicated.
- Monitor for medication side effects and review adherence.

Psychological

- Educate the patient about identified illness and recovery plan.
- Determine if specialist psychological approaches are required: short-term cognitive behavioural, or interpersonal therapy and longer-term psychodynamic approaches, as indicated.
- Instigate partner and family interventions, as indicated.
- Consider motivational interviewing as an approach to drug and alcohol dependence.
- Consider if a neuropsychology assessment is required.

Social

- Consider role of multidisciplinary team, including the role of social workers in housing, financial support, employment, relationships (support groups) and home supports to reduce stressors.
- Consider need for support from drug and alcohol services.

Major Depressive Disorder

- Depression is one of the most common psychiatric disorders in PLWH.
- In South Africa, up to **25%** of PLWH experience depression:
  - **5–10%** Major Depressive Disorder (MDD)
  - **15–20%** Minor depressive disorders
- HIV-positive individuals have approximately **twice the risk** of major depression compared with HIV-negative individuals.
- Risk factors include:
  - Female gender
  - Personal or family history of mood disorders
  - Substance use and anxiety disorders
  - Low social support
  - Psychosocial stressors
  - Current medical illness and unsuppressed viral load
- Depression may occur at critical periods, particularly:
  - Following HIV diagnosis
  - During advanced stages of illness
- Consequences of depression:
  - Poor treatment adherence
  - Reduced engagement in care
  - Self-neglect
  - Increased suicidal ideation and behaviour
- **Routine screening and early treatment** of depression improve HIV-related outcomes and overall wellbeing.

Grief vs Depression in HIV

- Grief is a normal response to loss.
- HIV-related losses may include health, relationships, independence, and bereavement.
- Grief is influenced by individual, cultural, religious, family, and social factors.
- **Complicated grief** involves prolonged, intense grief that impairs daily functioning.
- Early recognition and support are important

Differentiating Grief/Bereavement from Depression

Grief/Bereavement	Depression
Expected, culturally accepted response to loss	Diagnose depression only when depressive symptoms persist for **2 months or longer**
Guilt is focused on an aspect of the loss	Guilt is preoccupied with a negative self-image
Moments of pleasure and happiness	Feelings of emptiness and despair are constant
Preoccupation with the deceased	Preoccupation with self
Not demoralising or humiliating	Demoralising and humiliating
Overt expression of anger	Anger is not as pronounced
Diminishes in intensity over time	Consistent sense of depletion
Suicidal gestures are rare	Suicidal gestures are not unusual
Responsive to support	Unresponsive to support
Elicits sympathy, concern and a desire to embrace	Elicits irritation, frustration and a desire to avoid from others
Usually functions	Inability to function at work, home and/or school

Screening for Psychiatric Conditions- PHQ-9

Over the past 2 weeks how often have you been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep; or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching TV	0	1	2	3
8. Moving or speaking so slowly that others could have noticed. Or the opposite - being so fidgety and restless that you have been moving around a lot more than usual	0	1	2	3

Over the past 2 weeks how often have you been bothered by any of the following problems	Not at all	Several days	More than half the days	Nearly every day
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Add columns				
Total				
0 - 4: No depression 5 - 9: Mild depression 10 - 14: Moderate depression 15 - 19: Moderately severe 20 - 27: Severe				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you checked any of the problems, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people				

Total score:

Total score	Depression severity
0 - 4	No depression
5 - 9	Mild depression
10 - 14	Moderate depression
15 - 19	Moderately severe depression
20 - 27	Severe depression

Risk Assessment- SAD PERSONS Scale

- Prevalence of suicide ideation was also higher among HIV positive carers (15.1%) and carers living with someone with HIV (13.9%) compared to carers living in HIV-free households (11%)

- Unlike high-income countries where psychiatric disorders are the main drivers of suicide, in low-resourced settings such as South Africa, socio-economic factors—including unemployment and food insecurity—play a major role in suicidal behaviour.

