HIV Mental Health for the 21st Century

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Published by NYU Press

Winiarski, Mark G.
HIV Mental Health for the 21st Century.
Project MUSE. muse.jhu.edu/book/15730.

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Psychiatry plays a significant role in the treatment of the immense and complex mental health needs related to HIV/AIDS. Although psychiatrists have a unique place in overseeing psychopharmacological interventions, it would be a travesty if the role of psychiatry in HIV care were to be limited to prescription of psychiatric medications. As HIV disease develops into a chronic illness, psychiatry has the opportunity to span the gulf between biological and psychosocial/spiritual approaches.

Because the virus is prevalent in groups with multiple problems, such as homelessness, chronic mental illness, and substance use, diagnosis and treatment planning become increasingly complicated. One must identify symptoms as psychiatric or neurological; although accuracy in identifying symptoms improves with time and training, diagnoses are still missed and the patient is blamed for misbehavior. A psychiatrist is the best qualified person to answer such typical and complex questions as: Are psychiatric symptoms due to one's chronic mental illness, substance use, "physical" illness outside of HIV/AIDS, HIV/AIDS-related medical illness, medication toxicity, psychological reaction to distress, inadequate housing, nutrition, or some combination of these above?

Given the correct diagnoses, complex patient management can be handled by a diverse treatment team consisting of primary-care providers
(physicians, physician assistants, nurse practitioners), psychiatrists, nurses, psychologists, social workers, and other mental health specialists.

I am a psychiatrist committed to caring for HIV-affected persons in Seattle, Washington, and work in a medical specialty clinic serving more than 850 persons with HIV disease. I currently direct a federally funded project that attempts to integrate psychiatry and primary care by training physicians to recognize acute neuropsychiatric problems arising from HIV/AIDS, such as delirium, as well as more chronic conditions, such as AIDS Dementia Complex.

I became interested in this work early in my medical training, while on a neurology rotation during my psychiatric residency. A young man named Dale entered the hospital with a headache, fever, and mental status changes. Before long, it became clear that he had cryptococcal meningitis. Therapy for this illness was inadequate then. I watched as Dale became increasingly ill from this infection. He had walked into his hospital room at the time of admission; now he was bed-bound. I relied heavily on the AIDS social worker to find a community placement where Dale could spend his final days. No nursing home would accept him because of his medical needs, because he had AIDS, and the hospital was not prepared to provide long-term care. Recreational therapy was grossly underfunded, but we had access to VCR equipment. One day I brought in a couple of musicals and watched them with Dale when things were quiet in the hospital. It was one of the greatest moments in my medical career. I learned a valuable distinction between curing and caring. Late one night on call, I telephoned Dale’s parents to inform them that his condition appeared to be worsening. His elderly mother asked if they should come immediately. I explained that it was difficult to judge how long Dale would live but that she and her husband could probably wait until morning. Dale died in the middle of the night. Despite having known that his death was near, Dale’s mother cried when I called back with the news. My experience with Dale and his family continues to influence my medical practice eight years later.

This chapter is about what I believe the roles of a psychiatrist are in HIV care—physician, consultant/liaison, educator, therapist, and visionary. I believe that comprehensive care of the HIV-affected person is multidisciplinary care. My clinical practice reflects that model.
**Background Reading**

At the beginning of the HIV/AIDS epidemic, patients typically died quickly from acute infections, such as *Pneumocystis carinii* pneumonia (PCP). The role of psychiatrists and other mental health providers was limited, if it existed at all. As more individuals became affected, experts in the field distinguished two groups of people with HIV/AIDS and mental illness: those with preexisting chronic and/or recurrent psychiatric illness who subsequently become HIV infected and HIV-infected persons who later develop neuropsychiatric or psychosocial problems related to their infection.

