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fyi voices

Voices of Positive Women's newsletter

Depression is a Serious Problem

by Shari Margolese

Depression is a serious problem for many HIV+ women. In fact, studies show that almost 60 percent of HIV+ women display clinical signs of depression and up to 75 percent display at least some depressive symptoms. HIV+ women are 20 percent more likely to be depressed than HIV+ men.

Many factors contribute to the high rate of depression among HIV+ women. Experts believe that lower household income, active drug use, alcohol use, and sexual and physical abuse may all add to the risk. Relationship status and social support may also be related to depression.

While scientists have linked chronic depression in women with a decline in CD4 cells, the specific connection is still unclear. However, clinical depression is one of the leading causes of non-adherence to HIV medications.

If you are experiencing depressive symptoms, you may be more likely to miss doses, take the wrong dose, or take the dose with the wrong food or at the wrong time. Non-adherence can lead to the development of resistance, which causes the HIV medications to be less effective at fighting the virus. This can cause your CD4 cells to go down and/or your viral load to go up.

Studies have shown that HIV+ women with depression are twice as likely to die as those with few or no depressive symptoms. Clearly, it is important that depression be diagnosed and treated as quickly as possible so that a more positive outcome can be achieved.

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Identifying Depression

Symptoms of depression include:

- Changes in appetite or weight
- Aches or pains
- Feelings of sadness, guilt, and/or low self-worth
- Irritability
- Lack of interest or pleasure in activities
- Low sex drive
- Thoughts of self-harm or suicide
- Difficulty making decisions or concentrating
- Changes in sleep patterns
- Fatigue or loss of energy

Some of the early signs of depression can be similar to those of HIV, making diagnosis more complex. Depression can also be confused with sadness. But compared to sadness, depression is more intense, lasts longer, and interferes more with your day-to-day functioning. Depression is not a normal part of being HIV+ and it is important to report any of the above-mentioned symptoms to your medical provider and discuss treatment options.

Sometimes substance use can mask depression. This happens when people try to "self-medicate" by using drugs or alcohol to make their problems go away. If you feel that an underlying issue, such as depression or anxiety, causes or contributes to your substance use, ask your doctor or AIDS service agency for a referral to a mental health professional.

Treatment Options

The good news is that depression is very treatable. Treatments include psychotherapy, medication, alternative therapies, or any combination of the three.

Various mental health professionals can provide psychotherapy, including psychologists, psychiatrists, and social workers. It may also be helpful to seek the support of other HIV+ women through support groups or peer counseling.

Antidepressant medications are often prescribed for depression or anxiety and have been shown to help decrease symptoms. Caution should be used when combining HIV medications with those for depression. Many of the popular kinds of antidepressant and anti-anxiety drugs can interact with some HIV medications.

Generally, the safest class of antidepressants for use with HIV medications is selective serotonin re-uptake inhibitors (SSRI's) such as Prozac, Zoloft, and Serzone. Popular herbal preparations used for depression that include St. Johns Wort should not be used with HIV medications.

Meditation, massage, yoga, breathing and relaxation exercises are all alternative therapies that may help you feel better. Acupuncture and acupressure therapies may help reduce stress and improve your mood. Good nutrition and exercise are beneficial, no matter which treatments you choose. Also have your testosterone level checked. Low testosterone can cause depression.

Many people, including members of some racial and ethnic minority groups, are skeptical about the value of mental health treatment. Even if you have heard family and friends say that people who see therapists or take antidepressants are "crazy" or weak, try not to let these prejudices prevent you from getting treatment that will make you feel and live better.

References

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ANTI-HIV AGENTS:

Unexpected impact of HAART on depression in some women with HIV/AIDS

by Sean R. Hosein

Because HAART has had such a dramatic impact on extending survival and reducing symptoms of HIV disease, some psychologists have assumed that HAART users would be at reduced risk for developing depression.