SAD PERSONS Scale - Score Card

Letter	Risk factor	Description
S	Sex	Male gender represents a higher risk
A	Age	Extremes of age are at higher risk, e.g. under 18 years and over 55 years
D	Depression	Depression or other psychiatric comorbidity increases risk
P	Previous attempts	Those with a history of suicide attempts are at higher risk
E	Ethanol	Alcohol or other substance use/abuse
R	Rational thinking loss	E.g. psychosis with command hallucinations
S	Social support	No social support confers a higher risk
O	Organised plan	Presence of an organised plan
N	No spouse	No spouse
S	Sickness	Medical or psychiatric illness may confer a higher risk

SAD PERSONS Scale Score Card

Score	Recommended action
0–2 points	The patient may be sent home, but follow-up must be ensured
3–4 points	Close follow-up must be ensured and hospitalisation considered
5–6 points	Hospitalisation is strongly considered
7–10 points	Ensure hospitalisation and consider involuntary admission if necessary

Anxiety Disorders

- Anxiety disorders are common in PLWH and may affect **20–60%** of patients.
- Common disorders include:
  - Generalised Anxiety Disorder (up to 15%)
  - Panic Disorder (up to 10%)
  - Social Anxiety, Agoraphobia, and PTSD
- Anxiety often worsens during HIV diagnosis, disease progression, and major life stressors.
- Risk factors:
  - Female gender
  - Perceived stigma
  - Poor social support
  - Chronic pain
- Consequences:
  - Poor treatment adherence
  - Increased high-risk behaviours
  - Reduced quality of life
- **Treatment:**
  - Cognitive Behavioural Therapy (CBT)
  - Relaxation and breathing techniques
  - Stress management and psychosocial support
  - SSRIs (first-line pharmacotherapy)
  - Mirtazapine or Venlafaxine when indicated
- Early recognition and treatment improve both mental health and HIV outcomes.

Bipolar Disorder

- Severe mental disorders are common in HIV:
  - 2.6–59.3% prevalence in people with SMDs (sub-Saharan Africa)
  - SMDs in up to 15% of PLWH
  - New-onset psychosis: 0.2–15.2%
- Mania may be:
  - Primary (bipolar disorder) or secondary to HIV, CNS infections, ART, substance use, or delirium
  - More common in advanced HIV (low CD4, high viral load)
- Clinical features:
  - Irritability, agitation, disinhibition
  - Talkativeness, poor concentration, cognitive slowing
  - Possible psychosis
- Exclude: CNS infection, drugs, substance use, delirium
- Treatment:
  - Optimise ART
  - Mood stabilisers (lithium, sodium valproate)
  - Atypical antipsychotics
  - Short-term benzodiazepines
  - Hospitalise if severe; monitor interactions and toxicity

Psychotic Disorder

- Conduct a comprehensive **risk assessment** and determine the appropriate treatment setting (outpatient vs. inpatient care).
- Ensure close collaboration between **HIV and mental health services**.
- Promote adherence to both **antipsychotic medication** and **ART**.
- Most antipsychotics can be used safely with ART, but **drug interactions** should be monitored.
- Patients with HIV may be more susceptible to **extrapyramidal side effects (EPS)** due to CNS involvement.
- **Atypical antipsychotics** are generally preferred:
  - Olanzapine
  - Quetiapine
  - Risperidone
- Monitor for **metabolic side effects**, including:
  - Weight gain
  - Hyperlipidaemia
  - Glucose abnormalities/diabetes
- Regular clinical and laboratory monitoring is recommended.

Neurocognitive Disorders

- HIV neuro-invasion causes a spectrum of HIV-Associated Neurocognitive Disorder (HAND):
  - Asymptomatic Neurocognitive Impairment (ANI)
  - Mild Neurocognitive Disorder (MND)
  - HIV-Associated Dementia (HAD/HIV-D)
- Cognitive features:
  - Psychomotor slowing
  - Memory and attention impairment
  - Executive dysfunction
  - Language/visuospatial deficits
  - Behavioural apathy
- Epidemiology:
  - MND: 42.4% pre-ART; 25.4% on ART (South Africa)
  - HIV-D: 35/1,000 person-years untreated; 3/1,000 on ART
- Impact:
  - Poor ART adherence
  - Reduced work performance and unemployment
  - Impaired daily functioning and quality of life
- Prevention:
  - Early HIV diagnosis, timely ART initiation, and adherence support reduce HAND burden

Screening for Neurocognitive Disorders

Simioni Neurocognitive Symptom Questions

Ask the patient the following questions. Each answer should be **“Never,” “Hardly ever,”** or **“Yes, definitely.”** Any **“Yes, definitely”** answer equals a positive screen.