**Persons with Preexisting Psychiatric Illness**

Studies addressing the number of acutely hospitalized psychiatric inpatients infected with HIV-1 found that between 5.2 percent and 7.1 percent of individuals studied were HIV-seropositive (Cournos, Empfield, & Horwath, 1991; Sacks, Dermatis, & Looser-Ott, 1992). Among longer-stay patients at a state hospital, HIV seroprevalence has been reported as 4 percent (Meyer, McKinnon, & Cournos, 1993). Injection drug use is a well-documented risk factor for HIV infection. Recent information shows that alcoholics and noninjection drug users also are at higher risk: Sero-prevalence rates in these populations range from 4.5 percent to 11.4 percent (Lee, Travin, & Bluestone, 1992; Schleifer, Keller, & Franklin, 1990). One cohort of 300 alcoholic patients showed 10.3 percent of patients were HIV-infected, 77.4 percent of whom were undetected during inpatient alcohol treatment (Mahler, Yi, & Sacks, 1994).

Several investigators have identified higher-risk behaviors among persons with mental illness, including engaging in casual sex, trading sex for money or a place to stay, combining sex with substance use, having unprotected heterosexual intercourse with known HIV-positive partners, having unprotected anal intercourse with men, and sharing needles or drug paraphernalia (Kelly, 1992; Sacks, 1990). The understanding of AIDS risk behaviors appears to be compromised among psychiatric inpatients. But few programs developed to date address the special needs that chronic mentally ill patients have regarding AIDS education (Baer, 1988; Carmen & Brady, 1990).

In addition to prevention/education challenges, persons with mental illness who subsequently become HIV-infected also present providers
with unique challenges around treatment compliance and diagnosis. What is the most effective method for keeping a homeless individual with schizophrenia and tuberculosis engaged for the several weeks to months of medications required both to ensure proper treatment of the lung infection and to minimize the risk of exposure to the general population? Are the current psychiatric symptoms seen in an immunocompromised patient an exacerbation of bipolar disorder or indicative of a central nervous system infection?

**Persons Who Develop Neuropsychiatric or Psychosocial/Spiritual Problems as a Result of HIV/AIDS Infection**

The World Health Organization Neuropsychiatric AIDS Study, which attempted to study a population representative of the current epidemic, reported a higher prevalence of current mental disorders among symptomatic HIV-1 infected persons than among HIV-1 seronegative controls (Maj, Janssen, & Starace, 1994). AIDS dementia, characterized by cognitive impairment, motor dysfunction, and changes in mood/personality, typically occurs in significantly immunocompromised AIDS patients. Earlier reports suggested a prevalence at a single point in time from 8 percent to 16 percent, with prevalence over the life of the individual approaching 40 to 50 percent (McArthur, 1987; World Health Organization, 1989). More recent studies suggest that this illness occurs in 10 to 20 percent of AIDS patients.

Delirium, defined as an acute confusional state with a physiological cause, is characterized by disturbances of consciousness and attention, changes in cognition or perceptual disturbances, and acute onset with a fluctuating course (American Psychiatric Association, 1994). Many providers mistake delirium for dementia. Many take it for granted as a natural part of dying. Misconceptions result in underrecognition and inappropriate treatment of this condition. In one study of hospitalized AIDS patients, delirium accounted for 57 percent of the identifiable organic mental disorders seen in the study group (Fernandez & Levy, 1989).

The research literature also includes reports of other neurological diseases presenting with psychiatric symptoms: toxoplasmosis and psychosis; cryptococcal meningitis and mania; dementia and depression (Beresford, Blow, & Hall, 1986; Boccellari, Dilley, & Shore, 1988; Kermani, Borod, & Brown, 1985; Navia & Price, 1987; Perry & Jacobsen, 1986; Price & Forejt, 1988; Rundell, Wise, & Ursano, 1986; Schmidt & Miller, 1988). Adequate
population-based descriptive studies that outline the frequency and the severity of psychiatric illness in HIV/AIDS patients, and the subsequent effect of such an illness on function and general health, remain missing from the literature.