Research into the impact of HAART on depressive illness in PHAs has focused mostly on men. To try to understand the impact of HAART on depression in women with HIV/AIDS, researchers in New York City have been performing psychological tests both before and after HAART became available. The study team found that although the physical health of the women improved with HAART, there was not any major improvement in their psychological health.

Study details

Between 1994 and 1996, when HAART was largely unavailable, researchers recruited 146 women with HIV/AIDS and gave them a number of tests to assess their psychological health. The same tests were given to another group of 121 women with HIV/AIDS, interviewed between 2000 and 2002, when HAART was available. Researchers then carefully selected women with similar characteristics from both groups, matching their age, CD4+ count, health status, ethnicity and other factors. After trying to find similar matches, they were left with 74 women from each group, whose profile was as follows:

- average age – 37 years
- 40% were Black
- 31% were White
- 28% were Hispanic
- 47% had AIDS
- 43% had symptoms of HIV disease
- 10% were free from symptoms of HIV disease
- 46% had, at some point in their lives, injected street drugs
- about 67% had children who were living with them

Results

More than 50% of the women in either time period had symptoms suggesting depressive illness. Rates of depression were not significantly different between the two groups of women.

The research team examined the use of one class of anti-HIV drugs—protease inhibitors (PIs). Regimens that include this class of drug have strong anti-HIV effects and perhaps might be associated with better health outcomes, including reduced risk of depression. Among women in the more recent time period, researchers found the following:

- 37% had never used PIs
- 28% had previously used PIs
- 24% were currently using PIs

There were no significant differences between any of these sub-groups in rates of depression. Overall, the findings from this study suggest that women with HIV/AIDS in the present era experience similar levels of depression as did women in the pre-HAART era.

To try to make sense of their unexpected findings, the research team produced two possible explanations:

1. In addition to coping with the stress of everyday living with HIV/AIDS, women in both groups, most of whom had low incomes, faced other serious challenges such as substance use, violence and being a single parent. The researchers said these challenges likely posed a more "imminent

threat to their psychological and physical well-being than did HIV infection."

The research team notes that several other studies have found that some women either at risk for HIV infection or who are HIV positive do not "view the disease as the most challenging stressor they confront." In one study, these women found that issues related to "violence, separation from their children and drug use to be far more disruptive than their illness." The stress from these problems may be so distressing that having more HIV treatment options does not improve their psychological health.

2. Another possible explanation is that as a result of the availability of HAART women may have developed unrealistic hope about the roles they might be able to assume or resume because of improvements in their health. These roles could have included regaining custody of children, returning to school (or work) and becoming pregnant. Unfortunately the women in the study may not have been able to reach these goals and dreams, which could have resulted in depression.

The extensive psychological testing undergone by the women and the fact that there was so little difference between the two time periods suggests that little change in rates of depression among women with HIV has occurred. These findings are from one American city. Results may be different for HIV positive women in other cities, rural areas or countries. The findings from this study underscore the need for mental health and other support services to improve the quality of life for women with HIV/AIDS.

References

Siegel K, Karus D and Dean L. Psychosocial characteristics of New York City HIV-infected women before and after the advent of HAART. American Journal of Public Health 2004;94(7):1127-1132.

Reprinted from CATIE's Treatment Update 144, 2004 August/September Volume 16 Issue 5

Living with PMS

by Deidre Maclean

The physical and emotional symptoms of PMS usually develop one to 14 days before menstruation. Although almost all women experience some signs of PMS, many HIV-positive women have reported increased and more intense symptoms. There are almost as many remedies for PMS as there are symptoms, and you may have to try several different approaches or combinations before finding something that works for you.

A change in diet about two weeks before your period may help with PMS. Many experts recommend cutting down or cutting out caffeine and sugar (which may stimulate symptoms), salt (which can increase bloating), and alcohol (which may make depression worse).

Some women have found that regular exercise helps relieve PMS symptoms.