Question	Never	Hardly ever	Yes, definitely
Do you experience frequent memory loss, for example, forgetting special events, recent appointments, etc.?	☐	☐	☐
Do you feel that you are slower when reasoning, planning activities or solving problems?	☐	☐	☐
Do you have difficulties paying attention, for example, to a conversation, a book or a movie?	☐	☐	☐

Screening Tests

- There is no globally accepted screening policy or practice

Other tools proposed for use include:

- International HIV Dementia Scale (IHDS) (validated in SA)
- Montreal Cognitive Assessment (MOCA)
- the HIV-Dementia scale
- Cognitive Assessment Tool – Rapid Version (awaiting validation)
- A positive screen does not equate to a diagnosis of HAND; three further steps are required for clinical confirmation

Diagnostic Approach to HAND

Table 4. Three-step diagnostic approach to HAND in clinical practice

Step*	None	Mild - moderate	Severe
1. Is neuropsychological impairment present? (use symptom questions and at least one brief objective measure e.g. IHDS, MMSE, HDS, MoCA)	☐	☐	☐
2. To what extent are confounding illnesses contributing to the neurocognitive disorder? (depression, alcohol abuse, head injury, epilepsy, nutritional deficiency, CNS OI and neurosyphilis)	☐	☐	☐
3. Is functional impairment present? (measure basic daily activities including pill-taking and complex tasks, e.g. cleaning, cooking, shopping, money management, work tasks or driving)	☐	☐	☐

IHDS = International HIV Dementia Scale; MMSE = mini mental state examination; HDS = HIV dementia scale; MoCA = Montreal Cognitive Assessment; CNS = central nervous system; OI = opportunistic infection; HIV-D = HIV-dementia; MND = mild neurocognitive disorder; NP = neuropsychological; HCWs = healthcare workers; CT = computed tomography.

Clinicians then need to confirm whether HIV-D or MND is present:

- HIV-D: severe NP impairment + at least mild - moderate functional impairment +/- mild - moderate contribution from confounders.
- MND: either Severe NP impairment + no reported functional impairment, or mild - moderate NP impairment + at least mild - moderate functional impairment.

* Notes: Step 1: Clinicians may perform more advanced neuropsychological testing or combine bedside tests. Primary HCWs may refer patients for such detailed assessment.
Step 2: If clinical examination reveals no focal abnormality or comorbid medical conditions, lumbar puncture, CT scanning and blood tests rarely add diagnostic information. If delirium, confusion or psychiatric/behavioural symptoms are present, these further investigations are mandatory. Actively manage underlying confounding conditions.
Step 3: The extent of functional impairment is often under-rated – seek objective measures including third-party reports and clinical assessment of simple tasks where possible.

Assessment of Neurocognitive Disorders

HIV-Associated Neurocognitive Disorders (HAND)

- Commonly affected cognitive domains:
  - Working memory
  - Attention
  - Information processing speed
  - Active information retrieval
- Clinical presentation varies with severity:
  - **Mild:** Difficulty with complex cognitive tasks
  - **Moderate:** Slowness, apathy, and reduced efficiency
  - **Severe (HAD):** Marked cognitive decline, disinhibition, apathy, and motor dysfunction
- Despite ART reducing morbidity and mortality, cognitive impairment remains common in HIV.