In addition to neuropsychiatric illness, mental health providers working with HIV/AIDS patients commonly address spiritual or existential crises across the spectrum of HIV disease. Farmer and Kleinman (1989) describe AIDS as human suffering despite the rational-technical language of disease. Kuhn (1988) advocates viewing spirituality as a legitimate and purposeful area of medical investigation. The current literature certainly supports the need to comfort and to maintain hope in HIV/AIDS patients and their families as they deal with this devastating illness (Rabkin, Williams, Neugebauer, Remien, & Goetz, 1990). Mental health providers have entered the battle against HIV/AIDS around issues of suicide (McKegney & O'Dowd, 1992; Cote, Biggar, & Dannenberg, 1992), multiple losses/grief (Coates et al., 1987; Rabkin et al., 1990; Rait, 1991; Winiarz, 1991), and existential dilemmas (Farmer & Kleinman, 1989; Yarnell & Battin, 1988).

Psychiatrists working in the area of HIV/AIDS certainly possess a unique role in overseeing psychopharmacological interventions. Unfortunately, much of the literature in this area consists of anecdotal information and case reports. Only recently have controlled medication trials in HIV/AIDS patients for common psychiatric illnesses such as depression been published (Rabkin, Rabkin, Harrison, & Wagner, 1994). Many psychiatrists working with HIV/AIDS patients rely heavily on clinical experience, recognizing that medication usage in this population still remains an art as well as a science. General guidelines, such as "less is better" and "benzos (benzodiazepines) are bad," provide starting points in clinical decision making.

My Clinical Work

The focus of the Seattle-King County Department of Public Health project, Integration of Psychiatry and Primary Care, directly met the challenge of providing comprehensive care for persons with HIV/AIDS. In 1991 we received a Ryan White C.A.R.E. Act Title II Special Projects of National Significance grant for psychiatric services in the Madison Clinic, an outpatient clinic serving more than 850 persons with HIV/AIDS. The project firmly established psychiatry as an integral part of the multidisciplinary
treatment team of providers, allowing exploration of the unique role of psychiatry in the treatment of HIV disease. Primary care providers, nurses, social workers, mental health specialists and psychiatrists make up the team. Each team member brings his or her professional perspective, joining in a "horizontally integrated" team approach to patient care. No one member is the designated team leader. No group of members are delegated as perennial followers. The team member with a concern about a particular patient initiates discussion about that concern, bridging traditional boundaries of medical versus nonmedical, psychological versus social, and so on. For the team to work successfully, it is imperative that all providers involved in a patient's care meet and discuss their working relationship (Ferguson & Varnam, 1994).

The Roles of Psychiatry

The unique role of psychiatry in the treatment of HIV/AIDS patients encompasses and balances each aspect of the biopsychosocial/spiritual model; the psychiatrist is at once physician, consultant/liaison, educator, therapist, and visionary.

Psychiatrist as Physician

Charles sat in the office chair breathing heavily after his walk to the clinic. Diagnosed with alcohol dependence and bipolar disorder, he saw his psychiatrist more often than his medical provider. In fact, his recent problems around accepting his HIV status had led him to avoid seeing the internal medicine doctor. A bout of alcohol use two weeks ago resulted in a fall that fractured his upper arm; the pain made it difficult to move; his sleep was decreased. Depressed, tired, out of breath, and in pain, he waited for the psychiatrist.

Upon entering the room, the psychiatrist noticed that Charles looked different: He was short of breath; his color was pale; he had lost weight. Rather than focus only on the psychiatric medications, the doctor asked several questions about Charles' current symptoms. It rapidly became clear that Charles needed a physical examination followed by a chest x-ray to address his respiratory disease. The need for consultation with a primary-care provider was explained to Charles, and he agreed to an examination. The diagnosis was pneumonia.

In this clinical example, the psychiatrist was in the best position to
appreciate the interaction between medical and psychiatric illness. Alcohol abuse led to a fracture of Charles’s arm, which led to serious pain and decreased mobility, which facilitated the development of pneumonia, which ultimately resulted in depression and problems with sleep. If the psychiatric provider had merely addressed Charles’s depression, sleep disturbance, alcohol abuse, and psychiatric medications, a serious infection would have gone untreated. As physicians, psychiatrists utilize a set of methods gleaned from basic science to understand the workings of the human body. These methods emphasize diagnosis, which determines appropriate treatment (Weissman, 1994). Identification and treatment of comorbid conditions can lead to increased level of function, decreased disability, and improved quality of life (Streim & Katz, 1995). Psychiatric facilitation of primary care for HIV patients may affect survival, given the association between survival and lack of medical care (Dorrell, Snow, & Ong, 1995), higher T-helper, also known as CD4, cell count at the initial visit (Hogg, Strathdee, Craib, O'Shaughnessy, Montaner, & Schecter, 1994), and *Pneumocystis carinii* pneumonia prophylaxis and antiretroviral therapy (Osmond, Charlebois, Lang, Shiboski, & Moss, 1994).