A daily supplement of 50 to 200 mg of vitamin B6 along with 200 to 800 IU of vitamin E may also help. The daily dose of amprenavir (Agenerase) already contains 1,744 IU of vitamin E, so anyone using this protease inhibitor should not take extra vitamin E.

Evening primrose capsules may help reduce breast pain, bloating, grouchiness, and depression. Try one or two capsules twice a day during the first two weeks of your cycle, then increase the dose to six capsules a day in the last two weeks.

Taking Anaprox, Ponstan, or Motrin (anti-inflammatory drugs that relieve cramps) for a week or so before your period may reduce PMS symptoms.
There are several prescription drugs that may help with the severe emotional symptoms of PMS. Ativan can be useful for anxiety, and Prozac and Xanax can improve mood swings, irritability, and depression.

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Reprinted from CATIE

You Are What You Eat: Treating Depression Naturally

By Masina Wright, Naturopathic Doctor

It's a difficult situation: you are apathetic, indifferent, and sad. You don't have the energy to go shopping, decide what to cook, and make it, never mind the clean up. The irony is, the fast foods eaten instead could be exacerbating your depression, while a hot bowl of brown rice, black beans, and spinach could be the cure you have been waiting for.

Neurotransmitters are made on a daily basis in the body and brain, and are responsible for much of our brain chemistry. Serotonin is the primary neurotransmitter associated with mood, and is the focus of most conventional antidepressant medications. Your body needs high amounts of B vitamins, adequate minerals, essential fatty acids, and complex carbohydrates to synthesize serotonin, melatonin and other brain chemicals that keep us calm and happy. Whole grains a.k.a. complex carbohydrates like brown rice, oats, barley, and quinoa trigger the production of serotonin. Processed flour products a.k.a. simple carbohydrates like bread, bagels and crackers will not trigger serotonin production. Therefore, a diet high in processed carbohydrates and low in whole grains can lead to chronically low serotonin levels characterized by feeling depressed, having trouble sleeping, and easy weight gain.

L-Tryptophan is an amino acid also needed for the production of serotonin. This used to be available as a single amino acid supplement, but is no longer available in Canada due to some contaminated batches years ago. It is the least abundant amino acids in foods, and tends to be deficient in most dietary proteins. Foods high in tryptophan include cottage cheese (highest at 400mg per cup) and other dairy products, turkey, salmon, cashews, peanuts, raisins, oatmeal, shrimp, avocado, sweet potato and spinach. 1000-3000 mg of tryptophan per day is the therapeutic dosage to treat depression. 5-HTP is the supplement version now available. 5-Hydroxytryptophan is an intermediate product created in the conversion of L-tryptophan to serotonin. It is a step that can be limited by stress, nutrient deficiencies, insulin resistance and age; therefore, by taking the supplement you offer your body the immediate materials to produce more serotonin. The doses used in studies have been 50-300 mg of 5-HTP three times a day. I recommend starting low at 50 mg, and at the same time focusing on foods high in tryptophan and complex carbohydrates. This promotes a natural increase in serotonin production and acts less like a drug. For example:

- **breakfast**: 50 mg 5HTP with a bowl of cottage cheese and fresh fruit or oatmeal and raisins
- **lunch**: 50 mg 5HTP, brown rice salad with celery and cashews on some baby spinach or turkey and avocado on spinach salad
- **dinner**: 50 mg 5HTP, salmon, quinoa and steamed broccoli or a bowl of brown rice with cheddar cheese and steamed broccoli.

Results take two-four weeks, so be patient and don't give up too soon. 5-HTP has been shown to be very safe with most medications; however it is NOT to be taken with antidepressants. If you are already on antidepressants, focus instead on the nutritional aspects to ensure you have all of the vitamin and minerals to continue to process the medications effectively, and help them work better for you.

