

**Mental Health Care**  
**for People With**  
**HIV Infection:**  
**HIV Clinical Guidelines**  
**for the**  
**Primary Care Practitioner**

**AIDS Institute**  
**New York State Department of Health**



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# INTRODUCTION

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We are particularly pleased to announce the publication of these new clinical practice guidelines, “Mental Health Care for People With HIV/AIDS: Clinical Guidelines for the Primary Care Practitioner.” The increasing recognition of co-morbid mental illness among people living with HIV has led to the need for guidelines that address the management of both HIV infection among people with mental illness and mental illness among people with HIV infection. These guidelines focus on this latter group and address the care of people with mental illness and HIV who are already engaged in HIV clinical care. They are chiefly intended to help HIV primary care practitioners meet the needs of these patients who are in their care.

With the demonstration of the benefits of highly active antiretroviral therapy (HAART) and the knowledge that adherence to its challenging treatment regimens is important, the need to provide access to these treatments for people with HIV and mental illness has become critical to their quality of life and their survival. The first step in increasing access to HAART for people with HIV and mental illness is to help HIV practitioners understand the clinical spectrum of mental illness and its manifestations in those who are HIV infected. By understanding the barriers that mental illness may present to adherence, practitioners can better help their patients to successfully initiate and maintain antiretroviral therapy.

During the 1990s, at least fifteen studies assessed the seroprevalence of HIV among people with severe mental illness. Across a wide range of health care facilities that included hospitals, day treatment programs, and homeless shelters, the range of HIV seroprevalence extended from 1.8% to 22.9%. Similarly, studies funded through the national HIV/AIDS Mental Health Services Demonstration Program revealed high rates of depression, dysthymic disorder, and anxiety disorders among people with HIV seeking mental health services, while other studies suggest substantial rates of pre-existing mental illness in patients presenting for HIV care. In New York State, preliminary data analysis reveals that 2.4% of people with HIV receiving Medicaid services are also diagnosed with severe mental illness. Another 2.4% of people with HIV are diagnosed with severe mental illness and use chemical substances. In this group of over 62,000 individuals with HIV, nearly 3,000 individuals were also mentally ill.

The HIV primary care practitioner faces not only the challenge of coordinating and managing care for the seriously mentally ill but also the challenge of recognizing the mental health needs of those patients who are not seriously mentally ill. These needs may range from addressing the stress and uncertainty of living with HIV to recognizing and treating depression and anxiety to understanding post-traumatic stress disorder and domestic violence. One of the most important roles the HIV primary care practitioner can play is that of referring patients to appropriate mental health services where needed treatment can be provided. These guidelines emphasize this role, focusing on recognition of conditions and disorders, their appropriate treatment, and the

need for specific referrals to provide that treatment when it exceeds the level that can be provided in the primary care setting.

The introductory chapter addresses the role of the primary care practitioner, and the eight chapters that follow address sequentially the psychiatric evaluation of patients in the primary care setting; working with patients' personalities and styles; family issues; cognitive disorders; depression and mania; suicidality; anxiety disorders; and trauma and post-traumatic stress disorder. Appendices that identify resources for people with HIV and provide reference tables of medications are found at the end of the text.

We hope that these guidelines will provide basic information to primary HIV medical practitioners to help them recognize the mental health needs of their patients, understand the spectrum of treatments available to treat their mental illness, and better understand the mental health care delivery system and what it has to offer. Through the use of this information, we hope that practitioners will be able to provide better care to their patients who are dually diagnosed with HIV and mental illness or who are triply affected because of substance use.

These guidelines are also available on the web at HIV Clinical Resource <[www.hivguidelines.org](http://www.hivguidelines.org)>, where they may be viewed and downloaded without charge.

We welcome your feedback and encourage you to send comments by using the "Contact Us" link at <[www.hivguidelines.org](http://www.hivguidelines.org)> or by mail to:

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# CHAPTER 1

## THE ROLE OF THE PRIMARY CARE PRACTITIONER IN ASSESSING AND TREATING MENTAL HEALTH IN PERSONS WITH HIV

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The importance of primary care practitioners to the mental health of persons who live with HIV cannot be overemphasized. Because of the unique role of such practitioners in the health care system, they can help prevent or treat psychiatric illness and maximize patients' psychological health.

### **GENERAL RECOMMENDATIONS:**

**Mental health care for the person with HIV infection should be a collaborative effort involving primary care practitioners, patients, mental health clinicians, case managers, and also, when appropriate, substance abuse counselors or domestic violence service providers.**

**The stage of HIV infection and the severity of the psychiatric disorder should determine whether the medical practitioner or the psychiatrist should be the primary care practitioner.**

**Care should be coordinated between medical and psychiatric practitioners, and primary care practitioners should assist mental health clinicians in coordinating ongoing care when patients are referred to a mental health treatment program.**

**Practitioners should develop and maintain the necessary skills to recognize and address the psychiatric disorders commonly associated with HIV and the factors that may trigger distress in persons living with HIV.**

Primary care practitioners should have heightened acumen with respect to mental health conditions so that they will be able to determine whether patients may be developing more serious conditions (e.g., suicidal ideation, depression, or anxiety disorder) and will be able to judge whether a patient's needs can be adequately treated by the primary care and case management team or whether the patient will need to be referred to a mental health professional.

### **I. PSYCHOLOGICAL IMPACT OF HIV**

#### **RECOMMENDATION:**

**Practitioners should be aware of specific and general factors that may trigger or exacerbate mental distress or psychological disorders in HIV-infected persons and their families.**

HIV is a chronic stressor that places HIV-infected persons as well as their immediate and extended families at risk for psychological distress and psychiatric disorders. Because patients and their families may have histories of substance use, chronic mental illness, poverty, physical abuse, violence, and isolation, they may have limited coping skills. Specific crisis points and psychosocial factors can precipitate mental distress in HIV-infected persons and their families (see Table 1-1).

**TABLE 1-1  
CRISIS POINTS FOR HIV-INFECTED PERSONS**

- Learning of HIV-positive status
- Disclosure of HIV status to family and friends
- Introduction of medication
- Occurrence of any physical illness
- Recognition of new symptoms/progression of disease (e.g., major drop in CD4 cells, rise in viral load)
- Necessity of hospitalization (particularly the first hospitalization)
- Death of a significant other
- Diagnosis of AIDS
- Changes in major aspects of lifestyle (e.g., loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

Adapted with permission from Duffy V. The 14 crisis points of AIDS. *AIDS Patient Care STDs* 1994;8:28-32. Copyright 1994, Mary Ann Liebert, Inc.

## II. MENTALLY ILL SUBSTANCE USERS

### RECOMMENDATIONS:

**Primary care practitioners should provide their substance-using patients with information about appropriate substance use-related services and, if necessary, make referrals** (see Appendix IV).

**For patients who are enrolled in a methadone treatment program and complain of drug withdrawal symptoms after starting HAART or other medications, coordination of care with their methadone program should be maintained so that dosage adjustments can be considered.**

A high rate of HIV infection is found among persons with serious mental illness who are also substance users. Patients who are substance users and have mental illness are generally called “dually diagnosed” or mentally ill, chemical-abusing (MICA) patients. Mentally ill substance users are an especially challenging group of patients to treat, displaying a variety of behaviors that can range from erratic to enraging. Practitioners should provide information about the availability of sterile syringes through referral

to syringe exchange programs or pharmacies participating in the Expanded Syringe Access Program (ESAP) (see Appendix V).

**A. General Issues**

While the bizarre or combative behaviors of the HIV-infected MICA patient can be mistaken for psychiatric illness, substance users are often in some form of intoxication, withdrawal, and/or delirium from another cause (see Table 1-2). If these medical problems are treated, behavior often begins to move toward a more agreeable, manageable form. Even after treatment, a return to baseline behavior may take days to weeks to become evident.

Many substance-using patients use a combination of drugs and alcohol and are often in a state of mixed intoxication/withdrawal, which can have behavioral and physiologic manifestations. Withdrawal is best handled by detoxification in a hospital setting.

<b>TABLE 1-2 ORGANIC CONTRIBUTIONS TO ABERRANT BEHAVIOR</b>
<ul style="list-style-type: none"><li>• <b>Direct drug influence:</b> drug intoxication; drug withdrawal (or a combination*); drug-related delirium.</li><li>• <b>HIV-related central nervous system (CNS) disorders:</b> toxoplasmosis; cryptococcosis; progressive multifocal leukoencephalopathy (PML); lymphoma; HIV dementia.</li><li>• <b>Underlying chronic brain disorders or developmental disorders</b> (sometimes secondary to fetal alcohol syndrome or malnutrition): mental retardation; minimal brain dysfunction; dementia.</li><li>• <b>Psychiatric illness:</b> psychotic disorders; affective disorders; anxiety disorders; personality disorders.</li><li>• <b>Other:</b> infection; fever; hypoxia; anemia; subdural hematoma; delirium of any etiology (e.g., electrolyte imbalance, glucose imbalance); hepatic encephalopathy.</li></ul>

\* Because cocaine intoxication and sedative withdrawal are often hard to differentiate, cocaine users are often at risk for undiagnosed sedative withdrawal due to the use of sedatives in heavy doses to “come down” from cocaine.

## B. Management Issues

### RECOMMENDATIONS:

**HIV-infected MICA patients with insomnia, low energy, anxiety, and pain (which can be primary symptoms or symptoms of drug withdrawal) should be referred to an addiction specialist or psychiatrist for assessment and treatment.**

**Prescriptions for a controlled substance can be written by a primary care practitioner unless the prescriptions are part of a coordinated plan of care agreed upon by the medical practitioner and the psychiatrist.**

**Practitioners should realize that drug users, because of their high tolerance, often require larger doses of sedatives and opioids for treatment purposes than other patients.**

Differentiating legitimate need from the desire for mood-altering medications in HIV-infected MICA patients, even in the context of bona fide need, is extremely difficult. Thus, coordination and consultation with relevant addiction or mental health specialists are extremely helpful, especially because the pain of drug users is as undertreated, if not more so, than that of other patients. Patients who are actively using substances or who are homeless may find the demands of a medication schedule more challenging, while those on methadone may fear the interaction of HAART or other medications with their methadone, leading to symptoms of withdrawal (see Table 1-3).

<b>TABLE 1-3 MEDICATIONS KNOWN TO INDUCE ENZYMES AND DECREASE METHADONE LEVELS</b>
<ul style="list-style-type: none"><li>• Carbamazepine</li><li>• Nelfinavir</li><li>• Pentazocine</li><li>• Phenobarbital</li><li>• Phenytoin</li><li>• Rifabutin</li><li>• Rifampin</li><li>• Rifapentine</li></ul>

Adapted from *Gen Hosp Psychiatry*, Volume 22, Adler Cohen MA, Jacobson JM, Maximizing life's potentials in AIDS: A psychopharmacologic update, pp 375-388, 2000 with permission from Elsevier Science.

### III. PSYCHIATRIC DISORDERS

#### RECOMMENDATIONS:

**Primary care practitioners should have sufficient expertise to recognize and to treat appropriately the psychiatric disorders commonly associated with HIV and AIDS.**

**For patients with more severe mental illness, services based in the mental health system may be necessary.**

Because most patients with HIV and mental illness are seen in primary care settings, primary care practitioners are often the first to assess the risk of mental distress and to observe its signs and symptoms.

These psychiatric disorders include:

- Mood disorders
- Substance use
- Personality disorders
- Adjustment disorders
- Cognitive disorders
- Depression
- Suicide risk
- Anxiety disorders

#### A. Psychotropic Medications

##### RECOMMENDATIONS:

**To provide comprehensive care, primary care professionals should be familiar with the commonly prescribed psychotropic medications and should be confident in their use of these medications. Specifically, primary care practitioners should understand how these agents work, their side effects, and for whom they work best.**

**Primary care practitioners, in addition, should be aware of how these medications may interact with HIV-related drugs (see Appendix I).**

#### B. Adherence

Adherence to HAART regimens by people with HIV and mental health conditions requires extra attention and involvement of the care team. When patients are also taking psychotropic medications, adherence may be even more difficult. Referral to specialized adherence services should be made.

##### RECOMMENDATIONS:

**Practitioners should carefully assess adherence and reasons for non-adherence on a case-by-case basis.**

**For patients with HIV and mental illness who do not adhere fully or who refuse treatment, close coordination between the primary care practitioner and psychiatrist should be maintained.**

An important consideration for patients who are mentally ill is adherence to both HIV and psychotropic medication regimens. Fluctuations in mental status or impairments in cognitive function may interfere with patients' ability to follow directions. Adherence to medication regimens, including HAART, has been shown to be affected by psychosocial, cultural, and substance use factors. Psychotic disorders, affective disorders, or personality characteristics, such as pessimism, apathy, and poor coping styles, can decrease adherence. Lack of social support, poor self-image, and fears of stigma can also make the initiation of treatment more difficult.

### **C. Referral or Consultation**

#### **RECOMMENDATIONS:**

**The practitioner should familiarize him/herself with the resources available in the community to make the most appropriate referral (see Appendix IV).**

**Consultation with a psychiatrist, psychologist, nurse practitioner, or certified social worker is appropriate when the patient refuses treatment, when advice is needed in regard to the patient's needs for psychotherapy, or if the patient needs a complete psychiatric evaluation or assessment in regard to his/her risk of suicide. When the practitioner is in need of information concerning psychotropic medications, a psychiatrist or nurse practitioner with expertise in psychiatry should be consulted.**

**When there is a concern about the presence of serious mental illness in a patient, the most appropriate referral is to a psychiatrist.**

**Practitioners should contact a psychiatric service to establish intensive case management for mentally ill patients requiring such care, particularly if the patient uses substances.**

**Practitioners should opt for referral or consultation when unfamiliar with the patient's needs for prescription of psychotropic medications, assessment of mental status, or further management of the mental condition.**

**The primary care practitioner should routinely consider mental health aspects of care when treating patients who are also being cared for by a mental health provider (see Table 1-4).**

**Practitioners should maintain ongoing communication with psychiatric personnel to provide optimal care.**

**TABLE 1-4**  
**THE ROLE OF THE PRIMARY CARE PRACTITIONER WHEN WORKING**  
**IN COORDINATION WITH THE MENTAL HEALTH PROVIDER**

- Ask follow-up questions of patients regarding mental health and treatment progress as a routine part of office visits.
- Include mental health issues in medical problem lists and progress notes and in corresponding medical assessments and plans.
- Consider patients' mental status, particularly suicidal ideas and alcohol use or other substance use, before prescribing medications.
- Monitor interactions between patients' physical and mental conditions and the effects of psychotropic and other medications.
- Maintain follow-up phone contact with patients' mental health treatment programs, including notifying programs of medication changes.
- Monitor patients' attendance and missed appointments.
- Consider substance use as a factor in the above recommendations when appropriate.
- Consider mental illness and/or substance use as possible underlying causes when unexplained signs (e.g., weight loss), symptoms, or laboratory abnormalities become apparent or when there are changes in behavior or adherence with medical treatment.

