Disorders associated with depressed mood have been estimated to occur in a majority of HIV infected patients over the course of infection. Depressive spectrum disorders frequently occur at the point that an HIV infected patient is confronted by greater HIV symptom burden (Atkinson et al. 2008; Sherr et al. 2008). The depressive disorders run the gamut from adjustment disorder to dysthymic disorder to major depressive disorder and bipolar affective disorder (with depressive episodes) with and without psychotic features. Data from the Veterans Aging Cohort 5-Site Study demonstrated that depression rates increased with age (Justice et al. 2004), although this is not without exceptions (Karl Goodkin et al. 2003; Rabkin et al. 2004). Social support is a critically important co-factor in examining a depression diathesis in the older HIV infected persons (Shippy & Karpiak 2005; Shippy & Karpiak 2005). Newly infected older HIV adults, in particular, may be isolated from supportive networks due to the stigma of HIV/AIDS and due to ageism and may suffer from higher incidence of depression. Untreated depression is a predictor of non-adherence to medication regimens, which in turn has an adverse effect on overall morbidity and mortality (Gonzalez et al. 2011).

The elevated physical symptom burden associated with depressive disorders and suicide risk may be further enhanced by psychoactive substance use and elevated pain level (Tsao et al. 2005) as well as with other psychiatric disorders and substance use disorders generally are at high risk for major depressive disorder (Berger-Greenstein et al. 2007), and older patients may be yet at greater risk. One must screen out other causes of depressive symptoms presenting in HIV infected patients, including HIV wasting syndrome and early HIV-associated depression (HAD) as well as iatrogenic causes (e.g., interferon-alpha toxicity in the treatment of HCV co-infection). Vitamin B12 deficiency has been associated with major depressive disorder in HIV infected patients (Baldewicz et al. 2000), and the treatment of vitamin B12 deficiency and possible vitamin B12 supplementation above normal levels may reduce risk of depressive spectrum disorders. Early HAD in an older patient typically presents with apathy, lethargy, and social withdrawal and may easily be confused with major depressive disorder (Goodkin 2009). It is important to note that major depressive disorder in older HIV infected patients may be treated with the same medications that would be indicated for younger patients. Side effect profiles and drug-drug interactions should be specifically considered in the choice of drug. Activating antidepressants with minimal effects on the CYP 450 isoenzyme system, such as venlafaxine, may be preferred. Of the selective serotonin reuptake inhibitors, paroxetine and citalopram would be preferred to fluoxetine.