If your depression is worse in the winter and eases in the summer, you could have seasonal affective disorder, characterized by depression, fatigue, excessive sleeping and eating, carbohydrate cravings, weight gain, and loss of libido. Light therapy is a natural, noninvasive, effective and well-researched method of treatment for SAD. This involves using a 2500 lux cool white lightbox for 2 hours a day, morning, noon or night. Studies have compared using

full spectrum vs cool white light and both showed significant antidepressant results in a four-week study. (Alt Med Review v 10, n 1, 2005) Taking a one hour walk outdoors daily in natural light was also effective.

These treatments can help everyone, regardless of the extent of the depression; however for some women nutrition and light therapy may not be enough to fully ease the cloud of depression. This is when some of the other aspects of naturopathic medicine are important to incorporate. Homeopathic medicine is a complex and highly effective therapy that is completely safe with (or without) HIV medications. It involves looking at your constitution: the constellation of events, symptoms, genetics and emotions that brought you to the place you are at today and matching that picture to a single homeopathic remedy. The remedy then helps your mind/body to unravel and reintegrate the events, returning you to your optimal state of health. The results are not always fast, but they are effective and often curative.

Acupuncture has an excellent track record with HIV as well. Unlike everything else (except talk therapy and light therapy) is it a treatment that does not involve taking anything. Instead, it is a 30-45 minute window of time for you and your mind/body to balance and re-calibrate towards health. Chinese medicine also looks at the body differently, so anger may be read as liver congestion, and grief could be lung qi deficiency. By reformulating our conceptions of emotional wellness and physical health, depression can become less about mental health and more a symptom of physical imbalance.

Depression is certainly a complicated illness. It is multidimensional, and often requires addressing from many different angles to recover from. Good quality food and other pillars of health like fresh air, clean water, healthy touch, play time, enough sleep, and friends to talk to are important to have in place. When these aren't enough, or if pillars are not in place, is when it can help to turn to naturopathic doctors, massage therapists, psychotherapists, social services, chiropractors and good medical doctors. There are many treatments out there for depression. Let us help you find what is right for you.

What is the relationship between recreational drug use and depression?

by Laura Pinsky

Many recreational drugs can cause depression or anxiety; this includes alcohol or alcohol withdrawal, amphetamines, cocaine, ecstasy, crystal and ketamine (Special K).

We lack adequate scientific data about the relationship between depression and recreational drug use, but do have significant understanding based on clinical experience.

Depression may lead you to seek relief in the use of alcohol or other recreational drugs. In turn, these drugs may cause or exacerbate depression. If you are taking antidepressants and extensively using recreational drugs, it will decrease your chances of getting better. You need to seek help in reducing drug use as well as getting direct treatment for the depression.

It is important to be honest with your psychiatrist about the extent of your recreational drug use. You have a need and right to report this without receiving a morally judgmental response.

The drug Ecstasy affects the serotonin system, the same neurotransmitters that are affected by antidepressants. There is growing reason to fear that Ecstasy may have very long-term effects that may ultimately bring on depression and anxiety problems. For some individuals, it may not take much Ecstasy use for this to occur. "Crystal" (methamphetamine) is likely to lead to periods of depression and anxiety. In addition, its use may lead to the development of paranoid psychotic symptoms.

Both alcohol and marijuana, when used on a frequent basis for an extended period of time, tend to lead to depressive symptoms in some people. If you are

depressed and are smoking pot or drinking alcohol regularly, you may be able to decrease your depression by abstaining from substance use for a period of time.

Can other medical problems or medications cause symptoms of depression?

Yes. This is one of the reasons that your psychiatrist needs to take a careful history. For example, HIV-positive men can have low testosterone levels which may cause decreased energy, loss of sexual desire and feelings of depression. You can determine your testosterone level with a simple blood test, and should receive testosterone replacement if your level is abnormally low.

Sustiva, an drug used to treat HIV, can cause a variety of psychological side effects. If your depression coincides with starting Sustiva and becomes severe or lasts more than a few weeks, you should consider switching to another anti-HIV drug to see if the depression improves.

In advanced symptomatic HIV disease, a number of opportunistic infections (OIs) as well as HIV itself can affect the brain so as to produce symptoms of depression. Antidepressant medication may still be indicated, but the underlying problem should be diagnosed first and treated if possible.