Some primary care practitioners may not be fully aware of the many psychological symptoms and disorders commonly noted in people who live with HIV. The medications used to treat these problems also may be unfamiliar. In such cases, referral or consultation may be the "treatment of choice." Knowing the roles of the various mental health professionals and when to consult with and refer patients to them is as important as any other treatment that can be provided. It is also advisable to ascertain from a particular individual whether he/she has the necessary professional training and experience to deliver mental health services.

- Psychiatrists are licensed physicians with graduate training at the doctoral level who have completed 4 years of post-graduate internship and residency. They should have familiarity with medical illnesses and their treatment, as well as an ability to diagnose and treat any psychiatric disorder with medication and/or psychotherapy.
- Psychologists are licensed professionals with graduate training at the doctoral level who have completed a 1-year internship. They are able to diagnose psychiatric disorders but only treat patients with psychotherapy. They also have expertise in intellectual/academic testing and assessment.

- Nurse practitioners and social workers are licensed professionals who have completed graduate level training and have developed expertise or concentrated their work in mental health.

**When there is a concern about the presence of serious mental illness in a patient, the most appropriate referral is to a psychiatrist** who is qualified by training and experience to 1) make a full diagnostic evaluation, 2) consider all the organic, psychological, environmental, and psychosocial factors, 3) prescribe medication as needed, and 4) make the appropriate referrals, if necessary, to other mental health professionals.

Serious mental illness usually refers to schizophrenia, schizoaffective disorder, and other mental illnesses, such as bipolar disorder and depression, that can have psychotic features. Persons with pre-existing serious mental illness (i.e., psychotic disorders) are substantially more likely to become infected with HIV than those in the general population. Patients with such serious mental illnesses pose challenges for all health care providers, but improving their medical and psychiatric care may greatly enhance their quality of life. Since people with mental illness are likely to be part of the primary care patient population, primary care practitioners should be aware of their special needs.

The easiest way to find out if patients have, or have had, serious mental illness is to ask them about past psychiatric treatments and/or hospitalizations. In talking with patients, practitioners may discover mental illness exhibited by patients' bizarre ideas or delusions or by their disorganized thinking and language. The hallucinations of mentally ill patients are usually auditory. Patients may hear voices telling them to harm themselves or others. Such episodes are considered psychiatric emergencies and will require immediate referral of the patients for psychiatric evaluation and treatment. Similarly, if a patient is suspected to suffer from a serious mental illness but is not currently receiving mental health care, he or she should be referred for psychiatric evaluation.

If a patient needs ongoing psychotherapy, other licensed mental health professionals (e.g., psychiatrist, psychologist, social worker) should also be able to provide this treatment. Because some individual mental health professionals may have more specific expertise or interest in working with special populations (e.g., couples, families, adolescents, children, substance users, or victims of domestic violence), the practitioner should familiarize him/herself with the resources available in the community to make the most appropriate referral (see Appendix IV).

## **D. Treatment Programs**

Many HIV/AIDS clinics offer mental health services or work closely with specially trained professionals who can counsel patients or provide information.

Various mental health programs exist that attend to patients' different psychiatric conditions and needs. Such programs are categorized into four general areas: outpatient mental health services, community support programs, emergency services, and inpatient psychiatric programs. HIV/AIDS-specific mental health programs are funded by the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services and by the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. Summaries of the general types of programs follow. Referrals to these programs are usually made by mental health clinicians following their evaluation of patients. Availability of the programs varies regionally.

### **1. Outpatient Mental Health Programs**

Outpatient mental health programs are designed to meet the needs of patients who require psychiatric care and who can participate on an ambulatory basis. There are four categories of outpatient mental health programs:

- **Outpatient treatment**

Outpatient treatment includes a variety of services, such as assessment, medication, and psychotherapy. This treatment, offered both by clinics and in private mental health settings by practitioners in their own offices, can reduce symptoms in, improve daily functioning of, and provide ongoing support to patients.

- **Partial hospitalization**

These programs provide active treatment within a medically supervised environment and are designed to stabilize and ameliorate acute symptoms. These programs offer an alternative to inpatient hospitalization and, while primarily serving as a means to reduce the length of hospital stays, they also provide patients with a transitional therapeutic environment.

- **Intensive psychiatric rehabilitative treatment (IPRT) programs**

These are time-limited programs with active psychiatric rehabilitation and are designed to assist more seriously ill patients to reach goals.

- **Continuing day treatment programs**

These programs provide mental health treatment and rehabilitation to more chronically mentally ill patients who benefit from the ongoing structure of such programs.

## 2. Community Support Programs

Patients with severe and persistent mental illness may benefit from programs that provide help to enable them to live as independently as possible in the community. These programs fall into the following three broad categories:

- **Intensive Case Management program**

Managing patients with severe mental illness and HIV infection presents significant challenges. These patients require a coordinated effort, providing them with a wide range of medical, psychiatric, and social services. To accomplish this coordination, the Intensive Case Management (ICM) program was developed by the New York State Office of Mental Health. This program assigns case managers to individuals who have been identified as being in need of high levels of mental health care. Case managers then maintain contact with patients to ensure that they are receiving the benefits of all appropriate services. To participate in an ICM program, patients must be referred by a psychiatric service. Once patients are enrolled in an ICM program, ongoing communication between primary care practitioners and psychiatric personnel is key to providing them with optimal care.

- **Educational, vocational, and social rehabilitation programs**

These programs assist patients with severe mental illnesses to develop skills necessary to enable them to live more independently.

- **Mental health residential programs**

These programs include supported permanent housing, transitional housing, and family care programs.

## 3. Emergency Programs

These programs provide services to individuals in the community who are experiencing psychiatric crises. Services include:

- **Mobile crisis teams**
- **Emergency room intervention and observation**
- **Crisis residences**

## 4. Inpatient Psychiatric Programs

These programs include acute care in psychiatric units and also extended care stays at psychiatric hospitals.

#### **IV. RISK REDUCTION**

##### **RECOMMENDATIONS:**

**Mentally ill patients should be counseled on how to reduce their risk of HIV infection and how to avoid infecting their partners.**

**Patients will benefit from education regarding safer sex practices, including how to use condoms and other barrier methods.**

Demonstrating how to use condoms and other barrier methods is one counseling strategy, and provision of information about how to make sterile syringes available through referral to syringe exchange programs or pharmacies participating in the ESAP is another. Such treatment is as important as any other care for these patients. Practitioners should consult with local mental health care providers about the availability of HIV risk-reduction groups for people with mental illness who are also substance users.



# CHAPTER 2

## PSYCHIATRIC/MENTAL STATUS EVALUATIONS IN PRIMARY CARE SETTINGS

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### GENERAL RECOMMENDATION:

**Because of the high prevalence of psychiatric problems in people with HIV infection, practitioners should perform a thorough baseline psychiatric evaluation, including history and complete mental status examination for all HIV-infected patients, documenting their responses and the practitioners' assessments.**

This chapter provides guidelines for performing a complete psychiatric history and mental status examination (MSE) of the patient with HIV infection. This evaluation will document baseline function as well as reveal any psychopathology for which further follow-up, pharmacologic intervention, or psychiatric referral may be necessary. Additional guidelines for the diagnosis and treatment of various conditions are outlined in following chapters.

The skills necessary to perform a good psychiatric evaluation (e.g., the ability to ask revealing questions, make observations, and organize gathered data) do not differ from those needed for medical assessments. In fact, primary care practitioners perform many parts of the psychological examination without even realizing it. For example, noting a patient's hygiene, behavior, mood, and orientation and assessing the patient's ability to understand a care plan—all standard practice for a medical evaluation—are also part of a mental status assessment. Other parts of the examination may require direct questioning. When questions are asked in a straightforward manner, patients are rarely offended.

### I. HISTORY AND EXAMINATION

#### A. Elements of a Complete Psychiatric History of Patients With HIV

The practitioner should include the following elements in obtaining the patient's history:

- History of psychiatric disorders in patient or family
- Number of psychiatric hospitalizations
- History of outpatient mental health treatment
- History of psychotropic medications used by the patient or family members

- Efficacy of psychotropic medications used by the patient or family members

*Psychiatric illnesses have a genetic component and, thus, a given medication may be more effective for an individual if others in the family also responded to that medication for a similar symptom constellation.*

- History of suicide or violence

*To obtain this information, ask:*

- *Have you ever felt so depressed or angry that you thought about hurting yourself or others?*
- *Did you ever actually try to hurt yourself or anyone else? What did you do?*
- *Are you in a relationship in which you have been physically hurt or felt threatened?*

- History of education and performance in school

*This helps establish patients' baseline intellectual functions and, therefore, allows practitioners to adjust their expectations.*

- History of occupational functioning
- History of relationship functioning
- Family support/personal support
- Legal history
- Risk behavior history

## **B. Selected Elements of a Complete Mental Status Examination**

### **RECOMMENDATION:**

**The practitioner should use observation and questioning when conducting a general assessment.**

Appearance, behavior, attitude, and speech can be observed, whereas questioning will provide information regarding the patient's mood, the patient's understanding in regard to the state of current illness, and the patient's abilities in regard to daily functioning.

### **1. General Assessment of Appearance and Behavior**

The practitioner should observe the following:

- **Appearance:** Hygiene, grooming, clothing appropriate for season and occasion, clothing worn appropriately.
- **Behavior:** Sits quietly, jumps out of seat, paces, touches things, exhibits disorganization.
- **Attitude:** Cooperative, belligerent.
- **Speech:** Soft, loud, slow, rapid, slurred, spontaneous, sparse.

## 2. Assessment of Insight and Judgment About Current Illness and Daily Functioning

The practitioner should specifically assess the patient's insight and judgement related to his/her HIV infection. Does the patient show an adequate understanding of his or her illness and its treatment?

To ascertain whether the patient behaves in health-promoting ways, the practitioner should ask questions such as:

- *Do you attempt to reduce risk of infecting others?*
- *Do you practice safe sex?*
- *Do you attempt to live in a healthy manner, eats well, rest, not use substances?*
- *Do you take medication as prescribed?*

## 3. Assessment of Mood

### a. General

To ascertain the patient's mood (e.g., sad, cheerful, anxious, irritable, labile), the practitioner should ask questions such as:

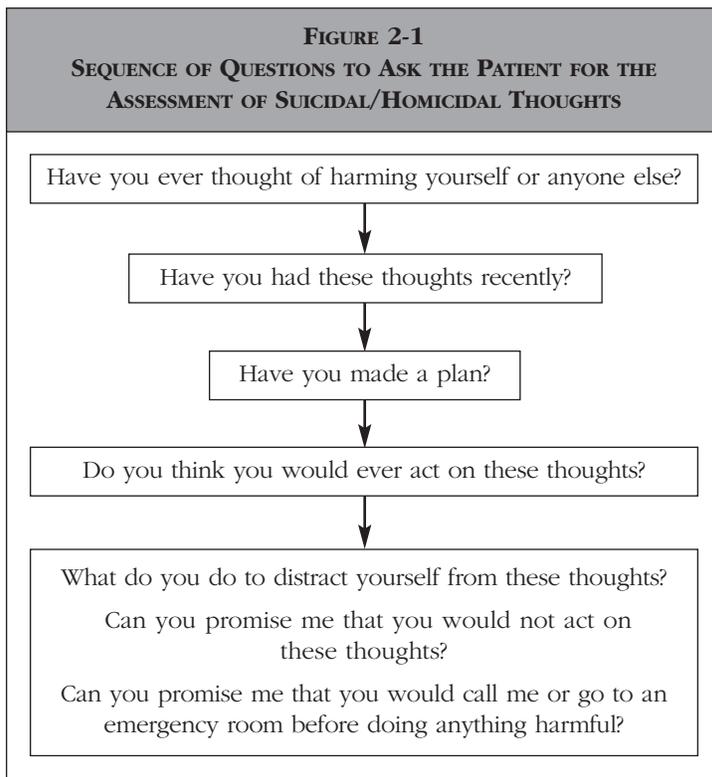
- *Do you feel sad or depressed?*
- *Are you able to enjoy anything?*
- *Do you feel anxious or irritable?*

### b. Assessment of Suicidal and Homicidal Ideation

#### RECOMMENDATION:

**Practitioners should address and document any suicidal or homicidal thoughts, even though they may not necessitate emergency intervention. The decision of whether to institute emergency intervention should be determined by assessing the patient's level of intent and degree of control as well as the patient's ability to uphold a contract against the intention to harm self or others** (see Figure 2-1).

Practitioners should closely monitor patients who give answers indicating intention to harm themselves or others. If they have limited ability to control their intentions or to contract with practitioners against the intention, patients should immediately be referred for further psychiatric assessment and care.



#### 4. Assessment of Thoughts

##### RECOMMENDATION:

**If the practitioner receives a positive response to any of the following questions regarding thought content, perception, and thought processes or observes that the patient seems to have a thought disorder, the practitioner should refer the patient not already under psychiatric care for further psychiatric evaluation and consider the need for psychotropic medication.**

- **Thought content:**

To ascertain whether the patient has delusions, the practitioner should ask questions such as:

- *Have you ever felt that your thoughts were being controlled or broadcast out loud or that you could read other people's thoughts?*
- *Have you ever felt you were chosen for a special mission?*
- *Have you ever felt people were plotting against you?*

- **Perception:**

To ascertain whether the patient has hallucinations, the practitioner should ask questions such as:

- *Have you ever heard voices or seen or smelled things that other people did not?*
- *Have you ever received a message over the television or radio that was meant for you alone?*

- **Thought processes:**

To ascertain whether the patient shows disorganized thought/language, the practitioner should note if the patient has:

- *Overabundance or paucity of ideas.*
- *Irrelevant or illogical thought processes.*

## 5. Assessment of Cognitive Status

### RECOMMENDATIONS:

**Practitioners should perform and document follow-up evaluations of cognitive status on a yearly basis.**

**Practitioners should standardize their evaluation instruments to allow accurate comparison of baseline and subsequent evaluations.**

**Practitioners should choose one assessment instrument, use it for the initial evaluation and, if possible, also use it for all subsequent evaluations. The choice of which instrument to use for assessment may not be as important as establishing a baseline status with one instrument and using the same instrument for subsequent examinations** (see Appendix III for examples of assessment instruments).

**Practitioners should document the baseline cognitive function of patients because this baseline will serve as the best control for each patient over time.**

It is essential that practitioners document all patients' baseline cognitive status because changes in cognitive function may reflect the onset of HIV-related dementia or delirium secondary to central nervous system (CNS) infections or malignancy.