Frascati Classification of HAND

Category	Cognitive Impairment	Functional Impact
ANI (Asymptomatic Neurocognitive Impairment)	≥2 cognitive domains impaired (>1 SD below mean)	No functional impairment
MND (Mild Neurocognitive Disorder)	≥2 cognitive domains impaired (>1 SD below mean)	Mild functional impairment
HAD (HIV-Associated Dementia)	≥2 cognitive domains impaired (>2 SD below mean)	Marked functional impairment

HIV Associated Neurocognitive Disorder

Clinical Features of HAND

- **Cognitive decline** is often the earliest clinical sign of HAND.
- Early manifestations include:
  - Loss of motor skills and dexterity
  - Slowed movement (psychomotor slowing)
  - Poor coordination and tremors
- Progressive cognitive symptoms include:
  - Attention and concentration deficits
  - Memory impairment and delayed learning
  - Executive dysfunction
- Behavioural and psychosocial changes:
  - Irritability
  - Apathy and social withdrawal
  - Reduced interest in previously enjoyed activities
  - Symptoms may be mistaken for depression
- **HIV-Associated Dementia (HAD)** is the most severe form of HAND and is typically associated with:
  - Advanced HIV disease
  - Low CD4+ lymphocyte counts
  - Marked cognitive, behavioural, and functional impairment.

Delirium

- Sudden change in cognition suggests delirium
- Common in advanced HIV and hospitalised patients (up to 22%)

Key features:

- Fluctuating level of consciousness
- Impaired attention and concentration
- Disorientation (time/place)
- Variable course with lucid intervals
- May include hallucinations (any modality) and delusions

Assessment & investigations:

- Clinical exam: head trauma, focal neurological signs, tremor, ophthalmological exam
- Initial tests: FBC, ESR/CRP, U&E, LFTs, thyroid function, glucose, urinalysis, drug screen, medication levels, chest X-ray
- Infectious work-up: toxoplasma, CMV, HSV, syphilis serology, cryptococcal antigen, blood cultures
- Further tests: B12/folate, ABGs/pulse oximetry
- CSF analysis (HIV RNA, opportunistic infections)
- Brain imaging (CT/MRI)
- EEG

Treatment of Delirium

Treatment guided by investigation findings; cause may remain unidentified

- General management:
  - Environmental measures: adequate lighting, orientation cues, limit staff changes
  - Reduce agitation and support sleep–wake cycle
- Medication:
  - Antipsychotics commonly used (start low, titrate carefully)
  - Parenteral treatment may be needed occasionally and used cautiously
  - Benzodiazepines only indicated in alcohol withdrawal delirium
- Caution:
  - Benzodiazepines should be used carefully due to interactions with antiretroviral therapy
  - Risk of confusion, excessive sedation, and ataxia

Substance Use Disorders

- Substance abuse increases HIV risk (direct: needle sharing; indirect: impaired judgment) and is highly prevalent in PLWH (≈50–75%)
- Common psychiatric comorbidity → requires integrated, coordinated assessment
- Clinical approach:
  - Empathic history and harm reduction education
  - Assess readiness to change (Stages of Change)
  - Psychological/psychosocial interventions ± pharmacological treatment (specialist input)
  - Alcohol withdrawal may require supervised detox
- Epidemiology:
  - ~24% of PLWH have SUDs
  - Most common: alcohol, tobacco (then cannabis, opioids, others)
- Risk factors:
  - Poor attendance, ART non-adherence, unsuppressed viral load
  - Male sex, unemployment
- Impact:
  - Poor ART adherence and worse HIV outcomes
  - Routine SUD screening recommended

Combined Psychiatric Disorders

- People living with HIV often experience multiple interacting psychiatric and neurological disorders (psychiatric–neurologic multimorbidity)
- These conditions do not occur in isolation and follow a syndemic pattern, driven by shared inflammatory, neurotoxic, and neurodegenerative processes
- PTSD commonly co-occurs with substance use (alcohol, tobacco, illicit drugs), contributing to poorer clinical outcomes
- Nearly 1 in 5 heavy alcohol users may have probable PTSD; lifetime smoking is independently associated with PTSD symptoms
- PTSD, substance use disorder, and major depressive disorder (MDD) frequently co-occur and worsen disease complexity
- Generalised anxiety disorder (GAD) is a strong independent predictor of MDD in PLWH (very high association), suggesting shared or mutually reinforcing pathways
- PTSD also commonly co-exists with MDD
- HIV-associated neurocognitive disorder (HAND) and MDD frequently overlap
- Depressive symptoms are associated with worse neurocognitive performance, particularly in HAND-related domains
- Overall, psychiatric and neurological comorbidities interact to increase disease burden, reduce quality of life, and negatively affect ART adherence