Credits

Laura Pinsky is a psychotherapist in private practice and at the Columbia University Counseling and Psychological Services.

Reprinted from Project Inform
http://www.projectinform.org/

HIV Updates

by Devan Nambiar

Common at Its Core: HIV-related Stigma Across Contexts.
This report spans across 4 countries; Ethiopia, Tanzania, Zambia and Vietnam conducted by the International Center for Research on Women. This document suggests that there are many more similarities than differences in the key causes of stigma, its impact, and its consequences. Full report at, http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf

Exercise helps control type 2 diabetes
This study looked at the three interventions; diet vs. exercise vs. diet and exercise among women with type 2 diabetes. It was found that regular exercise not only reduces waist size but also reduces the amount of visceral fat surrounding organs in the abdomen. On the plus side, women in all three groups experienced an approximate 44 percent increase in insulin sensitivity. For full report refer to, www.natap.org , News Updates, 04/01/05

HIV load and CD4+ cell count affect HPV detection in HIV-infected women
This study looks at the interaction between association of viral load, CD4+ and human papillomavirus (HPV). Results of this study show that periodic screening by Pap smear and /or cervical screening for HPV is necessary for HIV positive women. 1848 HIV-positive and 514 HIV-negative women with available HPV test results contributed data to the analysis of HPV natural history. For full article refer to, www.natap.org Women and HIV, 04/22/05

Breast and uterine cancer reduced in women with AIDS
This study found that women with AIDS have a lower risk of developing cancer of the breast and uterine corpus (endometrium), perhaps due to alterations in body fat and hormone imbalance. For full report refer to, www.natap.org News Updates, 04/28/05

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Lately there have been a lot of questions from women about disclosure and the law. I came across the following briefing note on HIV disclosure and criminal law in Canada I hope everyone will find helpful.

Claudia

Essential facts about criminal law & HIV disclosure

by Anna Alexandrova and Glenn Betteridge

People living with HIV have a legal duty to disclose …

As a result of the *Cuerrier* decision of the Supreme Court of Canada, people living with HIV have a legal duty to disclose their HIV status before engaging in behaviours that put another person at significant risk of serious bodily harm. The Court clearly stated that risk of HIV infection is risk of a serious bodily harm

An HIV-positive person does not have to infect the other person with HIV to be criminally charged. It is enough that they put the other person at a significant risk of HIV infection.

The two most common situations where there is a significant risk of HIV transmission are: (1) unprotected sexual intercourse (anal or vaginal); or (2) sharing injecting equipment (needles and syringes) that contains HIV-infected blood.

Practically speaking, this means that people living with HIV must disclose their HIV status before having unprotected intercourse (vaginal or anal) and before sharing injecting equipment (needles and syringes) that contains HIV-infected blood.

In the *Cuerrier* case, the Supreme Court suggested that careful use of a condom may reduce the risk of HIV transmission to the point where the risk of serious bodily harm is not significant. And as a result, an HIV-positive person who properly uses a condom might not have a legal duty to disclose his or her HIV status before engaging in sexual intercourse. But this was only a suggestion by the Supreme Court, and it is not the law.

Whether or not a person living with HIV has a legal duty to disclose their HIV status before sex (or sharing injection drug equipment) will depend upon the risk of HIV transmission associated with the sexual (or drug injecting) activity.

People living with HIV do not have to disclose their HIV status to sexual partners before engaging in activities that pose no risk or negligible risk of HIV transmission. [kissing; cuddling; mutual masturbation; digital-anal intercourse, insertive or receptive fellatio/cunnilingus with a condom.]

It is unclear whether or not people living with HIV have a legal duty to disclose their HIV status to sexual partners before engaging in activities that pose low risk of HIV transmission [oral sex without a condom; intercourse with a condom]. In R v Edwards, a lower court judge indicated that there is no legal duty to disclose HIV status before unprotected oral sex because it is a low risk activity.