- Practitioners should refer to Chapter 5: *Cognitive Disorders and HIV/AIDS* for information on diagnosis and treatment of specific cognitive disorders.
- Establishment of the baseline cognitive function status also increases the value and specificity of examinations given when CNS pathology is suspected. Moreover, it limits the influence of various confounding factors such as level of education, cumulative results of trauma, or effects of drug and alcohol use.

### C. Monitoring

#### **RECOMMENDATION:**

**Practitioners should repeat cognitive assessment and screening for depression and other psychiatric disorders at yearly intervals or more frequently if there seems to be a change from baseline.**

# CHAPTER 3

## WORKING WITH PATIENTS’ PERSONALITIES AND STYLES

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Personality disorders can represent some of the most difficult challenges for practitioners, especially when they are confronted with these challenges in a busy ambulatory care setting. By paying attention to basic communication skills, which can sometimes prevent or alleviate disruptive behavior, practitioners can minimize these challenges. Practitioners should maintain eye contact and appropriate body language, listen attentively, and be careful with use of humor to patients or around patients. The message that should be consistently conveyed to patients with disruptive behavior is that the practitioner’s intent is to assist the patient in the best way possible.

### **GENERAL RECOMMENDATIONS:**

**Practitioners should recognize that maladaptive traits and personality disorders are unlikely to change and should center interventions on how patients can maximize healthy behaviors. If this goal cannot be attained, a mental health professional should be consulted.**

**Practitioners should identify treatable disorders that are not attributable solely to personality. Psychotropic medications are rarely useful for treatment of patients with personality disorders alone.**

**Because the interaction style of patients with severe personality disorders may lead to problems between patients and practitioners, a team approach is useful when managing patients with maladaptive styles.**

**Practitioners should call attention only to those personality traits that disrupt health care or other health-promoting behaviors and should focus on specific behaviors when offering alternative approaches.**

**Medical support staff should be clear about what to do when a crisis arises in the waiting area.**

Patients who exhibit persistent, pervasive, and inflexible patterns of personality traits that lead to distress or impairment suffer from a personality disorder. It is difficult for primary care practitioners to work with such patients. After ruling out treatable disorders (e.g., dementia, delirium, depression, anxiety, and substance use), a practitioner may find it helpful to consult with a mental health professional to obtain a proper diagnosis. In identifying and understanding the various personality types and behavior styles they may encounter in patients, practitioners should understand how these can affect patient-practitioner interactions, as well as how problems related to personality and style may be prevented or transcended.

Individuals with a personality disorder experience sustained social impairment due to maladaptive behaviors that interfere in their personal relationships, work, study, and self-care. *The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)* groups personality disorders according to descriptive similarities. However, individuals often present with features from more than one group. The diagnosis of a specific personality disorder may not be as important as identifying and focusing on specific maladaptive personality traits that make treatment planning and provision of health care difficult and offering patients alternative approaches. This is important because people are often defensive, angry, or depressed when these difficulties are brought to their attention.

When considering a diagnosis of personality disorder, it is important that practitioners assess for domestic violence because victims of domestic violence sometimes behave in ways that suggest personality disorders to those who are unfamiliar with the effect of such violence (see Chapter 4: *Family Issues for Patients With HIV/AIDS*). If the patient's safety needs are attended to, these behaviors may disappear. When a patient with a pre-existing personality disorder is also a victim of domestic violence, it is important to attempt to separate the consequences of the violence from those of the personality disorder so that an important avenue of intervention is not overlooked.

Patient care is a team effort. Focus should be on establishing consistency among team members, including non-professional staff, in setting limits, and making those limits known to the patients in clear, predictable, and supportive ways. Involvement of the medical support staff is critical since they are often the first to interact with patients as they arrive at the clinic. Staff should be clear about what to do when a crisis arises in the waiting area.

It is of particular importance that practitioners work collaboratively with a mental health team when treating patients with personality disorders who have revealed suicidal thoughts and negative behaviors such as self-mutilation (see Chapter 7: *Suicidality in Patients With HIV/AIDS*).

Finally, patients who are affected by personality disorders may benefit from the structured and supportive environment provided in day treatment programs.

## **I. PERSONALITY TYPES AND BEHAVIOR STYLES: PARADIGMS**

Personality is the sum of an individual's behavioral and emotional characteristics. Facets of personality especially relevant to patient care include attitudes, styles of interaction, behaviors for coping, and moods. Although specific personality disorder diagnoses can be found in the *DSM-IV*, practitioners may find it more helpful when working with difficult patients with personality disorders to group the patients by presentation rather than focusing on specific diagnoses.

The three personality paradigms discussed here are grouped by “type” and “style” rather than by diagnosis, as there can be considerable overlap in behavior among the different personality disorder diagnoses.

#### **A. Dramatic, Emotional, or Erratic Patients**

*Dramatic, dependent, and overdemanding patients* have increased dependency and poor tolerance for frustration. These patients often benefit from efforts to extend their social and health care support networks. They are often reassured by their practitioners’ consistent readiness to care for them; however, setting limits may be necessary to prevent excessive and unrealistic demands. If setting these limits results in constant mood swings or increased self-destructive threats, practitioners should refer patients to mental health practitioners.

*Dramatic, emotionally involved, and captivating patients* develop intense, idealized relationships with primary care professionals. They develop jealousy quickly when their practitioner’s attention turns to other matters. Often these patients are anxious about medical interventions. They usually respond best to warm involvement by health care providers. Practitioners need, however, to maintain their boundaries. If patients with this style are disruptive or their denial interferes with their health and self-care, they should be referred to mental health practitioners.

*Superior patients* have exaggerated self-confidence. They may be smug, grandiose, or vain. Often their mood fluctuates between demanding brilliance from primary care practitioners and needing to devalue or degrade these same practitioners. These patients may get “pushed away” by providers who feel they are being challenged. However, these patients usually respond best when health care practitioners recognize patients’ strengths and achievements and are interested in patients’ opinions about HIV/AIDS and its treatment. Without challenging the patients’ need to feel superior, practitioners should carefully demonstrate their own competence. For example, the practitioner might say the following: “*May I see that article you have on HIV treatment?*” and review the article, following with “*This is helpful. Can I keep a copy in the file? Now, for the next month, can you try* [practitioner offers treatment recommendation]?” These patients should be referred for psychiatric treatment when all attempts at therapy result in non-adherence.

*Sociopathic patients* ignore the usual social rules through lying, theft, reckless behavior, and disregard for others. They usually lack empathy and may alternate between being demanding and abusive or flattering and ingratiating. Most often these patients respond best to strict and clear rules as well as realistic limits on practitioner availability.

#### **B. Anxious or Fearful Patients**

*Orderly and controlled patients* use knowledge and routine to push away fear and uncertainty. They may be stubborn, rigid, and preoccupied with right and wrong. Illness and treatment are threats to their

need for control. These patients usually respond best to a clearly stated approach with attention paid to details but without a struggle over who is in charge. When obsessions or compulsions interfere with their functioning [which suggests obsessive compulsive disorder (OCD)], these patients should be referred to mental health practitioners.

*Anxiously dependent, avoiding, or passive-aggressive patients* are anxiously dependent on the primary care practitioner and often need constant reassurance. They may exhibit displaced anger. Resistance to therapy may accompany their dependency (even when they have participated in treatment planning). Generally, these patients respond best when their dependency is tolerated, which may, however, require that the health care network be broadened to alleviate excessive demands on any individual provider. More frequent but briefer appointments may be helpful with these patients. Scheduling interactions with them may help minimize their excessive demands at inconvenient times. When possible, practitioners should forewarn these patients of change. If such patients frustrate all attempts at treatment, they should be referred to mental health practitioners.

### **C. Odd or Eccentric Patients**

*Guarded, suspicious, and argumentative patients* are doubtful of others' intentions and motives. They may be openly or covertly suspicious of interventions. When dealing with such patients, the best approach is to acknowledge their perceptions of the world without debate or agreement and to refocus their attention on health care treatment. If these patients seem delusional with fixed, false beliefs or their thinking is disordered, they should be referred for psychiatric treatment, because either possibility may indicate psychosis.

*Aloof or uninvolved patients* are remote or uninterested in the details of their illness, and they have little sense of interpersonal relatedness. Uncomfortable with the involvement of professionals in their lives, they may miss appointments. Usually, these patients respond best when health care providers show that they understand the patients' style and respect their privacy. Primary care practitioners should explain the need for personal questions but not push patients to increase their social involvement. When complex mental status evaluations or differential diagnosis for depression or psychosis is needed, referral to psychiatric practitioners is warranted.

*Idiosyncratic patients* tend to dress differently, have peculiar beliefs (not culturally sanctioned), and speak in constricted, digressive ways. These patients may act guarded or present with unusual complaints that do not have clear physiologic patterns. When these patients present with complaints that overlap with symptoms of co-existent somatic disorders, the situation becomes even more complicated. Usually, idiosyncratic patients respond best to a consistent approach to their complaints that does not challenge their truthfulness or reinforce their perspective. For example, practitioners could comment, "*Your custom of eating chocolate*

*pudding and rice every hour has kept you healthy so far, but now the virus needs a new tradition. These medications won't mix with that food. Here is a schedule for taking medications and eating. Can you fit a new tradition in here?"* For these patients, referral to psychiatric care is useful when schizophrenia is suspected, when eccentricity seems to lack any basis in reality, or when odd behavior persistently places the patient at risk of harm.

While no patient will fit exactly into any paradigm of personality type or style presented here, practitioners will likely encounter such personality traits in the care of HIV-infected patients. Since psychotropic medications are rarely useful for the treatment of patients with personality disorders, practitioners should consider offering the milieu of psychosocial supports within structured programs such as AIDS day treatment programs.

#### **D. Low Cognitive or Borderline Functioning Patients**

*Low cognitive or borderline functioning patients* may mask their inability to process information. They could present as any of the above categories. Practitioners should understand whether a patient is processing information and, if so, how the patient processes the information. These patients often make practitioners feel confused and agitated. A mental status exam will help identify these patients.



# CHAPTER 4

## FAMILY ISSUES FOR PATIENTS WITH HIV/AIDS

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### GENERAL RECOMMENDATIONS:

**Practitioners should assess family configuration, functioning, and existing social support as part of the routine evaluation of patients who are primary caretakers of children. These assessments should ideally be done during times of stability.**

**Practitioners should be aware of the impact of single parent homes, same sex parent homes, and teenage parent homes where there is little to no adult presence.**

**Practitioners should refer children who present with behavioral changes in response to illness of a family member for mental health evaluation.**

As more women of childbearing age become HIV infected, HIV/AIDS increasingly becomes a disease that involves the family. Primary care practitioners working with HIV-infected parents should, therefore, be aware of the needs of their patients' families, as the burden of HIV infection becomes much greater when children are involved. By providing treatment and solutions for common problems found in HIV-affected families, primary care practitioners help ease the pressure on these patients.

Family members of an HIV-infected person also may face particular difficulties. When confronted with the knowledge of a person's illness or lifestyle, family members can become confused or angry. If not addressed, these emotions can be turned against the HIV-infected person. Children who are infected must cope with and adapt to their own chronic and perhaps terminal illness. They often lack the emotional maturity that can help adults, yet they still must try to deal with the psychological effects that the disease can have on them and their families. Similarly, children who live with an HIV-infected family member must bear the psychological impact of this situation. The impact can be especially traumatic if the infected family member is the child's parent or sibling.

Assessing the family's configuration, functioning, and existing social support should be a routine part of evaluating an HIV-infected patient who is the primary caretaker of children. Determining how a family functioned and how family members interacted before the patient was diagnosed with HIV infection will allow primary care practitioners to assess more effectively family problems that may develop over the course of HIV disease.

Components of a basic assessment can be compiled by asking the following questions:

- *Who makes up the household (including adults and children)? What are the relationships among household members?*
- *What are the ages of children and adolescents? If they don't live with the parents being assessed, with whom do they live?*
- *How do the patient's children and adolescents function? Are there problems at home or at school or during times of parent's illness?*
- *Are there people in the patient's extended families or social networks who can be called on during times of crisis?*

## I. COMMUNICATING HIV STATUS

### RECOMMENDATIONS:

**Practitioners should encourage patients with HIV infection to communicate with their children, family members, and significant others about the disease. If patients are reluctant to engage in these discussions, however, practitioners should respect their wishes** (see Section V: *Domestic Violence and HIV Infection*).

**Practitioners should consider referring patients with HIV infection for mental health or social services if they present with advanced HIV/AIDS without having informed their children and other relations about their disease.**

Communicating with children and extended family members can be very difficult for parents with HIV infection. Many parents appropriately choose to defer discussing their illness during the early stages of infection when health problems are minimal or nonexistent. As the disease progresses, parents may feel increased pressure to talk about the illness with children and family members, especially during times when parental functioning is disrupted (e.g., during hospitalizations or when the illness becomes debilitating).

Because parents may feel guilt or shame about behaviors associated with HIV infection (e.g., drug use, choice of partner), they may have difficulty communicating with their children and families about the disease. In addition, many adults believe that not telling children painful facts will somehow reduce the impact. Ultimately, children cannot be protected from the realities of parental illness and loss. Children need their parents to acknowledge the illness and to indicate, particularly as parents' health worsens, that the children's needs will continue to be met. Emphasis is usually placed on parents simply disclosing their HIV status to their children; however, children need ongoing communication concerning parents' health status and prognosis. Such communication could play an important role in decreasing children's anxiety and increasing their ability to adapt to parental illness.

Nevertheless, health care providers should respect the wishes of parents who are either unwilling or unable to explain the nature of their illness to their children. Parents should be encouraged to discuss the more general issues surrounding illness and prognosis with their children. If, however, during the late stages of HIV disease, parents are still unable to discuss the situation with family members, primary care practitioners should consider referring patients to mental health or social services. Often the complex mental health and psychosocial issues holding parents back from revealing the truth about their illness require ongoing mental health intervention before parents can open up to their children or families.

## **II. ARRANGING FOR FUTURE CARE OF CHILDREN**

### **RECOMMENDATIONS:**

**Primary care practitioners should refer parents to social service providers for assistance with formal and informal options, each having unique advantages and disadvantages, for the placement of children.**

**Primary care practitioners should also be aware of the permanency planning resources available to their patients** (see Appendix VI).

When preparing for the possibility of death, HIV-infected parents face the difficult task of planning for their children's living arrangements. Any such planning is best done by taking into account family wishes and resources. Options that involve family court or children's services can take months to implement and, therefore, should be considered early enough in the course of the disease so that the plan may be operative and available when needed. In general, this planning is best carried out with the help of personnel familiar with the various options available to parents.