Principles of Pharmacotherapy

- Clinicians must understand psychotropic medication use in HIV due to high risk of drug–drug interactions and side effects
- Many antiretroviral drugs (especially protease inhibitors and NNRTIs) are metabolised via CYP450 3A4 and 2D6 enzymes
- These enzymes can be inhibited or induced by both ART and psychotropic medications, increasing interaction risk
- Altered serum protein binding in HIV patients may change free drug levels and effects
- Careful prescribing is required, with consultation of updated drug references or pharmacists
- Common psychotropic medication considerations:
    a. SSRIs are commonly used for depression and anxiety
    b. Preferred SSRIs due to fewer interactions: citalopram, escitalopram, sertraline
    c. Benzodiazepines are used short-term; prefer shorter half-life agents (lorazepam, oxazepam, temazepam) due to prolonged effects with interactions
    d. Mood stabilisers (valproate, carbamazepine) and antipsychotics may interact with ART and require caution
    e. Lithium is not hepatically metabolised but requires close monitoring due to narrow therapeutic window

Antiretroviral medications may also affect mental health:

- Some can influence mood and sleep
- Efavirenz is associated with neuropsychiatric side effects, including sleep disturbance and suicidality
- Evidence shows approximately a two-fold increased risk of suicidal thinking/behaviour with efavirenz-based regimens

Clinical considerations when using efavirenz:

- Take history of mental illness and suicidal/self-harm behaviour into account
- Ensure mental health support is integrated into the treatment plan
- Monitor closely when used in at-risk patients

Medications

Successful ART associated with: no substance abuse, no homelessness/incarceration, retention in psychiatric care, adherence to psychiatric treatment, and regular mental health follow-up (reduces ART discontinuation)

- ART in mental illness should follow standard national guidelines
- Efavirenz (EFV):
  - Can be used in many CMDs and some SMDs; not routinely avoided
  - Advantages: lower pill burden, fewer drug–drug interactions, favourable vs nevirapine/lopinavir-ritonavir
- EFV side effects:
  - Common: vivid dreams, dizziness (resolve in 2–4 weeks; reassure)
  - Less common: anxiety, agitation, abnormal thinking, suicidal ideation, mania, psychosis
- EFV considerations:
  - Switch if persistent psychosis or intolerable side effects
  - Use in acute psychosis/severe depression is controversial; monitor closely
- Clinical precautions:
  - Do not delay ART for mental illness treatment
  - Screen for depression/anxiety
  - Inform patients about neuropsychiatric effects
- Neuropsychiatric risks of ART:
  - HIV CNS inflammation and ART neurotoxicity contribute to symptoms
  - NRTIs: neurotoxic (e.g. didanosine, stavudine)
  - NNRTIs (EFV): frequent neuropsychiatric effects
  - Integrase inhibitors (e.g. dolutegravir): better tolerated but may cause insomnia, anxiety, depression
  - Prefer lower CNS toxicity regimens where possible

Psychosocial Aspects for Patients

- Mental health disorders in this population are driven by clinical and psychosocial factors
- Key contributors: stigma, poor social support, substance use, and opportunistic infections (e.g., cryptococcal meningitis in advanced HIV)
- Impulse control and behavioural/conduct disorders may increase HIV risk via high-risk behaviours (unprotected sex, multiple partners, substance use)
- Epidemiology:
  - Age 18–25: higher anxiety rates
  - Men: >2× higher depression rates than women
  - Illiteracy: strongly associated with anxiety
  - Unemployment and low/moderate social support: increased depression and anxiety
- Cultural context, healthcare access, and socioeconomic status influence psychiatric comorbidity patterns and severity