In the Williams case, the Supreme Court of Canada opened up the possibility that a person who is aware of the risk that he or she has contracted HIV may have a legal duty to tell his or her sex partner about this before engaging in unprotected sexual intercourse. So a person who thinks he or she may be HIV-positive, even if he or she does not know for sure, may have a duty to tell sexual and injection drug use partners before engaging in high-risk behaviour.

The Supreme Court in the Williams decision also left the door open for people living with HIV to be held criminally liable for engaging in activities that would put an HIV-positive person at risk of re-infection with HIV. Depending on the medical and scientific evidence, it may be possible to prove that re-infection with a different or drug-resistant strain of HIV can result in a serious bodily harm that would endanger the life of someone who was already HIV-positive. So even if people living with HIV know that their sexual or drug injecting partner is HIV-positive, they may have a legal obligation to disclose their HIV status to that person when engaging in activities that have a significant risk of HIV transmission. But a court has not definitively decided this issue.

What Criminal Code charges do people living with HIV face if they breach the legal duty to disclose?

People who are charged under the Criminal Code for putting others at risk of HIV infection are likely to be charged with either aggravated assault or common nuisance, or both.

Under the Criminal Code, a person commits an assault when he or she applies force intentionally to another person without the other person's consent. Force means touching. The person's consent to the touching (or sex) is not valid if it is obtained by fraud. Fraud means either lying or not telling. The maximum term of imprisonment for assault is 5 years.

Under the Criminal Code an assault becomes an aggravated assault where a person commits an assault that endangers the life of another. The maximum term of imprisonment for aggravated assault is 14 years. In the *Cuerrier* case, the Supreme Court decided that an HIV-positive person who has unprotected sexual intercourse without disclosing his HIV status is guilty of aggravated assault because of the risk of infection with HIV, which endangers the other person's life. In the Williams decision, the Supreme Court was faced with a situation where an HIV-positive person had unprotected sexual intercourse with someone who was likely HIV- positive. The Court decided that where there is a reasonable doubt whether or not the other person was HIV-positive before the unprotected sexual intercourse, the person's life may not have been endangered. So the HIV-positive person cannot be found guilty of the Criminal Code offence of aggravated assault. But he or she would be guilty of attempted aggravated assault. The maximum term of imprisonment for attempted aggravated assault is 7 years.

Under the Criminal Code, a person is guilty of common nuisance if he or she fails to discharge a legal duty and as a result endangers the lives, safety or health of the public. People living with HIV have a legal duty to disclose their HIV status before engaging in any activity that carries a significant risk of HIV transmission. People living with HIV have been convicted of common nuisance for having unprotected sexual intercourse without first telling their sexual partner that they were HIV-positive. The maximum term of imprisonment for common nuisance is 2 years.

This Briefing Note was prepared and distributed by the Canadian HIV/AIDS Legal Network, in partnership with the Canadian AIDS Society. If you have questions about the Briefing Note or want to give us your feedback, please contact:

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For more information …

For people who want more information and to develop a deeper understanding of all of the issues involved, you can read:

- 8 info sheets on Criminal Law & HIV [Canadian AIDS Society & Canadian HIV AIDS Legal Network]. The law in these info sheets was updated in 1999. Since that time, the Supreme Court has released its judgment in R v Williams and there have been a number of other court decisions. The important court decisions are mentioned in this Briefing Note. The info sheets are available at: www.aidslaw.ca/Maincontent/infosheets.htm
- After *Cuerrier*: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status [Canadian HIV/AIDS Legal Network, 1999], available at www.aidslaw.ca/Maincontent/issues/criminallaw/finalreports/cuerrier/tofc.htm
- Note on R v Williams (criminal liability for HIV exposure), 18 September 2003 [Canadian HIV/AIDS Legal Network], available at: www.aidslaw.ca/Maincontent/issues/criminallaw/williams-comment.htm
- HIV Transmission: Guidelines for Assessing Risk (3rd edition, 1999) [Canadian AIDS Society]. A 4th edition of the Transmission Guidelines is going to be published in the spring of 2004. The Transmission Guidelines are available from the Canadian AIDS Information Centre: www.aidssida.cpha.ca

Living with Depression

Living with depression has been an ongoing battle. I'm a very proud woman, so to come to grips with the realization that I was feeling this way and could not just snap out of it was the first obstacle that I had to face in doing something about my depression.