## **III. SUBSTANCE USE**

### **RECOMMENDATIONS:**

**Practitioners should look for psychiatric problems, abuse, neglect, and trauma in families in which HIV-infected parents or other household members use substances.**

**For patients who are substance users, treatment planning should include the input of substance abuse counselors.**

Substance use and the resulting guilt, shame, and complicated family dynamics may significantly impair parents with HIV infection. When children and adolescents are involved, the communication and planning necessary to support the family during this critical time can become overwhelmingly challenging. To primary care practitioners, parents with advanced HIV/AIDS who have never addressed the issues that involve their children and other relations may present as having the most disorganized families with the greatest burden of psychiatric and substance use. Children and adolescents from this type of background may be at greatest risk for behavior problems and may need to be referred

for mental health evaluation. Children from more stable backgrounds may act out under the stress of living with an ill parent and may also require referral.

Families affected by substance use should be of special concern to primary care practitioners. Within these families, there is a strong possibility of pre-existing psychiatric disorders, abuse, neglect, and trauma, which are all difficult problems to treat, particularly when associated with HIV illness. As parents' health declines, pressures increase, and the family members' ability to cope in these situations can be severely compromised. Referral for assessment and care by a mental health professional may be necessary to maintain family integrity and stability. For more information, see *Evaluation and Management of Substance Use in HIV Primary Care*. Albany, NY: New York State Department of Health, AIDS Institute, 1995.

#### **IV. RECOGNIZING AND MANAGING ABUSE AND NEGLECT IN HIV-AFFECTED FAMILIES**

##### **RECOMMENDATIONS:**

**Practitioners should be aware of and should attempt to explore in a calm and respectful manner the possibility of abuse and/or neglect in HIV-infected families.**

**Whether or not the parent will become involved in attempts to ameliorate child maltreatment, primary care practitioners must report all cases of suspected abuse or neglect for further investigation to the New York State Central Registry at 1-800-635-1522.**

**If no physical evidence exists to support the suspicion of child abuse yet abuse is still suspected, primary care practitioners should enlist the aid of child protection teams, child and adolescent mental health clinicians, or social work staff with child protection expertise to help assess the case. Clinicians can call child protective services (Administration for Children's Services in New York City, Office of Children and Family Services in New York State) to consult whether or not they should report something when presentation is unclear.**

**Children who report or present with physical evidence of abuse or neglect should be referred immediately to pediatric personnel or to the pediatric emergency room in a hospital setting.**

Since abuse and neglect of children is more prevalent in families in which caregivers are actively and chronically using drugs and/or alcohol, practitioners should be focused on the signs of such trauma:

- **Physical abuse**—which may present as unexplained bruises or fractures.
- **Sexual abuse**—which is defined as any sexual act between an adult and a child or an older child and a younger child and which may present as urinary tract infection or sexually transmitted infection.

- **Neglect**—which is by far the most prevalent form of maltreatment and which is characterized by failure to provide basic needs, such as food, shelter, medical care, or schooling.

Because some caregivers will lie to cover up abuse or neglect, primary care practitioners should be observant in dealing with families in which abuse is suspected. Conclusions concerning abuse can be reached based on direct reports from children, observations of parents interacting with children, evidence of physical injury or neglect, or failure to thrive in infants. When primary care practitioners report cases of suspected abuse or neglect to the New York State Central Registry, they will be assigned a registry number and will be asked to complete the Report of Suspected Child Abuse or Maltreatment form (DSS-2221-A) including the assigned registry number. In New York City, this form must be forwarded to the Administration for Children's Services.

If necessary, the child who reports or presents with physical evidence of abuse or neglect may be separated from the abusive caregiver to ensure the child's safety. Steps such as having security guards accompany families to the emergency room may be taken to enforce cooperation.

## V. DOMESTIC VIOLENCE AND HIV INFECTION

### RECOMMENDATIONS:

**Practitioners should look for evidence of both physical and psychological abuse in relationships in which one or both of the partners are HIV infected** (see Table 4-1).

**Practitioners should respond to the victims of domestic violence in such a way that mental and medical needs are addressed without endangering the victims' lives.**

**Practitioners should use simple questions when screening for risk of domestic violence** (see Table 4-2).

**Treatment planning for patients who are victims of domestic violence should include the input of domestic violence advocates but only with the patient's consent.**

People who access HIV-related services are at high risk for violence, related both to disclosure of their HIV status and to their risk-reduction efforts. Individuals who are ill or disabled are also very vulnerable to an abusive partner's tactics. HIV service providers are often well positioned to offer both referrals and direct services to victims and to those at risk for domestic violence who may not contact other medical or social service professionals. Assessment for domestic violence is being recognized increasingly as a standard of care in providing HIV-related services.

Domestic violence may be either psychological (e.g., economic control, verbal degradation) or physical (e.g., rape, assault). Domestic violence occurs in both heterosexual and homosexual relationships at a similar rate. However, a higher proportion of victims of domestic violence sustain mental

health problems, particularly depression, suicide attempts, substance use/dependency, and post-traumatic stress disorder (PTSD), than that of the general population.

**TABLE 4-1  
COMMON BEHAVIORS OF BATTERERS**

<p>If batterer is not the HIV patient</p>	<ul style="list-style-type: none"> <li>• attributing violent behaviors to stress of caring for a partner with HIV/AIDS</li> <li>• intentionally isolating the partner by revealing or threatening to reveal his/her HIV status</li> <li>• denying the partner access to nutrition, services, assistance, or health care</li> <li>• refusing to let the partner be treated for injuries caused by battering</li> <li>• forcing the partner to undergo unnecessary treatment (including psychiatric referrals or hospitalization)</li> <li>• refusing to fill prescriptions or disposing of medication</li> </ul>
<p>If the batterer is HIV infected</p>	<ul style="list-style-type: none"> <li>• evincing no responsibility to the partner</li> <li>• using HIV/AIDS to control the partner by demanding excessive caregiving or playing on feelings of guilt</li> <li>• intentionally trying to infect the partner by refusal to engage in risk-reduction behaviors or to practice safe sex or by not informing the partner of the HIV infection</li> <li>• trying to get the practitioner to see the violence as a cry for help and sympathy (e.g., as a response to the illness, solely a mental health problem, a result of substance use or of earlier victimization).</li> <li>• blaming the partner for infecting the batterer, even if the batterer was actually the source of infection</li> </ul>

Simple questions should be used when screening for risk of domestic violence. Table 4-2 contains questions that are part of a screening tool jointly developed and widely circulated within New York State through a collaboration among the New York State Department of Health, the Office for the Prevention of Domestic Violence, and the Medical Society of the State of New York. They are consistent with screening questions recommended by the American Medical Association and others.

**TABLE 4-2  
SCREENING QUESTIONS TO DETERMINE RISK OF DOMESTIC VIOLENCE**

<ul style="list-style-type: none"> <li>• Do you ever feel unsafe at home?</li> <li>• Are you in a relationship in which you have been physically hurt or felt threatened?</li> <li>• Have you ever been or are you currently concerned about harming your partner or someone close to you?</li> </ul>
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## A. Referring Patients With HIV/AIDS Who Are Victims of Domestic Violence

### RECOMMENDATION:

**Practitioners should be aware that living with an abusive partner is not, in itself, a symptom of an underlying mental health problem and that many of the concerns of the victim are legitimate safety issues.**

Some victims of domestic violence find that the mental health problems abate when the abuse stops, whereas others need ongoing therapeutic assistance.

Safety should be the primary goal of all interventions. No action should be taken that places the patient in danger, regardless of its potential benefits. A practitioner's ability to respond to a patient's medical and mental health needs, without endangering the patient, will be enhanced if the practitioner remembers the following:

- Symptoms often reflect safety issues. Practitioners should not attribute these symptoms, or the fact that the patient stays in a relationship with a batterer, to underlying mental health problems.
- The practitioner should offer information about local domestic violence services whenever it is suspected or confirmed that a patient is being battered. With the patient's consent, the practitioner should collaborate with domestic violence service providers.
- Not all victims of domestic violence need therapy. The practitioner should not refer for therapy in lieu of domestic violence services. Referral for mental health services should be made if victims need or request them, but victimization should not necessarily be treated as a mental health problem.
- If there seems to be indication for mental health referral, the practitioner should refer the patient to individual therapy, not couples' counseling. Couples' counseling has great potential to endanger the victim (who may be beaten for saying "the wrong thing" in therapy) and reinforce the batterer's controlling tactics.
- The practitioner should always interview a patient privately, out of sight and hearing of his/her partner and children. It should not be assumed that an adult accompanying the patient is not his/her partner.
- The practitioner should ask patients directly whether their partner is hurting or threatening them.

- The practitioner should empathize with the patient's fear and confusion. Reassurance should be given that the patient's feelings are legitimate and normal, and he/she should be reminded that he/she does not deserve to be abused.
- The practitioner should not act without the patient's consent, including calling the police. New York State law does not mandate reporting of adult domestic violence; doing so without the victim's consent violates patient confidentiality. If, however, a practitioner is mandated to make a child abuse report, this should be done with the patient's knowledge and with attention to the patient's safety.
- The practitioner should avoid victim-blaming language in documentation.
- The practitioner cannot solve the problem, but he/she can provide ongoing support. The practitioner should support the patient's right to make his/her own decisions, including those with which the practitioner disagrees.

#### **B. Referring Patients With HIV/AIDS Who Are the Perpetrators of Domestic Violence**

A practitioner's ability to respond to the medical and mental health needs of a patient who is the batterer without endangering his/her partner will be enhanced if the practitioner remembers the following:

- Most domestic violence service providers work with victims, not with batterers. However, because some batterers present themselves as victims, suspected batterers should be referred only to specialized batterers' programs. This is especially important in the case of lesbian batterers who can gain entry to shelters because they are women.
- Patients who are batterers should be referred for mental health (and substance use) services if they need them for other reasons, but battering should not necessarily be treated as a mental health problem. Batterers commonly use their attendance at counseling or substance use services as ways to manipulate their partners into dropping charges or remaining in the relationship. Being referred for mental health services when domestic violence is the only identified problem also supports batterers' attempts to deny responsibility for their behavior by implicitly attributing it to factors other than their own choice.
- When domestic violence is identified, practitioners should make the safety of the victimized partner the primary goal of all interventions.

Individuals who are battered will frequently deny any difficulties both out of fear of the batterer and a misguided wish to protect him/her. The patient's history and behavior may provide confirmation of the diagnosis (see Table 4-3).

**TABLE 4-3  
COMMON INDICATIONS OF DOMESTIC VIOLENCE**

Common Presenting Problems and History in Patients Involved in Domestic Violence	<ul style="list-style-type: none"> <li>• Stress and anxiety disorders including PTSD and panic attacks</li> <li>• Alcohol or substance dependence or use</li> <li>• Insomnia</li> <li>• Eating disorders</li> <li>• Fatigue, malaise, and vague or psychosomatic complaints</li> <li>• Chronic pain</li> <li>• Severe headaches</li> <li>• Depression</li> <li>• Trauma-related injuries</li> <li>• Suicidal ideation or attempts</li> <li>• Relationship problems</li> <li>• Exacerbation of chronic illnesses (e.g., asthma, migraines)</li> </ul>
Behavioral Cues of Domestic Violence Victims	<ul style="list-style-type: none"> <li>• Change in appointment pattern</li> <li>• Flat or incongruent affectation</li> <li>• Fearfulness toward partner</li> <li>• Apologizes for or rationalizes partner's behavior (even non-abusive behavior)</li> <li>• Bases plans and decisions on what partner wants rather than on his/her own wishes</li> <li>• Performs degrading, inhumane, or inappropriate tasks</li> <li>• Refers to partner's temper frequently</li> <li>• Focuses on how he/she harmed partner</li> <li>• Flees from home or seeks shelter frequently</li> </ul>
Batterer's History and Behavior	<ul style="list-style-type: none"> <li>• Suicide attempts</li> <li>• Intoxication, alcoholism, drug use</li> <li>• Aggressive or abusive toward partner, practitioner, or other staff</li> <li>• Overly attentive to partner</li> <li>• Cancels partner's appointments</li> <li>• Aggressively presents self as victim</li> <li>• Visible defensive injury pattern</li> <li>• Refuses/resents needed medical or mental health care for partner</li> </ul>



# CHAPTER 5

## COGNITIVE DISORDERS AND HIV/AIDS

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### GENERAL RECOMMENDATION:

**Because the early stages of dementia and delirium are often subtle and difficult to recognize, the primary care practitioner should be particularly aware of the early stages of the two syndromes and their symptoms.**

Cognitive disorders traditionally refer to neuropsychiatric syndromes attributed to a medical condition. HIV is neuroinvasive and neurotropic. Accordingly, some people with HIV infection develop neurologic complications that may result from direct or indirect effects of the virus. In people with HIV infection or AIDS, these complications include dementia, delirium, neurobehavioral impairments, myelopathy (functional disturbances and/or pathologic changes in the spinal cord), and aseptic meningitis.

Dementia is the most common cognitive disorder in people with HIV/AIDS, and delirium is the most common cognitive disorder in hospitalized patients with AIDS. The prompt diagnosis and treatment of dementia and delirium may decrease morbidity and mortality.

### I. AIDS DEMENTIA COMPLEX

AIDS dementia complex (ADC), also known as HIV-associated dementia (HAD), produces a highly variable clinical course and a spectrum of symptoms ranging from minor cognitive motor dysfunction to profound dementia (see Table 5-1). Some patients experience only subtle symptoms, such as forgetfulness and diminished writing or visual/motor skills, for which they can compensate with help. Some patients experience a gradual mental decline, whereas others deteriorate rapidly over a relatively short period of time. As immunodeficiency progresses, the prevalence of dementia increases. Patients who are older at the time of an AIDS diagnosis are at greater risk of developing this syndrome.

The incidence of HAD has decreased since the introduction of highly active antiretroviral therapy (HAART). In addition, there have been marked improvements in the cognitive status of some people with HIV-associated dementia associated with the initiation of HAART. This has been postulated to be due to an improvement in immune status as evidenced by increased CD4 cells, a decrease in total viral load, or a direct antiretroviral effect within the nervous system.