**Psychiatrist as Consultant/Liaison**

Peter approached the nursing station asking for juice. Despite his admission to the hospital only the previous evening, the staff were well aware of his presence on the unit. Throughout the night, he left his room to find the nurses and to make some request. He rapidly earned the reputation of being “high maintenance” and “intrusive.” As the unit clerk was explaining who his nurse would be for that shift, Peter started to urinate in the hallway. Quickly, several staff members rushed to stop him. As they approached, he repeated his request for juice. He became agitated and hostile as staff returned him to his room. A psychiatric consult was requested to evaluate Peter’s behavior, which the staff perceived to occur when his demands were not immediately met.

The consulting psychiatrist interviewed Peter and found him to be pleasant and cooperative; he demonstrated problems recalling information and moved very slowly; Peter denied having symptoms of mood, anxiety, or psychotic illness. Upon meeting with the staff, the psychiatrist discovered that Peter was repeatedly instructed in the use of his call button as the preferred way of calling for nursing assistance but that Peter “refused” to comply with these instructions. The consulting psychiatrist looked further into the medical record. Peter was clearly immunocom-
promised; the brain scan showed tissue wasting, and the lumbar puncture showed an elevated β-2-microglobulin level (a surrogate marker in spinal fluid for the presence of HIV dementia). After completing her evaluation, the psychiatrist diagnosed Peter as having dementia. Upon recognizing that Peter's behavior was due to frontal lobe disinhibition and memory impairment, the staff began a treatment plan to manage his behavior during hospitalization.

Consult/liaison psychiatry is a specialty area within the area of psychiatry. Peter's case illustrates how the role of psychiatric consultants in HIV/AIDS care goes beyond recommendation of psychiatric medications and facilitation of civil commitment. This function provides a remarkable opportunity to influence patient care without being directly responsible for the patient. This unique perspective often results in a more neutral evaluation than is given by primary-care providers, nursing staff, and social workers who have ongoing interactions with the patient and who may be emotionally involved.

One assumption in having psychiatrists serve as consultants is that direct-care providers recognize the need for psychiatric consultation. This is a documented problem throughout medicine and is not unique to HIV/AIDS (Koenig, Meador, Cohen, & Blazer, 1988; Mayou, Hawton, & Feldman, 1988; Ormel, Koeter, van der Bruik, & van de Willige, 1990; Regier, Goldberg, & Taube, 1978). Psychiatric liaison services tend to work toward better recognition of psychiatric illness in primary-care settings, as well as assist in the discussion of various legal and ethical issues confronted in the care of complicated patients. Liaisons take a more proactive role: affiliating with specific providers or clinics, providing continual reinforcement regarding the importance of psychiatric intervention, and bridging gaps between more medically oriented providers and psychosocial or spiritual healers.

The psychiatric consultant/liaison relies heavily on the relationships forged with direct-care providers. Without the information obtained from discussion with these providers or from review of their chart notes, the psychiatric consultant cannot complete her assessment. Without support from the staff caring directly for the patient, the best-formed treatment plan will surely fail.

*Psychiatrist as Educator*

Petra's family adamantly refused to allow a psychiatric assessment. Over the last few weeks, her condition had deteriorated, and family
members were bracing themselves for her death. In the family’s community, good people, normal people, did not see psychiatrists. Petra had a fatal illness; her experiences of seeing visions and talking confusedly were merely a part of dying. With encouragement from Petra’s home health nurse, who had seen Petra and her family through much of the illness, the family agreed to talk to the psychiatrist in the presence of the nurse.