When I tested HIV positive, I slowly began to wilt, I didn't want to get up for work, I didn't want to eat, I didn't want to play with my two year old son; all I really wanted to do was stay in bed or watch TV all day and night. My great escape was alcohol; whenever I had a chance to drink, I did. It was the one time that I felt some momentary happiness, but the buzz always died off and I would always be faced with having the truth of my life slap me in the face the next day, and that started the vicious cycle again of self hatred and depression all over again.

"Living with depression has been an ongoing battle. I'm a very proud woman, so to come to grips with the realization that I was feeling this way and could not just snap out of it was the first obstacle that I had to face in doing something about my depression."

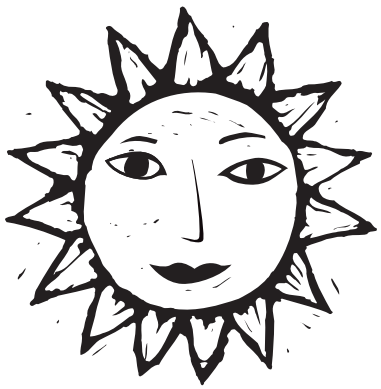
There came a time where I quit working and went on disability because of the depression. During that time I started to devote all my time to my son and would push myself to do activities with him. I realized I had to do something with my life. I was 27 at the time and felt so isolated and lonely, so I reached out to a therapist who heard me out. I would go there twice a week and cry and talk about everything that was bothering me, eventually the clouds began to lift. I learnt some coping mechanisms for when I felt so depressed, I had a supportive circle of friends that were there for me, started exercising and doing meaningful work in the community

Medication was the next hurdle I needed to get over, culturally it wasn't appropriate for me to go on medication for depression; it labeled me as having a mental health issue. I felt ashamed and vulnerable. Eventually I had to put those thoughts and feelings aside and had to stand up to my friends and family that didn't believe medication was the answer for me. What people don't understand is that it's not just about going on medication, you have to deal with things on a holistic level. The more things you can do to improve your mental health the better. Talk to someone regularly about how your feeling, eat well, sleep well, exercise, find hobbies and do things you enjoy.

10 years later, I still struggle with depression but the episodes don't last as long as they did initially. I know who I can reach out to when I'm feeling anxious and depressed. And lately long walks by myself always seem to help. When there is no one to talk to I call the distress centre and have found them helpful when I feel I am in a time of crisis.

Depression is an uphill battle but the thing that has changed is that now I am hopeful that I will eventually reach the top, wipe the sweat off my brow and finally be able to fully enjoy that glorious sunset of life.