**TABLE 5-1**  
**CLINICAL MANIFESTATIONS OF HIV-ASSOCIATED DEMENTIA**

<b>Type of Impairment</b>	<b>Manifestations</b>
Affective	<ul style="list-style-type: none"> <li>- Apathy (depression-like features)</li> <li>- Irritability</li> <li>- Mania, new-onset psychosis</li> </ul>
Behavioral	<ul style="list-style-type: none"> <li>- Psychomotor retardation (e.g., slowed speech or response time)</li> <li>- Personality changes</li> </ul>
Cognitive	<ul style="list-style-type: none"> <li>- Lack of visuospatial memory (e.g., misplacing things)</li> <li>- Lack of visuomotor coordination (e.g., eye movement abnormalities)</li> <li>- Difficulty with complex sequencing (e.g., difficulty in performing previously learned complex tasks)</li> <li>- Impaired concentration and attention</li> <li>- Impaired verbal memory (e.g., word-finding ability)</li> </ul>
Motor	<ul style="list-style-type: none"> <li>- Unsteady gait, loss of balance</li> <li>- Leg weakness</li> <li>- Tremors, poor handwriting</li> </ul>

**A. Approaching the Diagnosis**

**RECOMMENDATIONS:**

**Practitioners should use a brief, standardized rating scale when the presence of early-stage ADC is suspected. To follow the course of ADC, the practitioner should re-administer the scale. Before a diagnosis of ADC can be made, however, other causes of change in mental status must be ruled out.**

**Neuroimaging studies, such as computed tomography (CT) and/or magnetic resonance imaging (MRI) scans, and a general medical evaluation should be performed to rule out other treatable central nervous system (CNS) pathology.**

**Patients should be referred for psychiatric or psychological assessment when diagnosis is uncertain or other psychiatric disorders are suspected.**

**Practitioners should consult with a psychiatrist or neurologist as required if dementia is suspected.**

CT and MRI scans are nonspecific in ADC because they reveal only brain atrophy and ventricular enlargement. Substance use disorders/intoxication should always be included in the differential diagnosis.

Signs of the earlier stages of ADC may be subtle. Some patients may complain of forgetfulness or decreased concentration, whereas others may be unaware of symptoms. A decline in motor skills, especially fine movements, may be present in early ADC. When early-stage ADC is suspected, the usual screening tests employed for cognitive disorders are of limited value. Abbreviated forms of the mental status exam have been adopted and widely used in clinical practice, specifically to assess cognitive function. These forms usually include orientation, registration, attention and calculation, recall, language, and visual motor integrity. To follow disease progression, practitioners should readminister the chosen scale at intervals.

Because late-stage ADC resembles late-stage dementia of Alzheimer's disease, it is generally easier to recognize than early-stage ADC. Seizures, global cognitive deterioration, mutism, incontinence, and severe confusion are common symptoms.

## **B. Treatment of ADC**

### **RECOMMENDATIONS:**

**Practitioners should consult with a psychiatrist as required for diagnostic purposes or for prescribing medication. A psychologist, nurse practitioner, or social worker may also help with behavioral strategies for the management of patients with ADC.**

**Practitioners should refer patients with ADC for psychiatric evaluation and treatment if they have a prior history of psychiatric disorders, are taking illicitly obtained psychotropic medications, do not respond to treatment, or have a dual diagnosis of substance use and mental illness.**

**Patients and their families should be educated about ADC and its course.**

Because the term "dementia" and the awareness of cognitive decline can be frightening to HIV-infected patients and to their families, educating patients and their families is crucial. Assessment of patients' decision-making capabilities as early as possible assures that they will be involved in short-, middle-, and long-term care decisions.

Three therapeutic modalities exist for treating patients with ADC:

### **1. Antiretroviral drugs**

Under this therapeutic approach, practitioners aim to treat the underlying cause of ADC through the use of combinations of antiretroviral drugs that penetrate the blood-brain barrier. These regimens may arrest or reverse the dementing process. Elimination of the cause of ADC or arrest of the progression of ADC would be the ideal outcome. Antiretroviral combinations that include drugs that penetrate the blood-brain barrier, particularly zidovudine, have been shown in some small studies to lead to improvement and, at the very least, to a partial return of functioning in patients previously diagnosed with ADC. Abacavir, efavirenz, lamivudine, nevirapine, and stavudine also penetrate the blood-brain barrier and may be effective. The strongest clinical evidence exists for zidovudine; however, didanosine and abacavir may have some effect, although there is less evidence to support this. Preliminary evidence, based on cerebrospinal fluid (CSF) levels rather than clinical data, shows nevirapine improves cognitive-motor symptoms. Indinavir is the only protease inhibitor that penetrates the CSF well, and a reasonable CSF level can be reached with current doses; however, there is a lack of clinical data to show that indinavir improves dementia. Efavirenz is contraindicated for use in pregnant women.

### **2. Pharmacologic treatment of symptoms**

Patients with ADC may also benefit from psychotropic medications used to target specific symptoms, such as psychomotor slowing, agitation, depression, and psychosis (see Table 5-2).

### **3. Non-pharmacologic treatment**

#### **RECOMMENDATIONS:**

**Practitioners should involve families and caregivers in medication management and appointments.**

**Practitioners should assess patients for functioning and decision-making capacity and should encourage patients to make decisions such as legal and health care proxy decisions while they are still capable of participating.**

**Practitioners should provide emotional support for patients in the early stages of ADC.**

**Practitioners should consult with a psychiatrist for management suggestions and assistance.**

**TABLE 5-2**  
**DRUGS USED TO TARGET SYMPTOMS OF ADC-ASSOCIATED DEMENTIA\***

Category	Drug	Dosage	Comment
Psychostimulant agents (for psychomotor slowing, apathy, and attention deficits)	Dextroamphetamine	5-15 mg/day	Controlled substances
	Methylphenidate	Initially 5-10 mg every morning; up to 3-times-a-day dosing; maximum dose: 30-45 mg/day	
	Pemoline	18.75-75 mg every day; once-a-day dosing	
Antipsychotic agents	Haloperidol	0.5-2 mg/day; up to tid	Use lowest effective dose to avoid extrapyramidal effects, anticholinergic effects, or orthostasis; patients with AIDS are quite sensitive
	Risperidone	0.5-1 mg; up to tid	
Antimanic agents	Lithium carbonate	600-1,200 mg/day up to blood levels of 0.6-1.2 mEq/L.	Use with caution; neurologic side effects and diarrhea may occur
	Valproic acid	250 mg tid; titrate up to blood level of 50-100 mg/mL	Use with caution; follow liver function tests
	Carbamazepine to 4-12 µg/mL	200 mg bid; titrate up	Can cause leukopenia; monitor WBC
	Gabapentin	100 mg tid; titrate to effect	
	Olanzapine	2.5 mg qd; titrate up to 10 mg	
Antidepressants (for depression)	Paroxetine	10-20 mg q hs (up to 50 mg)	Most sedating, so hs dose often preferred
	Sertraline	25-50 mg q am (up to 200 mg)	
	Fluoxetine	10-20 mg q am (up to 60 mg)	Most activating
	Citalopram	10-20 mg q am (up to 40 mg)	
	Desipramine	25 mg bid; titrate to 180 ng/mL	
	Trazodone	50-100 mg hs	Used mainly as a sleeping aid; can be calming for agitated patient

\*Be aware of possible interactions with medications used for HIV infection (see Appendix D).

In the non-pharmacologic management of patients with HIV-associated dementia, practitioners should do the following:

- When giving instruction:
  - Simplify complex tasks, especially drug regimens.
  - Suggest use of pill boxes, diaries, and time tables.
  - Repeat information.
  - Write instructions to provide structure for patient and caregiver.
- When presented with patients who are confused, agitated, or challenged by their experience:
  - Maintain orientation cues, and structure activities appropriately.
  - Try to keep the environment familiar, and prepare patients for change.
  - Redirect or distract patients from inappropriate behavior.
  - Maintain calm when patients become confused or agitated, and refrain from confronting an agitated patient.

## II. DELIRIUM ASSOCIATED WITH HIV

This disorder is the most common neuropsychiatric complication in hospitalized AIDS patients. Occasionally, patients may present some early signs of delirium in the primary care setting. It is thus essential that primary care practitioners be able to recognize the symptoms and refer patients to the hospital immediately.

### A. Approaching the Diagnosis

#### RECOMMENDATIONS:

**When there is a sudden change in a patient's cognitive status, consciousness or behavior, practitioners should suspect delirium and obtain a psychiatric consultation to assist in the diagnosis of delirium.**

**Practitioners should be highly observant of their patients, as there are many possible causes of delirium (e.g., metabolic abnormalities, sepsis, hypoxemia, anemia, CNS infections and malignancies, almost all HIV-related drugs, opioids, and illicit substances).**

The hallmarks of delirium are an impairment of consciousness, with a reduced ability to focus, sustain, or shift attention, and changes in cognition or development of perceptual disturbances that are not explained by a pre-existing dementia. These disturbances may develop over a short period of time, and the symptoms may fluctuate in

severity. Delirium is generally a direct physiologic consequence of a medical condition. Table 5-3 summarizes manifestations of delirium in patients with HIV/AIDS.

Delirium is often difficult to diagnose. When patients appear hypoactive, depression is a frequent misdiagnosis for delirium. Patients at high risk for developing delirium are those in advanced stages of immunosuppression; those with a history of opportunistic infections, substance use, head/brain injuries, or episodes of delirium; or those with ADC or infections and malignancies of the CNS.

<b>TABLE 5-3</b> <b>CLINICAL MANIFESTATIONS OF DELIRIUM IN PATIENTS WITH HIV</b>
<ul style="list-style-type: none"> <li>• Impairment of memory, orientation, prefrontal “executive” functions               <ul style="list-style-type: none"> <li>– Difficulty with abstraction</li> <li>– Difficulty with sequential thinking</li> <li>– Impaired temporal memory</li> <li>– Impaired judgment</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Disturbances in thought and language               <ul style="list-style-type: none"> <li>– Decreased verbal fluency</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Disturbances in perception               <ul style="list-style-type: none"> <li>– Hallucinations (primarily visual)</li> <li>– Delusions</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Disturbances in psychomotor function               <ul style="list-style-type: none"> <li>– Hypoactive</li> <li>– Hyperactive</li> <li>– Mixed hypo- and hyperactive</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Disturbances in sleep-wake cycle               <ul style="list-style-type: none"> <li>– Daytime lethargy</li> <li>– Nighttime agitation</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Delusions*</li> </ul>
<ul style="list-style-type: none"> <li>• Affective lability</li> </ul>
<ul style="list-style-type: none"> <li>• Neurologic abnormalities               <ul style="list-style-type: none"> <li>– Tremors</li> <li>– Myoclonus</li> <li>– Asterixis</li> <li>– Nystagmus</li> <li>– Ataxia</li> <li>– Cranial nerve palsies</li> <li>– Cerebellar signs</li> </ul> </li> </ul>

\* Delusions are usually paranoid but more disorganized than those seen in psychoses.

## **B. Treatment**

Treatment of delirium in patients with HIV/AIDS is based on the same principles used for treatment of delirium in patients with other medical illnesses. Correcting the underlying conditions that have led to delirium is the primary treatment. Symptoms such as confusion or agitation can be treated by using low doses of neuroleptics (e.g., haloperidol or risperidone). If symptoms of agitation put the patient or others at risk and are not controlled by low doses of antipsychotics, adding low doses of lorazepam may be helpful in achieving sedation. Psychiatric consultation may be helpful in management.

Finally, it should be kept in mind that patients with AIDS may be more sensitive to the side effects of psychotropic medications.

# CHAPTER 6

## DEPRESSION AND MANIA IN PATIENTS WITH HIV/AIDS

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### I. DEPRESSION

#### RECOMMENDATIONS:

**Practitioners should screen for depression on a yearly basis and when the symptoms suggest its presence.**

**Practitioners should closely monitor the following behavioral changes: a change in treatment adherence; an inability to make life choices including those related to medical care; a preoccupation with a particular problem, usually one that presents as minor; or a change in functioning, including an inability to perform activities of daily living, a return to substance use, or a self-imposed isolation.**

Clinical depression is the most commonly observed psychiatric disorder among patients with HIV infection and affects up to 20% of such patients. Multiple risk factors for depression exist in this group. The diagnosis of HIV infection itself may lead to sadness and fears of stigmatization. People with HIV infection who are members of stigmatized minorities may find it difficult to avoid internalizing negative self-images; moreover, HIV infection may result in wasting, weakness, pain, confusion, and disfigurement, which add to patients' negative feelings. Although sadness and grief are normal responses to these factors, clinical depression, which causes substantial morbidity and may increase mortality, is not. Practitioners should screen for depression on a yearly basis and more often when symptoms suggest. Many simple screening instruments are available for this purpose (see Appendix III).

### II. DIAGNOSIS

#### RECOMMENDATIONS:

**If the practitioner's evaluation indicates depression, even though the patient denies that he or she is depressed, the diagnosis should be made and treatment should be strongly recommended.**

**For diagnosis of depression, practitioners should be familiar with and use the diagnostic criteria established in the *Diagnostic and Statistical Manual of Mental Disorder-IV (DSM-IV)*.**

**Practitioners should be aware of potential side effects of all medications patients are taking. Specifically, efavirenz for HIV/AIDS and interferon- $\alpha$  for HCV are associated with episodes of depression varying in intensity. These medications may need to be discontinued or used with antidepressant therapy. Should these medications be continued, the primary care practitioner should work closely with a psychiatrist.**

Hopelessness, anhedonia (the absence of pleasure from performing usually pleasurable activities), and ruminative guilt are the three characteristics that distinguish depression from normal sadness and grief.

**A. Diagnostic Criteria for Major Depression**

Diagnosis of major depression requires the following:

- That at least one of the first two symptoms (i.e., depressed mood, loss of interest or pleasure) and four of the remaining symptoms listed in Table 6-1 be present for at least 2 weeks.
- That the symptoms not be accounted for by bereavement.
- That the symptoms not be caused by general medical illness, medications, or alcohol/drug use.
- That the symptoms result in significant impairment in social and occupational function.

<b>TABLE 6-1 SYMPTOMS OF MAJOR DEPRESSION</b>
<ul style="list-style-type: none"><li>• Depressed mood</li><li>• Loss of interest or pleasure</li><li>• Guilt feelings</li><li>• Suicidal thoughts</li><li>• Sleep disturbance</li><li>• Appetite/weight changes</li><li>• Attention/concentration problems</li><li>• Energy level changes/fatigue</li><li>• Psychomotor disturbance</li></ul>

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Because weight loss, irritability, restlessness, disturbed sleep, fatigue, anorexia, lethargy, or diminished interest in sex (all symptoms commonly observed in HIV-infected persons) may indicate depression, it is important for primary care practitioners to determine if patients are experiencing the effects of HIV, side effects of medications, or clinical depression. Screening for depression is particularly important during the crisis points noted in Chapter 1: *The Role of the Primary Care Practitioner in Assessing and Treating Mental Health in Persons With HIV*.