The psychiatrist began by listening to the family. She acknowledged their fears and accepted their judgments about psychiatry as a discipline. The psychiatrist spoke to the family about her experience with HIV/AIDS patients, admitting that Petra might be dying but maintaining that death did not need to include “visions” and incoherent ramblings. The family ultimately agreed to allow the psychiatrist to see Petra and to review her medical records. The psychiatrist explained to the family that Petra was experiencing delirium, probably caused by recent, simultaneous increases in pain medication, sedatives, and antidiarrhea medications. After conferring with Petra’s primary-care provider, medication changes were made. Petra died peacefully three weeks later, speaking coherently and sharing important moments with her family.

One key outcome of having psychiatrists serve as educators is the reduction of stigma associated with mental illness. This misunderstanding of psychiatric disease is not confined to the general public; medical professionals, despite their training, share many of these misperceptions. HIV/AIDS is a disease already characterized by shame, discrimination, and misunderstanding. When psychiatric illness is added to this tenuous situation, even the most empathic caregiver can succumb to stereotypes and frustration.

Psychiatrists, because of their unique biological perspective, can assist HIV/AIDS providers to recognize better psychiatric illness and understand better psychiatric pharmacological subtleties. Psychiatrists can educate other physicians, physician assistants, and nurse practitioners in prevention of iatrogenic disease due to medication toxicity. Psychiatrists, because of their appreciation for the psychosocial/spiritual characteristics of the patient, can listen carefully to providers’ and family members’ concerns, presenting their information in a manner that the recipient can relate directly to the patient or loved one. Optimal care for HIV/AIDS patients requires an educational component for patients, providers, and family members. Education, as a form of advocacy, empowers those who receive it.
Psychiatrist as Therapist

Canda worked as a prostitute for fifteen years. She was already addicted to heroin on her sixteenth birthday. At thirty, she tested positive for HIV. As her dreams of becoming a wife, mother, student, and artist disappeared in the shadow of her HIV status, Canda sought help at the local HIV clinic. She expressed a desire to stop working as a prostitute and to decrease her heroin use. In the course of therapy, her low self-esteem became obvious. When Canda impulsively overdosed on heroin, her primary-care provider expressed frustration and hopelessness about her non-compliance with appointments and medical interventions.

Canda continued in psychotherapy, focusing on relationship and family issues that contributed to her current situation. At one point, she required medication for treatment of major depression. At other times, she needed reassurance that medications were not indicated; medicating her pain would have interfered with the process of psychotherapy and with her personal growth. Over time, Canda completely stopped using heroin and working as a prostitute; she ended a physically abusive relationship; she enrolled in school and obtained her G.E.D.; and her art was displayed by a local restaurant.

Psychiatry is not synonymous with psychotherapy. In fact, in recent years some psychiatrists have distanced themselves from the practice of psychotherapy and embraced the definition of psychiatry as strictly a medical discipline. Nevertheless, 50 percent of residents in psychiatric training are in therapy and believe that therapy is essential to becoming a psychiatrist (Weissman, 1994). The "art" of medicine resides in the understanding and expertise that addresses that which is human, such as relationships, conscious and unconscious thought, and the complexity of "volitional" behavior. Psychiatry, and medicine in general, would suffer tremendously if no medical discipline devoted its time and resources to the better understanding and practice of this art.

Concerns regarding cost of care and limited funding may preclude psychiatrists from only performing psychotherapy in the future. Psychiatric psychotherapy may one day be restricted to complicated patients with severe personality disorders or who require both medications and psychotherapy. Among injection drug-using individuals, there is evidence to suggest that the risk of drug overdose may exceed the progression of HIV disease; in one four-year study, drug overdose accounted for seventeen of twenty-five patients who died (Eskild et al., 1994). The role of a skilled
psychotherapist with medical expertise needs to be better defined in working with such challenging patients. Because of their ability to integrate medical and psychosocial/spiritual perspectives, psychiatrists treating HIV/AIDS patients may be in a unique position to differentiate neurologic sequelae of the virus, psychiatric illness needing medications, psychological distress, and existential dilemmas. Research into the relationship between psychosocial factors and improved immunologic status and physical functioning needs to be a priority area for HIV psychiatric psychotherapy (Lutgendorf, Antoni, Schneiderman, & Fletcher, 1994).