A Voices Member



Mental Health Resources

Greater Toronto Area

Canadian Mental Health Association
Ph 416 484 7750

Mount Sinai Hospital
Clinic for HIV related concerns
Ph 416 586 8714

The AIDS Committee of Toronto
Call Jocelyne or Kristy at 416 340 8484

Voices of Positive Women
Call Kaddu at 416 324 8703 #32

360 Degree Health Care
Ph 416 360 1300

Centres for Mental Health

Centre for Mental Health - Guelph
Ph 519 836 6220

Centre for Mental Health - Kitchener
Ph 519 744 7645, 1 877 627 2642

Cochrane Timiskaming Branch/Timmins Office
Ph 705 267 8100

Cochrane Timiskmaming Branch/Kirkland Lake Office
Ph 705 567 9596

Cochrane Timiskmaming Branch/New Liskeard Office
Ph 705 647 4444

Durham Region Branch
Ph 905 436 8760

Elgin County Branch
Ph 519 633 1781

Fort Frances Branch
Ph 807 274 2347

Grey Bruce Branch
Ph 519 371 3642

Guelph-Wellington Branch/Waterloo Regional Branch
Ph 519 766 4450

Haldimand and Norfolk Branch
Ph 519 426 8211

Halton Region Branch
Ph 905 693 4270

Hamilton Branch
Ph 905 521 0090

Hastings and Prince Edward Counties Branch
Ph 613 969 8874

Huron-Perth Branch
Ph 519 273 1391

Kingston Branch
Ph 613 549 7027

Lambton County Branch
Ph 519 337 5411

Leeds-Granville Branch
Ph 613 345 0950

London-Middlesex Branch
Ph 519 434 9191

Niagara Branch
Ph 905 641 5222

Nipissing Regional Branch
Ph 705 474 1299

Ottawa Branch
Ph 613 737 7791

Oxford County Branch
Ph 519 539 8055

Peterborough Branch
Ph 705 748 6711

Sault Ste. Marie Branch
Ph 705 759 0458

Stormont, Dundas, Glengary/Prescott-Russell Branch
Ph 613 933 5845

Sudbury Branch
Ph 702 675 7252

Thunder Bay Branch
Ph 807 345 5564

Toronto Branch
Ph 416 789 7957

Victoria County Branch
Ph 705 328 2704

Waterloo Regional Branch
Ph 519 766 4450

Wellington-Dufferin Branch
Ph 519 766 4450

Windsor-Essex County Branch
Ph 519 255 7440

York Region Branch
Ph 905 853 8477

Distress Line
If you are feeling depressed, in distress or in crisis and you need to speak to someone right away, call the Distress Centre at 416 408 HELP (408 4357). This centre although located in Toronto, will refer you to your local distress centre or call Voices and we can find it for you. If you own a computer with internet access go to www.dcontario.org to find a local centre near you.

Farewell to Janet Rowe

Janet will be leaving Voices on June 16 to become program director at the 519 Community Centre. We wish Janet well, and we will miss her very much.

Janet has been a long time supporter of HIV positive women and a great advocate for women's issues during the past 10 years that she has been working in the HIV/AIDS community. Janet hopes to stay connected with Voices in many ways, including participating in the DIVAS fundraiser.

There is already a hiring committee in place — made up of Voices members, board members and community partners. We hope to have someone hired by August. It's going to be a big change for all of us as we have all grown attached to Janet for her great commitment to Voices.

We will miss you Jan, good luck with your future endeavors!

Voices of Positive Women

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What is Camp Wendake?

Camp Wendake (Huron for: A place set apart) is a camp for people living with HIV/AIDS and their care-givers, loved ones, and traditional/non-traditional families. It is the only camp of its kind in Canada. The camp has rustic cabins, and it is situated on the beautiful shores of Lake Huron near Bayfield.

Camp Wendake is a non-profit camp, sponsored by the AIDS Committee of the Diocese of Huron. We are staffed almost exclusively by volunteers and we rely on generous donations from the community to operate our program.

Camp Wendake is an amazing contradiction! People gather because of a common affliction, but find freedom from focusing upon the disease for a brief time – and find an opportunity to celebrate life. The camping experience occurs in a community where HIV/AIDS is the "norm". And so it may include open discussions where people choose to share personal information regarding lifestyle, HIV/AIDS status, or other private details. Campers may attend in order to learn and share more about coping with their overall health and social issues – or they may come for the rest and refreshment of a caring and understanding community.

You can find out more about Camp Wendake by reading our camp mission statement, our newsletters or by taking a virtual tour of the camp.
www.campwendake.org

fyi is produced and distributed by members, volunteers and staff of Voices of Positive Women. VOPW produces this publication for HIV positive women in Ontario. We encourage HIV positive women to share this publication with other positive women who may not be on the mailing list, and anyone who may benefit from the publication.

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