## B. Questions to Ask to Determine Whether Patient Is Depressed

The response to the direct question, “Are you depressed?,” often provides sufficient information for a diagnosis of depression. Other questions can include:

- What do you enjoy doing these days?  
Is that the way it has always been?
- Does anything bring you pleasure?
- Have you been feeling down?
- When people are ill and feeling depressed, they often want to just “get it all over with.” Have you felt that way?  
Have you thought about killing yourself?
- Have you been feeling guilty about things?  
Feeling like you’re no good or not a good person?
- Have you been blaming yourself for things?
- How have you been sleeping?
- I notice you’ve lost/gained weight; are you feeling more/less hungry, eating more/less than usual?
- Are you having trouble concentrating?  
Are you able to follow the plot of a book or a TV show?  
Is it harder than usual to make decisions?
- Are you feeling more tired or worn out than usual?
- You look a little jumpy/slow; are you feeling more restless/moving more slowly than usual? Has anyone else noticed this?

Many patients will not show the classic symptoms of depression, and some will be unable to recognize their problem as “depression.” In these cases, it is the responsibility of the primary care practitioner to make the diagnosis and reflect it back to the patient.

## III. REFERRAL AND TREATMENT

### A. Referral

#### RECOMMENDATION:

**Practitioners should procure immediate psychiatric intervention for all patients who are at high risk for suicide** (see Chapter 7: *Suicidality in Patients With HIV/AIDS*).

Referrals to psychiatrists may also be indicated when:

- Patients present with depression associated with dementia.
- Patients do not respond to trials of two different antidepressant medications.

- Symptoms worsen despite use of a medication.
- Higher-than-usual doses of medication are required to control symptoms.

## **B. Antidepressant Medications**

### **RECOMMENDATIONS:**

**Practitioners should learn about antidepressants and their drug-drug interactions with HIV-related medications.**

**Practitioners should, whenever possible, combine medication with mental health counseling.**

Because of potential side effects and drug-drug interactions, practitioners should become familiar with the safety profiles and interactions of antidepressants and HIV-related medications (see Appendix D).

When an antidepressant is indicated, the choice can be guided by patient history, family history, target symptoms, and the side effects and safety profiles of the medications. For example, if patients have responded to a specific medication in the past, they probably will again. If patients' relatives have responded well to a specific medication, the patients themselves may do the same. Drug characteristics, including useful side effects, may also guide medication choices as these side effects may actually treat other psychiatric and non-psychiatric symptoms such as insomnia, neuropathy, and anxiety (see Table 6-2).

For people with HIV, as in other vulnerable populations, the concept "start low, go slow" remains the cornerstone of medication use.

A patient may experience a wide range of depressive symptoms, some of which may be relieved by the side effects of particular antidepressant medications. For example, patients whose main complaint is insomnia may prefer antidepressants with more sedative effects.

Although for some patients medication alone may be sufficient to ease their depression, for others the combination of medication and mental health counseling will provide a more effective and, perhaps, quicker response.

**TABLE 6-2**  
**PHARMACOLOGIC TREATMENT OF MOOD DISORDER WITH DEPRESSIVE**  
**FEATURES AND MAJOR DEPRESSIVE DISORDER IN PERSONS WITH AIDS**

<b>Psychotropic Medication (Category)</b>	<b>Name</b>	<b>Dose Range</b>	<b>Primary Indication: Depression and Secondary Indications</b>
Antidepressants SSRIs	Citalopram (Celexa)	10-40 mg	Hepatic disease Post-traumatic stress disorder Borderline personality disorder
	Setraline (Zoloft)	50-150 mg	Post-traumatic stress disorder Social phobia
Tricyclics	Nortriptyline (Pamelor)	25-125 mg	Neuropathy Cocaine withdrawal Insomnia
	Desipramine (Norpramin)	25-150 mg	Neuropathy Cocaine withdrawal
	Doxepin (Sinequan)	25-100 mg	Pruritus Insomnia
Mood stabilizers	Gabapentin (Neurontin)	100-2400 mg	Mood stabilization Neuropathy Drug cravings
Antipsychotics	Olanzapine (Zyprexa)	2.5-20 mg	Psychotic features

Adapted from *Gen Hosp Psychiatry*, Volume 22, Adler Cohen MA, Jacobson JM, Maximizing life's potentials in AIDS: A psychopharmacologic update, pp 375-388, 2000 with permission from Elsevier Science.

### **1. Selective Serotonin Re-uptake Inhibitors (SSRIs) and Newer Antidepressant Medications**

**RECOMMENDATIONS:**

**Practitioners should review the side-effect profiles of anti-depressant agents before prescribing them. Practitioners should consult Appendix I before prescribing these agents as SSRI levels can rise significantly when prescribed concomitantly with non-nucleoside reverse transcriptase inhibitors (NNRTIs) or protease inhibitors (PIs).**

**Practitioners should ask patients specifically about sexual side effects with SSRIs.**

Selective serotonin re-uptake inhibitors are relatively safe and are usually well tolerated by patients. Although not necessarily more effective than the older tricyclic antidepressants (TCAs), SSRIs have become first-line treatments. In general, SSRIs have fewer drug interactions and a more benign side-effect profile than TCAs.

The most troubling side effect of SSRIs is sexual dysfunction (e.g., anorgasmia, decreased libido, or erectile and ejaculatory dysfunction), which has been widely reported and contributes to non-adherence. Dose reductions, drug holidays, or switching to another drug in the same class may help ease these effects for some patients. Other patients will require the use of another class of drug.

The second main concern about the use of SSRIs is their inhibition of cytochrome P450 isoenzymes. SSRIs should be prescribed with caution to patients also taking PIs and NNRTIs because of the potential for drug-drug interactions (see Appendix D).

Antidepressant agents even newer than the SSRIs include bupropion, mirtazapine, nefazodone, and venlafaxine. These antidepressant agents are also relatively safe and well tolerated. Practitioners should review the side-effect profiles of these agents before prescribing them. Levels of these agents can rise significantly when prescribed concomitantly with NNRTIs or PIs, and Appendix I should be consulted before prescribing.

## 2. Tricyclic Antidepressants

### **RECOMMENDATION:**

**Monitoring of drug levels in blood should be performed to ensure appropriate dosing.**

If patients cannot tolerate SSRIs, TCAs can prove equally effective. TCAs have anticholinergic effects that lead to sedation and constipation, which are side effects sometimes useful in patients with insomnia and chronic diarrhea, respectively. TCAs also cause weight gain and are useful in treatment of neuropathic pain. Treatment failure with TCAs is primarily caused by underdosing or inadequate length of treatment, with a 6-week trial of an adequate dose needed for best effect.

Monitoring of drug levels may be particularly important when there are concerns about adherence or absorption. Because TCAs can be lethal in overdose, an SSRI may be a safer choice when risk of suicide is a concern. TCA anticholinergic side effects (e.g., dry mouth, blurred vision, or orthostasis) can be disturbing to patients and can lead to non-adherence or treatment failure.

Concomitant use of TCAs and PIs or NNRTIs can lead to increased levels of the antidepressant. Caution should be used with such combinations (see Appendix D).

### C. Management and Long-Term Follow-Up

#### RECOMMENDATIONS:

**After starting antidepressant therapy, patients should be seen frequently as it may take 3 weeks or longer to affect patients' mood.**

**Patients who experience recurrent depression should be encouraged to remain on medication indefinitely.**

Sleep, energy level, and the ability to meet obligations tend to improve first. A brief visit or phone conversation every 1 or 2 weeks is advisable during the initiation of treatment. After 3 weeks, improvement in a patient's symptoms should be assessed in person. Little or no improvement suggests a need for a change in treatment. Most often an increase in dose is the first option if side effects are not an issue. If a several-week trial at a maximal dose is not effective, a change of medication, augmentation with another agent, or referral is appropriate.

Depression can be a chronic condition, with relapse being a common event. Treatment for 6 months to 1 year is suggested after the first episode of depression is resolved. Repeated episodes of depression suggest the need for lifelong treatment.

### D. Alternative Therapies for Depression

#### RECOMMENDATIONS:

**If patients wish to use alternative treatments instead of standard care, they should be advised that such treatments may take longer to be effective and that, as with the use of pharmaceuticals, the use of herbal treatments may lead to toxicities or drug interactions.**

**Concomitant use of St. John's wort with PIs or NNRTIs is not recommended because this may result in suboptimal antiretroviral drug concentrations.**

In addition to body therapies and acupuncture, herbal supplements, such as St. John's wort (*hypericum perforatum*), are commonly used alternative therapies for depression. St. John's wort induces the cytochrome P450 metabolic pathway, which should be taken into consideration when developing a treatment regimen.

#### IV. MANIA

##### RECOMMENDATIONS:

**Practitioners should immediately refer patients who are experiencing mania for psychiatric evaluation and care as this condition constitutes a psychiatric emergency.**

**Practitioners should consult with a psychiatrist or refer patients to one when it is not clear whether patients are hypomanic or depressed. Treating hypomanic patients with antidepressants may lead to a full-blown episode of mania.**

**Until patients are stabilized, maintaining consultation with a psychiatrist or having patients under psychiatric care is recommended.**

A patient who experiences mania requires emergency psychiatric intervention. For primary care practitioners, this means immediately referring the patient to a psychiatrist. Manic patients have severely impaired judgment and will not listen to advice. In addition, manic patients often enjoy their symptoms, which makes them resistant to treatment. To overcome this resistance, it is often helpful to involve such patients' families and friends.

In its full-blown form, mania is a period of abnormally elevated or irritable mood and is easy to identify. Practitioners should be familiar with the *DSM-IV* diagnostic criteria for mania listed in Table 6-3.

**TABLE 6-3  
SYMPTOMS OF MANIA**

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Increased talkativeness or pressure to speak
- Increased feeling of racing thoughts or fleeting ideas
- Increased attention to unimportant or irrelevant events or activities
- Increased goal-oriented activity or psychomotor agitation
- Increased, excessive involvement in pleasurable activities that have high potential for adverse consequences, (e.g., buying sprees, sexual indiscretions, unwise business ventures)

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## V. DIAGNOSTIC CRITERIA

### RECOMMENDATION:

**If there is question about the diagnosis of mania, practitioners should consult with or refer patients to a psychiatrist.**

If the patient's mood is expansive, at least three symptoms should be present. If the mood is irritable, four symptoms should be present (see Table 6-3). For the practitioner to conclude a diagnosis of mania, the patient's symptoms should impair usual functioning and last at least 1 week. Symptoms of mania are also present in bipolar disorder and hypomania.

#### A. Bipolar Disorder

Regardless of how many episodes of depression patients have, a single manic episode indicates that the depression diagnosis should be changed to bipolar disorder. This change in diagnosis requires a change in treatment. A single manic episode with or without a history of depression also indicates a diagnosis of bipolar disorder. Lithium was once the drug of choice, but today carbamazepine, valproic acid, gabapentin, or other anticonvulsant medications as well as antipsychotic medications are also used to control symptoms.

#### B. Hypomania

Symptoms of hypomania are similar to those of mania, but the impairment in functioning is not as extreme. The symptoms of hypomanic patients with irritable mood may resemble those of patients with depression. Treating such patients with an antidepressant, rather than the more appropriate mood stabilizer, may lead to a full-blown episode of mania.



# CHAPTER 7

## SUICIDALITY IN PATIENTS WITH HIV/AIDS

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### GENERAL RECOMMENDATION:

**Primary care practitioners should be prepared to assess their patients' risk of suicide, evaluate their suicidal intent, and offer appropriate treatment since patients with understandable suicidal thoughts will benefit from psychological support.**

HIV infection can lead to a confluence of severe medical, psychological, and social stresses that can result in alienation from family and friends, loss of job and income, and chronic physical pain. While many people who are infected with HIV think of suicide at some time, only a small minority of HIV-infected persons commit suicide. A great many people with HIV infection lead fulfilling lives (sometimes even more fulfilling after the HIV diagnosis); nevertheless, the potential for suicide in this population should be recognized.

Prevalence studies of suicidality in patients infected with HIV have yielded varied results. One early retrospective study of medical examiner reports indicated a 36-fold greater prevalence of suicide in persons with HIV infection than in age-matched persons without HIV. A more recent study by the same investigators found only a small increase in the rate of suicide compared to other populations. In the general population, approximately 70% of suicides are committed by those who are depressed. Because anyone with HIV infection is likely to experience periods of intense sadness, thoughts of suicide are not uncommon. However, such factors as improved social support and prognosis can decrease the depth of true clinical depression and, therefore, the potential for suicide. The risk of suicide today may be less than that during earlier years of the epidemic when patients had fewer treatment options and a greater sense of isolation.

### I. RISK FACTORS FOR SUICIDE

#### RECOMMENDATIONS:

**Practitioners should recognize the factors associated with suicide risk** (see Table 7-1).

**Practitioners should refer patients for a complete psychiatric evaluation when patients express more than fleeting suicidal thoughts.**

**Practitioners who have any doubt about managing patients with suicidal thoughts should refer such patients for mental health evaluation.**

Risk factors for suicide can be remembered with the use of the mnemonic "SAD PERSONS" as shown in Table 7-1. People with AIDS-related dementia or delirium, pre-existing personality disorders, or a history of substance use

**TABLE 7-1**  
**RISK FACTORS FOR SUICIDE IN HIV-INFECTED PATIENTS:**  
**ILLUSTRATIVE MNEMONIC “SAD PERSONS”**

<b>Risk factor</b>	<b>Comments/examples</b>
<b>S</b> ex	Males more often complete, females more often attempt
<b>A</b> ge	Teenage years and age >45 years
<b>D</b> epression	Hopelessness, despondency, decreased affectation
<b>P</b> rior attempts/Prior mental illness	Personal or family history
<b>E</b> mployment	Change or loss of job, retirement
<b>R</b> ecent stressors	Multiple losses or separation, severe anxiety, irritation, violence
<b>S</b> ubstance abuse	Especially alcohol dependence
<b>O</b> rganic disease	Failed medical treatment or first hospitalization for organic disease, chronic pain from organic disease
<b>N</b> ote written stating intention of suicide	Or similar behaviors: <ul style="list-style-type: none"> <li>• Having and stating a means of suicide</li> <li>• Giving away possessions</li> </ul>
<b>S</b> ingle, widowed, or divorced	

Adapted with permission from Patterson WM, Done HH, Bird J, Patterson GA. Evaluation of suicidal patients: The SAD PERSONS Scale. *Psychosomatics* 1983;24:343-345.

often have increased impulsiveness, impaired judgment, and decreased coping skills, all of which can lead to increased risk. Even in the absence of depressive symptoms, severe anxiety can indicate increased risk of suicide. The more risk factors a patient has, the greater the likelihood of suicide. If practitioners have any doubt about their ability to manage a patient with suicidal thoughts, the patient should be referred for an evaluation by a mental health professional.