*Psychiatrist as Visionary*

The word *psychiatry* stems from the Greek for mind and soul; psychiatrists are healers of the mind and the soul. Advances in the late 20th century established a union among the mind, the soul, and the brain that should not end in divorce (Weissman, 1994). Psychiatrists must work diligently to strengthen this union if HIV/AIDS patients are to be served properly.

The changing demographics of the HIV/AIDS population suggest an increasing need for psychiatric services in the 21st century. As patients continue to live longer with the disease, there will be a greater opportunity for development of psychiatric illness, both as a result of HIV neurologic disorders and as a reaction to living with a chronic illness. It is hoped that efforts to strengthen the collaborative partnerships among primary-care providers, nonphysician providers of mental health services, and psychiatrists will lead to increased recognition of psychiatric morbidity in HIV/AIDS patients, for diagnosis always precedes proper treatment. The epidemic’s movement into populations with multiple problems increases the complexity of addressing psychiatric illness in HIV/AIDS patients.

Psychiatrists wishing to work with HIV/AIDS patients must prepare to leave the private practice and medical clinic settings in which they currently work. Creative treatment approaches, including housing programs for people with mental illness, substance use, and HIV disease, will need on-site psychiatric services in order to maintain these challenging patients in the community and to decrease the need for psychiatric or medical hospitalization. Mobile treatment units that meet patients where they live may be one option for the care of homeless, mentally ill, HIV-infected persons. Links among the public and the private sectors and
university- and community-based agencies must be encouraged. Pooling
academic and front-line resources will result in better understanding of
the HIV population needing care, treatment ideas that work effectively,
and archaic perspectives that must be abandoned.

Psychiatrists must fully engage in the effort to abolish the stigma
associated with HIV/AIDS and mental illness. Working with other physi-
cians, nonphysician providers of mental health care, patients, and families,
psychiatrists can provide a unique perspective on the biopsychosocial/
spiritual aspects of HIV disease and impact the highly political process
that determines health policy. Until the economic stigma surrounding
HIV disease and mental illness is decreased, HIV/AIDS patients needing
psychiatric care will suffer.

The practice of psychiatry in the setting of HIV/AIDS must be deter-
mind by local circumstances and not merely by ideology (Ferguson &
Varnam, 1994). The increasing complexity of mental illness in HIV-
infected patients demands the best that all providers can offer. A collabora-
tive model that empowers each care provider to address psychiatric
illness in HIV from his or her unique perspective is the model of the
future. In that model, psychiatrists clearly have a multifaceted role in the
provision of services to HIV/AIDS patients, their families, and the other
members of the treatment team.

General psychiatric practice of the future, as well as HIV-specific psy-
chiatric practice, demands better definition of diagnostic subtypes in order
to achieve improved treatment outcomes (Council on Long Range Plan-
ning and Development, 1990). Is the depression seen in an AIDS patient
due to a “major depressive episode” or to depression associated with
AIDS dementia? Do the two illnesses respond equally well to current
modes of depression therapy, or does a different etiology require a differ-
ent intervention? Improvement in diagnosis will also achieve more uni-
form application of diagnostic labels, resulting in better communication
among care providers. Improvement in identification and communication
will then allow a clearer definition of treatment outcomes, providing the
opportunity for a clearer demonstration of benefit from psychiatric ser-

Future advances in the understanding of individual drug metabolism
will facilitate more individualized dose-response targets for each patient
(Michels & Markowitz, 1990). In other words, patients may one day
benefit from truly individualized medication treatment plans, rather than
population-based medication dosage recommendations. This is especially
important in HIV/AIDS patients, who tend to be prescribed ten and twenty medications simultaneously (Greenblatt, Hollander, McMaster, & Henke, 1991), to be particularly susceptible to adverse medication effects (Harb, Alldredge, Coleman, & Jacobson, 1993), and to exhibit altered patterns of drug metabolism (Lee, Wong, Benowitz, & Sullam, 1993).