Doctors’ Perspectives

- Managing a life-threatening disease can negatively affect doctors’ emotional well-being
- Stigma and patient-related fears contribute to psychological stress
- Ongoing care of chronic conditions may lead to burnout and compassion fatigue
- High treatment and follow-up demands can cause exhaustion and poor work–life balance
- Healthcare workers may experience stigma, particularly in high HIV-stigma settings
- This stigma can result in social isolation professionally and personally
- Negative perceptions from colleagues and communities may occur due to treating HIV-positive patients
- Healthcare worker frustration may arise from clinical workflow pressures and an overburdened system

Doctors' Experiences

- Healthcare workers may experience emotional and psychological effects from cumulative occupational stressors in the health sector
- Self-care is essential for effective patient care, yet stigma may prevent recognition and disclosure of burnout and vicarious trauma

Table 6. Symptoms of HCW burnout and vicarious trauma

Burnout	Vicarious trauma
Individual level	**Individual level**
• Overextended emotionally and physically by his/her work environment	• Feeling overwhelmed/helpless when hearing patients' trauma stories
• Responds to colleagues/patients in an impersonal way	• Feeling ineffective, unskilled and/or powerless
• Feels no sense of accomplishment in anything that he/she does	• Intrusive imagery of the trauma stories that they hear about
• Physical exhaustion: fatigue; insomnia; weight fluctuations	• Hyperarousal
• Emotional exhaustion: feeling responsible; psychosomatic symptoms	• Avoidance of places, people or work
• Psychological exhaustion: compassion fatigue	• Feeling angry and irritable
• Absenteeism	• Disconnect from other staff members
Organisational level	**Organisational level**
• Absenteeism and high staff turnover	• Impact of trauma stories on staff not acknowledged/recognised
• Disengaged from colleagues/patients	• Disengaged from colleagues/patients
• Increased team conflict	• Increased team conflict/poor teamwork
• Insufficient staff training/technical ability and lack of resources	• Insufficient training of staff to manage emotional impact of trauma

Nurses' Perspectives

CATEGORIES	SUB-CATEGORIES
Experiences of fear caring for MHCUs living with HIV/AIDS	Fear of being infected by MHCUs Fear of being attacked by MHCUs
Experiences of aggressive behaviour of MHCUs living with HIV/AIDS	Lack of insight into condition by MHCUs Aggressive outbursts of MHCUs place nurses at risk Intention to resign due stress of caring for MCHUs Emotional turmoil in caring for MHCUs living with HIV/AIDS
Experiences of difficulties in caring for MHCUs living with HIV/AIDS	Lack of support from management Attitude of personnel towards HIV positive MHCUs Duty to care
A need for support in caring for MHCUs living with HIV/AIDS	Continuous professional development Teamwork/support for each other

Burnout

- Prolonged emotional work leads to burnout: emotional exhaustion, depersonalisation, and reduced professional fulfilment
- Risk factors: high workload, difficult patients, healthcare worker empathy/personal factors, lack of control an self-care, poor organisational support, and low salaries
- Untreated burnout may progress to depression or chronic fatigue
- Can be assessed using the Maslach Burnout Inventory or the Oldenburg Burnout Inventory

- Vicarious trauma: repeated exposure to trauma leads to intrusive thoughts, avoidance, hyperarousal, and emotional distress (e.g., anger, helplessness, guilt)

Management (3 R's):

- Recognise early signs
- Reverse with stress management and support
- Build resilience through self-care and recovery (slow down, re-evaluate, seek support)

Carers' Perspectives

- Caregivers experience occupational stress (burnout not always present)
- Key stressors:
  - Patient suffering, deterioration, and death
  - Heavy workload and financial burden
  - Lack of support and coping skills
  - Fear of infection, stigma, and discrimination
  - Caring for patients with mental illness/behavioural issues
  - Family conflict, orphan care, and caregiver health problems
  - Limited HIV knowledge
- Emotional responses:
  - Anxiety, depression
  - Sadness, helplessness, hopelessness
  - Anger, frustration, overwhelm
- Positive aspects:
  - Job satisfaction and purpose
  - Improved relationships and personal growth
  - Support from others and healthcare system
  - Cultural values (e.g., Ubuntu) supporting caregiving commitment

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thank You