Sometimes suicide is consciously or unconsciously suggested to the patient by loved ones who cannot cope with the consequences of HIV and AIDS. Family, friends, and even health care workers who identify with a patient's hopelessness may further exacerbate suicidal thoughts (e.g., “Well, I might kill myself under these circumstances too.”). Rather than accept or reinforce such ideas, practitioners should explore with patients why they think about suicide. When a patient expresses more than a fleeting suicidal thought, referral to a psychiatrist for more complete evaluation is usually indicated. A significant percentage of patients who commit suicide will have seen their primary care practitioner in the month prior to their suicide. Therefore, better identification and treatment in the primary care setting may reduce the risk.

## II. DETECTION OF SUICIDAL INTENT

Detection of suicidal intent necessitates asking patients about suicidal thoughts. For many practitioners, however, such questions are difficult to ask. Physicians, for example, might feel that the act of asking might provoke suicidal thoughts or could disrupt the practitioner-patient relationship. In addition, the physician might be unsure of the consequences of hearing an affirmative answer (e.g., “I have 10 people in my waiting room. What do I do now?”).

However, when a patient recognizes concern and empathy in the practitioner’s gentle lead-in questions, the process of assessing suicidal intent may actually strengthen the practitioner-patient relationship. For example,

- It sounds as if you are in great pain. Have you ever thought life was not worth living?
- Do you often think about hurting yourself?... How might you do that?... You know, there is a big difference between having those thoughts and acting on them. Is this something you might actually do?

No evidence exists that assessing suicide risk increases the rate of suicide. It is more likely that a patient will feel relief in sharing his or her suicidal thoughts as this offers an opportunity to obtain help. Like other patients who need immediate intervention, suicidal patients require extra time and effort on the part of the practitioner. An assessment of a person’s risk factors (see Table 7-1) for serious suicide intent can help determine the need for immediate psychiatric assessment.

## III. MANAGEMENT OF SUICIDAL PATIENTS

### RECOMMENDATIONS:

**Practitioners should recognize family and friends of patients as crucial sources of support and should offer patients without family and friends as much organized support as possible by providing access to and information about community-based services.**

**Patients who want to kill themselves and who do not feel able to control their feelings should be referred, regardless of such patients’ risk factors, for psychiatric assessment.**

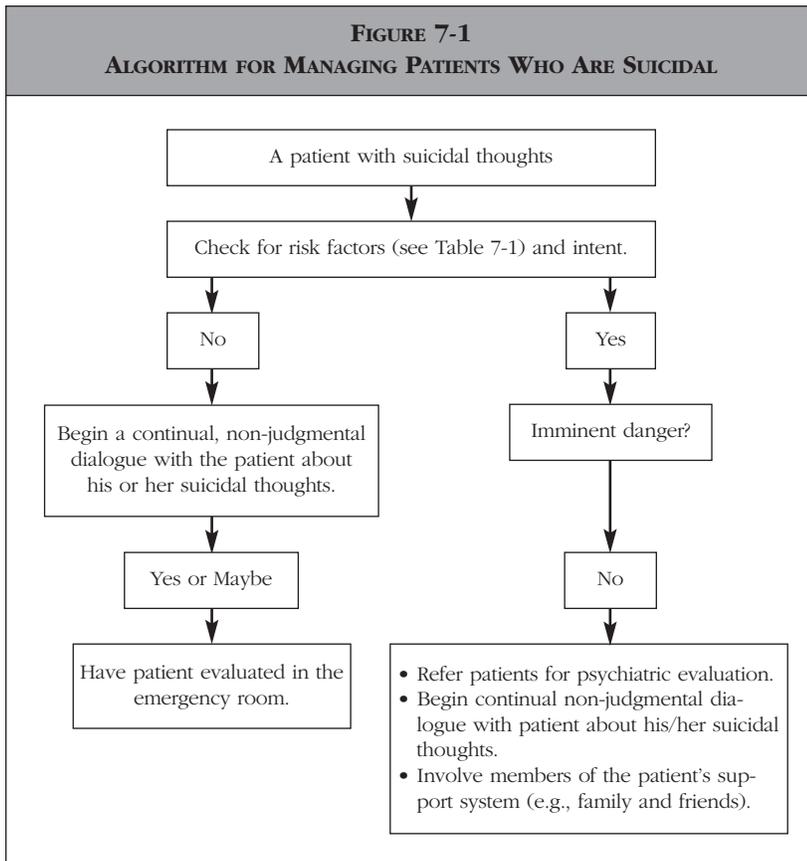
**Even when patients do not express imminent suicidal intent, it is advisable for a practitioner to consult with a psychiatrist in the treatment of patients with chronic suicidal potential.**

**In situations of less acute suicide risk, practitioners should discuss with patients the reasons why they want to kill themselves.**

**Patients with chronic suicidal potential should be referred for outpatient mental health evaluations.**

Figure 7-1 provides an algorithm for managing suicidal patients. Once a patient acknowledges that he or she has considered suicide, primary care practitioners should ask about planned intent and risk factors.

**FIGURE 7-1**  
**ALGORITHM FOR MANAGING PATIENTS WHO ARE SUICIDAL**



**A. Acute Suicidal Potential**

A patient who expresses actual intent to commit suicide needs the most immediate intervention and should be referred for immediate emergency room psychiatric evaluation. A primary care clinician's assessment that a patient is in imminent risk of suicide overrules the patient's right to refuse treatment. In these cases, the practitioner may need to call emergency services or police.

**B. Subacute Suicidal Potential**

When patients express suicide potential, it is important to ask why without assuming that the suicidality is a response to fears of illness and death. Patients' answers may be surprising. For example, they may fear physical pain and suffering. In these cases, addressing how to relieve the pain may markedly diminish the suicide potential. Patients with children may be concerned about how their children will get along in the event of parental death. By addressing permanency planning with these patients, practitioners may relieve the patient's anxiety and guilt. Thus, the potential for suicide may be greatly diminished by uncovering and addressing patients' fears.

### **C. Chronic Suicidal Potential**

For some patients, thinking about suicide may be an unconscious attempt to regain a sense of control over their lives. Patients may say or think, "Well, if things get too overwhelming, I can always kill myself." Such thoughts may lend some sense of control to patients by providing a future option that never has to be acted upon. When no other risk factors are present, most patients who express this type of suicidal thinking never act upon it.

### **IV. CONCLUSION**

When patients are suicidal, family and friends are crucial sources of support. Through contact with these persons, patients can diminish their isolation and hopelessness. Family therapy or couples' therapy may sometimes be helpful. For patients without family and friends or for those who have family/friends who are unable to provide the hoped-for care, it is extremely important for primary care practitioners to provide as much organized support as possible through community-based services.



# CHAPTER 8

## ANXIETY DISORDERS IN PATIENTS WITH HIV/AIDS

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### GENERAL RECOMMENDATION:

**Primary care practitioners should recognize the distinct anxiety disorders that are common in persons with HIV infection.**

Anxiety is a common symptom in patients with HIV infection. When anxiety is severe or persistent, patients may have an anxiety disorder. These disorders include adjustment disorder, obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and generalized anxiety disorder. Primary care practitioners need to be aware of the differences among the specific disorders in order to appropriately treat or refer patients and to help them receive optimal care. People with histories of anxiety disorders or major depression and those with limited social support are particularly susceptible, although anyone can experience severe anxiety during the course of HIV infection. As HIV disease progresses, anxiety may increase.

### I. DIAGNOSIS

#### RECOMMENDATIONS:

**When patients present with common medical symptoms (e.g., chest pain, diaphoresis, dizziness, gastrointestinal disturbances, and/or headache), practitioners should consider anxiety disorders when medical etiologies can not be established.**

**Primary care practitioners should be aware that disturbances of sleep patterns, which may result from illness or medication schedules, may lead to symptoms of anxiety and poor concentration during the day. Sleep management should be an adjunctive component of treatment in these patients.**

**If the diagnosis of anxiety disorder is difficult to establish or the patient does not respond to the initial medication choice, the patient should be referred to a psychiatrist.**

**A diagnosis of panic disorder or panic attack should be considered if the patient experiences episodic anxiety with multiple, overwhelming somatic symptoms that adversely affect his or her life (e.g., the patient dreads having another attack and avoids situations that might evoke panic) or the symptoms are sufficiently severe to require repeated emergency room visits.**

**If the patient does not have panic disorder, practitioners should next determine if the patient has generalized anxiety disorder or adjustment disorder.**

Underdiagnosed in the primary care setting, anxiety overlaps with many other common medical disorders with respect to symptoms such as chest pain, diaphoresis, dizziness, gastrointestinal disturbances, and headache. Practitioners should, therefore, consider both psychological causes (e.g., anxiety disorders) and medical etiologies. In addition to somatic complaints, people with anxiety disorders may also present with fear, insomnia, difficulty concentrating and remembering, diminished appetite, ruminations, compulsive rituals, and the need to avoid situations that make them anxious.

#### **A. Distinguishing Among Panic Disorder, Generalized Anxiety Disorder, and Adjustment Disorder**

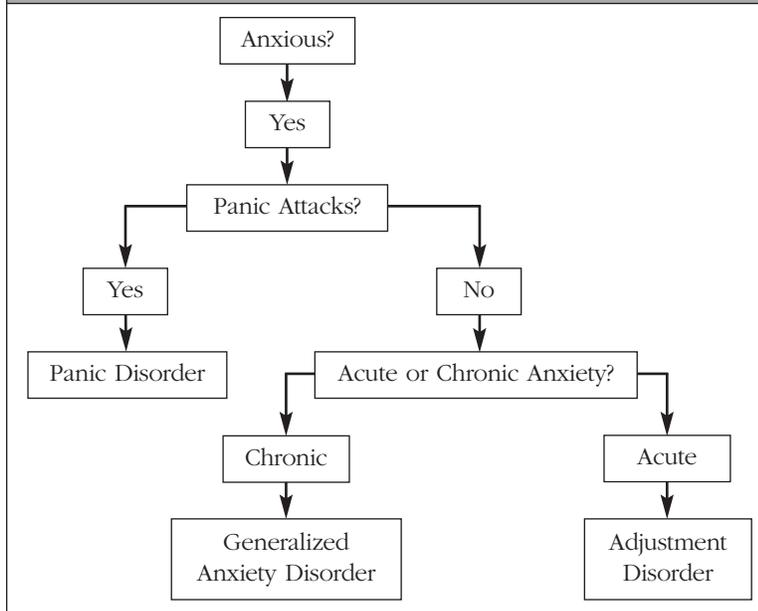
The practitioner should ask the patient the following questions to assist in the diagnosis of anxiety disorders:

- Are you feeling so restless that you experience difficulty in falling asleep?
- Once you fall asleep, do you have trouble staying asleep?
- Do you have trouble concentrating on things such as reading a book or watching television?
- Do you become easily annoyed or irritated?
- Are you anxious most of the time?

After medical illnesses have been excluded, practitioners should use a structured approach for distinguishing and treating panic disorder, generalized anxiety disorder, and adjustment disorder (see Figure 8-1). Positive answers to the following questions with absence of physical findings to explain the symptoms should enable the practitioner to determine if the patient is experiencing a panic attack:

- Did your heart race, skip, or pound?
- Did you sweat?
- Did you tremble?
- Were you short of breath?
- Did you feel as if you were choking?
- Did you have chest pain, tightness, or pressure?
- Did you have nausea or an upset stomach?
- Did you feel dizzy or faint?
- Did you feel unreal or detached from yourself?
- Did you feel as if you were losing control or going crazy?
- Were you afraid you were dying?
- Did you have tingling or numbness?
- Did you have chills or hot flashes?

**FIGURE 8-1**  
**ALGORITHM FOR DISTINGUISHING ANXIETY DISORDERS**



Persistent anxiety (for months or years) without a specific stressor that interferes with functioning is the hallmark of generalized anxiety disorder. Acute anxiety (for hours or weeks) in response to a stressor is the hallmark of adjustment disorder with anxious mood. When the stressor is chronic, as in the case of chronic illness, the adjustment disorder can become chronic.

**B. Medical Conditions and Medications That May Cause Anxiety**

**RECOMMENDATIONS:**

**Practitioners may need to exclude HIV-related central nervous system (CNS) disease or other medical conditions in patients who present with severe anxiety.**

**Practitioners should review the medication regimens of patients who present with sudden onset of anxiety without clear emotional cause and should obtain a thorough substance use history.**

Patients can present with anxiety-like symptoms due to delirium, other medical conditions, medications (see Table 8-1), or substance use. For example, anxiety may be triggered by CNS pathologies, including HIV-related infections, hypoxia, decreased perfusion of the brain, sepsis, delirium, dementia, metabolic imbalances, or endocrinopathies. In addition, patients may present with anxiety from the effects of withdrawal from caffeine, nicotine, alcohol, cocaine, and/or amphetamines.

<b>TABLE 8-1 MEDICATIONS THAT MAY CAUSE ANXIETY-LIKE SYMPTOMS IN HIV PATIENTS</b>	
<b>Category</b>	<b>Medications</b>
Antihypertensives	Reserpine Hydralazine
Antituberculosis agents	Isoniazid Cycloserine
Neuroleptics	Haloperidol Chlorpromazine Risperidone
Sympathomimetics	Ephedrine Epinephrine Dopamine Phenylephrine Phenylpropanolamine Pseudoephedrine
Miscellaneous	Amphetamine and methylphenidate Digitalis Levodopa Lidocaine Monosodium glutamate Nicotinic acid Procarbazine Steroids Theophylline and aminophylline Thyroid preparations

## **II. TREATMENT**

### **A. Psychological/Supportive Intervention in the Primary Care Setting**

When anxiety is present but does not affect patients' functioning, medication may not be needed. The primary care practitioner will find the following supportive strategies to be helpful:

- Identifying the psychological factors that contribute to anxiety (see Table 8-2).
- Expressing empathy.
- Reassuring patients about the cause of the physical symptoms experienced in panic/anxiety.
- Identifying patients' strengths and resources, such as support systems, which may be used to ease their anxiety.
- Teaching patients simple relaxation exercises. Slow, deep breathing while focusing on the breath moving in and out can

be helpful. The Jacobson method of progressive relaxation can also be beneficial. This technique involves systematic tensing and relaxing of muscle groups, starting with the feet and gradually involving the rest of the body. Patients' tension decreases as they become aware of and learn to release muscle tightness.

Although such strategies may be quite helpful, patients in great distress may require medication, psychotherapy, or specialized behavioral

**TABLE 8-2**  
**COMMON PSYCHOLOGICAL FACTORS THAT CONTRIBUTE TO ANXIETY**

- Loss of control over one's body and little or no knowledge about what medical problems might occur next
- Loss of functional ability leading to an increased sense of dependency
- Fear of pain
- Fear of one's mortality; anxiety not only about death but also about dying
- Fear of rejection by loved ones
- Fear of isolation
- Fear about how one's survivors (e.g., children, family, and significant others) will carry on
- Fear of consequences of medical treatment failure

treatments. For these patients, referral to a mental health professional for assessment and treatment is recommended (see Appendix IV).