**Tools for Clinical Practice: Utilizing a Psychiatrist**

Psychiatrists can serve many roles in the provision of care to HIV/AIDS patients, even when those patients receive the bulk of their care from other providers.

*Psychopharmacology*

Many patients seek mental health care from a nonphysician provider because medication is not their treatment of choice. Patients deserve to have clear explanations of the risks and benefits of medication for a given psychiatric illness in making this choice.

*It is important for nonphysician providers of mental health care to HIV/AIDS patients to form a relationship with a psychiatrist for purposes of medication consultation and referral, by taking these steps:*

1. If possible, find a consultant with HIV/AIDS experience and interest. Medication management in HIV/AIDS patients is complex. Differentiating medication side effects from underlying illness or other possible causes requires special understanding of the biopsychosocial/spiritual aspects of HIV/AIDS.

2. Develop a relationship with the consultant before it is needed. It is always easier to call and ask a question of someone you know than it is to call someone "out of the blue." Be clear about your agenda in establishing a relationship with a consultant, and determine what the consultant sees as limitations to that relationship.

3. Remain neutral in your discussion with the client about the "best" treatment options. As in any other area of the therapeutic relationship, neutrality is vital. Allow exploration of issues such as whether to use medications or which particular medication is most appropriate. Help the individual to clarify his or her own biases without introducing your own.

4. If a referral for a medication evaluation is made, obtain releases of information, and provide the consultant with as much information about
the individual’s illness and potential need for medication as possible. Important information to include in your referral includes:

- Demographics, such as age, ethnicity, and relationship status.
- HIV disease status, including category (A,B,C), T-helper (CD4) count/CD4%/viral load (if known). If you do not know or feel comfortable about gathering this information, give the psychiatrist the name and the phone number of the patient’s physician.
- Past psychiatric diagnoses, including substance use.
- Current psychiatric diagnoses, including substance use.
- Current symptoms that suggest a need for medication (i.e., why you are making a referral).
- Past medication trials, if any, including the patient’s experience with the medicine.
- Concerns the patient has expressed about seeing a psychiatrist or using medication.

In making a referral for a medication evaluation, it is important to be clear with the client and the consultant about the working relationships between each of you and how information will be shared after the consultation occurs.

Diagnostic Dilemmas

In addition to helping to resolve psychopharmacology questions, psychiatrists can assist with diagnostic conundrums. As discussed previously, HIV/AIDS patients may have several things going on simultaneously: mental illness, substance use, HIV-related illness, and other physical illness. Obtaining a second opinion on a patient’s condition can help clarify your treatment approach as well as reassure the patient, who may be concerned that symptoms represent the first stages of some frightening illness, such as dementia.

A unique aspect of HIV/AIDS is the psychiatric presentation of many serious, and in some cases life-threatening, neurological diseases. In cases where a client presents with psychiatric symptoms in the setting of severe immunocompromise (T-helper or CD4 count less than 200; CD4% less than 14), a psychiatric referral is indicated to ensure that a medical explanation for the symptoms cannot be found. In cases where the client is mildly to moderately immunocompromised (CD4 count between 200 and 500), a phone consultation is warranted to determine if further evalua-
tion is necessary. It is important to remember that any change in mental status, even a relatively subtle one that develops over a period of weeks, may reflect an underlying physical problem. It is best to err on the side of referral. The nonphysician provider may be the first to encounter this change in the client and therefore has the responsibility of informing the patient's other providers if the patient cannot do this her- or himself.

**Conclusion**

With HIV disease, the borders between the biological, psychological, social, and spiritual disappear. Individual practitioners, regardless of their disciplines, need to acknowledge this and practice accordingly. Institutions and agencies can no longer retain divisive care systems when dealing with a condition that demands new, integrated models of care. I believe that psychiatry has the opportunity to improve patients' lives significantly — to heal mind, soul, and brain. We now need dedication to that task.

**References**

This chapter was supported in part by grant BRH970127-02-0 provided by the Health Resources and Services Administration, Special Projects of National Significance. The views expressed are those of the author and do not represent those of HRSA.