#### **B. Pharmacologic Intervention in the Primary Care Setting**

##### **RECOMMENDATIONS:**

**Practitioners with patients whose anxiety interferes with their sleep or daily functioning may prescribe benzodiazepines to be used on an as-needed basis. The prescription should be limited to 2 to 4 weeks of medication.**

**Practitioners should use caution when treating patients with hepatic damage for anxiety because most benzodiazepines are metabolized by oxidation; lorazepam, oxazepam, and temazepam may be used, as they are metabolized primarily by glycosylation. Due to interactions, alprazolam, midazolam, and triazolam should be avoided when patients are receiving protease inhibitors.**

When psychopharmacologic treatment becomes necessary for HIV-infected patients with panic disorder, generalized anxiety disorder, or adjustment disorder, practitioners should generally “start low and go slow” when prescribing medications (see Table 8-3).

<b>TABLE 8-3</b>			
<b>MEDICATIONS FOR TREATING SPECIFIC ANXIETY DISORDERS*</b>			
<b>Disorder</b>	<b>Drug</b>	<b>General Comments</b>	<b>Specific Comments†</b>
Panic disorder	SSRI, TCA, BDZ	Premedicate with BDZ (for 3 days); begin SSRI (first-line); taper BDZ after 2 weeks	Begin at low doses
Generalized anxiety disorder	Bupirone, SSRI, BDZ	First-line; preferable for patients with CNS pathology (see following text)	Begin at low doses
Adjustment disorder with anxious mood	BDZ	Use as needed	Begin at low doses

\* Abbreviations: BDZ, benzodiazepine; TCA, tricyclic antidepressant; SSRI, selective serotonin re-uptake inhibitors.

† Certain BDZs are preferable in patients with liver disease or on protease inhibitors.

People with HIV infection, especially those who are symptomatic, are more sensitive to medication side effects. These patients may also respond to lower doses of anxiolytics than those usually prescribed for the general population. Furthermore, because these patients are often on multiple medications, the potential for drug-drug interactions is great. Benzodiazepines, buspirone, SSRIs, and TCAs are among the various medications that may be used for treating panic disorder, generalized anxiety disorder, and adjustment disorder. Each has interactions with HIV medications, and Appendix I should be carefully reviewed.

### **1. Benzodiazepines**

Benzodiazepines can be useful for the management of panic disorder, either as a primary or adjunctive treatment, as well as adjustment disorder with anxious mood when the patient’s anxiety interferes with his/her sleep or daily functioning, but the potential for abuse must be considered. Benzodiazepines may be prescribed for use on an as-needed basis. Benzodiazepines are behaviorally reinforcing drugs and produce both physical and psychological dependence when used too long or at too high dosage levels. Liability for addiction should be considered prior to the use of these agents, and their use should be strictly

time limited. Under these circumstances, prescription of benzodiazepines is usually limited to a time span of not more than 2 to 4 weeks.

Benzodiazepines are available in long-acting (diazepam, clonazepam) and intermediate- to short-acting (alprazolam, lorazepam, oxazepam) forms. Because most benzodiazepines are metabolized by oxidation, caution must be used when treating patients with hepatic damage. Lorazepam, oxazepam, and temazepam, however, are metabolized primarily by glycosylation, and as this metabolic pathway is relatively well preserved in the presence of liver damage, it would be preferable to use these benzodiazepines in patients with this condition. Several benzodiazepines (most significantly alprazolam, midazolam, and triazolam) have significant interactions with protease inhibitors and non-nucleoside reverse transcriptase inhibitors; Appendix I should be consulted before prescribing. In patients with CNS pathology, the use of benzodiazepines may lead to confusion or disinhibition. Therefore, in such patients who also have persistent anxiety, the use of buspirone or low-dose antipsychotics instead might be beneficial.

- Long-acting benzodiazepines have the advantage of a lower potential for short-term withdrawal effects but the disadvantages of longer elimination half-lives and accumulation. These medications can be preferable for patients who currently need several doses per day of a shorter-acting agent. Oral clonazepam 0.5 mg every 8 hours on an as-needed basis is an appropriate starting dose.
- Intermediate- to short-acting benzodiazepines can be eliminated from the system more quickly, which is an advantage when patients experience side effects. However, shorter-acting agents such as alprazolam may predispose patients to withdrawal symptoms after sudden discontinuation or even between doses. Oral alprazolam 0.25 mg every 4 to 6 hours as needed and oral lorazepam 0.5 mg every 4 to 6 hours as needed are appropriate starting doses.

## **2. Buspirone**

When patients have persistent anxiety (i.e., generalized anxiety disorder), medication may be required on a continual basis. In these situations, prescription of buspirone instead of a benzodiazepine may be indicated. However, since buspirone takes up to 3 to 6 weeks to be effective, practitioners may wish to initially prescribe a benzodiazepine as well and taper it later. Oral buspirone can be started at 5 mg two times a day and increased to a total of 60 mg per day. This medication may be particularly helpful for patients with anxiety and a history of alcohol dependence, as there is no potential for abuse.

### 3. Selective Serotonin Re-uptake Inhibitors and Tricyclic Antidepressants

SSRIs are now the medication of choice for treating panic attacks because of their efficacy and side-effect profile. TCAs are also effective but can have troubling side effects. SSRIs can also be used as first- or second-line treatment for generalized anxiety disorder.

The majority of patients with depressive disorders who are seen in the primary care setting also have symptoms of anxiety. Mixed anxiety-depressive conditions should be treated with an antidepressant as the first-line single agent, not with an anxiolytic. For treatment guidelines, see Chapter 6: *Depression and Mania in Patients With HIV/AIDS*. Due to significant interactions between these medications and antiretroviral agents, consult Appendix I before prescribing.

### 4. Other Pharmacologic Choices

Barbiturates and meprobamate can be effective anxiolytics, but they are not recommended treatments because of their side-effect profiles and potential for addiction. Barbiturates not only have a small therapeutic window, but they may lead to cognitive deficits. Meprobamate may lead to liver toxicity.

## C. Treating Patients With More Complex Anxiety Disorders

### RECOMMENDATION:

**Practitioners should refer patients who use substances and experience persistent anxiety, as well as patients who experience panic attacks, PTSD, or OCD, to mental health professionals.**

Persistently anxious patients with HIV infection who also use substances are a challenge for primary care practitioners to manage. One helpful technique to use with particularly demanding substance users who insist that they need higher dosages, early refills, or early appointment dates or who repeatedly challenge the practitioner's recollection is to retain copies of prescriptions and appointment cards in patient files. Such patients, along with patients diagnosed with anxiety disorders that are more difficult to treat (e.g., PTSD, OCD, or panic attacks), should be referred to mental health practitioners. If these patients refuse referral for psychiatric evaluation and treatment, primary care practitioners may then need to address such issues as denial and, in some cases, should not prescribe medication until the patient accepts referral.

Differing opinions exist in regard to prescribing benzodiazepines for patients with anxiety disorders who are also substance users. Although most practitioners prefer to attempt other treatments before

using these medications, some substance-using patients do benefit from benzodiazepines. In these cases, practitioners should inform patients about the long-term risks of abuse and have patients agree to the contract outlined in Table 8-4.

<b>TABLE 8-4</b> <b>TERMS OF AGREEMENT FOR SUBSTANCE-USING</b> <b>PATIENTS USING BENZODIAZEPINES</b>
<ul style="list-style-type: none"><li>• Practitioner will never prescribe more than a 30-day supply of benzodiazepines.</li><li>• Family and friends will monitor patient's adherence to the medication regimen.</li><li>• Practitioner will not provide additional benzodiazepines if patient uses up his/her monthly supply of medication early.</li><li>• Practitioner will provide only one replacement if patient loses his/her prescription; if patient loses a second prescription, there will be no replacement—no matter what explanation is provided.</li><li>• Practitioner will always write prescriptions for generic medications (name brands have greater street value).</li><li>• Practitioner will clearly document treatment plans so that policies will not be changed in their absence.</li></ul>



# CHAPTER 9

## TRAUMA AND POST-TRAUMATIC STRESS DISORDER IN PATIENTS WITH HIV/AIDS

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Post-traumatic stress disorder (PTSD) is a serious and debilitating illness that follows exposure to trauma in a subset of patients. PTSD can result from a single traumatic event, such as a car accident, rape, or experience of a natural disaster. PTSD can also result from an ongoing pattern of traumatic experiences, such as childhood (physical and/or sexual) abuse, domestic violence, homelessness, or severe chronic illness.

The development of a severe life-threatening illness (such as HIV/AIDS) may in itself be a traumatic event or may further compound an ongoing history of trauma.

### **GENERAL RECOMMENDATION:**

**Practitioners should be aware that:**

- **A history of traumatic experiences may impair patients' abilities to handle future stressors.**
- **Exposure to traumatic events can lead to increased risk-taking behavior, including substance use and unsafe sexual activity.**
- **Patients with PTSD or significant trauma histories also may be clinically depressed or may suffer from anxiety.**
- **Patients with PTSD may show a variety of symptoms and may vacillate between overwhelming emotions caused by memories of the event and emotional numbness and dissociation.**
- **For patients with PTSD, medical interventions may be seen as intrusive and, thus, can be re-traumatizing.**

### **I. PTSD PREVALENCE**

As many as 50% of adults and children have been exposed to traumatic events that can lead to PTSD. The rate of PTSD in trauma-exposed populations ranges from 12% to 50%, with the higher rates reflected in populations exposed to interpersonal violence.

Although PTSD has a lifetime prevalence rate of approximately 1.3% to 7.8% in the general population, the rates of PTSD in the HIV-infected population are much higher. Although chronic illness can sometimes in itself be a traumatic experience leading to PTSD, more often a history of physical or psychological trauma (and diagnosis of PTSD) co-occurs with an individual's HIV status.

## II. TRAUMA AND HEALTH

Trauma can affect both psychological and physical functioning. Some research has suggested that the physical effects of trauma have been related to significant health problems such as diminished functioning of the immune system and increased susceptibility to infections. The psychological effects of PTSD may manifest themselves in increased risk-taking behavior, such as substance use, poor eating habits, or unsafe sexual activity. In addition, patients with PTSD may suffer from depression, self-isolation, impairments in trust and attachments, and feelings of anger. Patients with HIV/AIDS may also be affected by past trauma to the point that it manifests in disease-management problems such as disrupted or negative interactions with medical personnel and/or medication non-adherence.

### A. Diagnosis

#### RECOMMENDATIONS:

**Practitioners should use the criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders-IV* for a diagnosis of PTSD in patients with HIV/AIDS (see Table 9-1).**

**Before a diagnosis of PTSD can be made, practitioners should exclude AIDS dementia complex or other HIV-related neuropsychiatric disorders.**

### B. Dissociation

Dissociation is a disruption in the ordinary integration of consciousness, memory, or identity. It can present as flashbacks, depersonalization, derealization, and/or episodes of lost time. Dissociative symptoms occur with PTSD and may be mistaken for HIV-related dementia or other HIV-related neuropsychiatric disorders.

**TABLE 9-1**  
**DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER**

**A. The person has been exposed to a traumatic event in which both of the following were present:**

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death, serious injury, or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness, or horror.

**B. The traumatic event is persistently re-experienced in one (or more) of the following ways:**

1. Recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions.
2. Recurrent distressing dreams of the event.
3. Acting or feeling as if the traumatic event were recurring (e.g., a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated).
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

**C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:**

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g., unable to have loving feelings).
7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

**D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:**

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

**E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.**

**F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.**

### **III. TREATMENT APPROACHES FOR TRAUMA SURVIVORS/PTSD/TRAUMATIC STRESS DISORDERS**

#### **RECOMMENDATIONS:**

**Because PTSD can cause significant morbidity, it should be treated along with other disorders (e.g., depression, anxiety, and substance use) with the aim of treatment being to reduce symptoms and fully reintegrate a safe sense of self.**

**Standard treatment should include psychotherapy and medication that is symptom focused.**

In patients with a history of traumatic experience, it is important to assess for the presence of PTSD by asking about the experience of the trauma and reviewing the symptoms.

Treatment with emphasis on psychological, physical, social, and moral wellness helps patients develop coping skills to respond to stressors. There is no single medication that treats all of the symptoms of PTSD. Currently, sertraline is the only FDA-approved treatment for PTSD. All SSRIs (in the same doses used for depression) are helpful in treating symptoms of depression and anxiety. Open trial studies of mood stabilizers have shown some benefits. Low doses of clonidine are useful for the treatment of flashbacks, nightmares, and associated sleep disturbances. If benzodiazapines are prescribed, careful monitoring is required due to the potential for abuse and concerns for disinhibition in those with significant dissociative symptoms.

Empirically validated psychosocial treatments include exposure therapy, anxiety management programs, and cognitive therapy. These treatments modify fear and false cognitions created in response to single or multiple traumas. Treatment is offered through individual and group modalities. Early evidence supports concurrent treatment of PTSD and addiction.

### **IV. REFERRAL FOR MENTAL HEALTH TREATMENT**

#### **RECOMMENDATIONS:**

**Patients with PTSD should be referred to mental health professionals for psychotherapy.**

**Referral to a psychiatrist for mental health assessment should be made when:**

- **Patients with clear-cut PTSD do not respond to medication (note: recent data suggest ongoing response to sertraline occurs after 4 to 5 months of treatment).**
- **DSM-IV criteria are partially met, dissociation or an unclear mental status exam is present, and patient does not respond to medication and/or brief cognitive interventions.**

PTSD can present in a straightforward fashion or as a confusing picture with dissociation and/or substance use. Some patients respond to medication and brief supportive interventions; most require psychotherapy and specialized mental health intervention/treatment.



## REFERENCES

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- Acuff C, Archambeault J, Greenberg B, Hoeltzel J, McDaniel JS, Meyer P, et al. *Mental Health Care for People Living With or Affected by HIV/AIDS: A Practical Guide—1999*. Washington, DC: US Department of Health and Human Services; 1999.
- Adler Cohen MA, Jacobson JM. Maximizing life's potentials in AIDS: A psychopharmacologic update. *Gen Hosp Psychiatry* 2000;22:375-388.
- American Psychiatric Association Commission on AIDS. *HIV-related Neuropsychiatric Complications and Treatments: Training Manual*. Washington, DC: American Psychiatric Association; 1998.
- Clay D. Mental health and psychosocial issues in HIV care. *Lippincotts Prim Care Pract* 2000;4:74-82.
- Cournos F, Forstein M, eds. *What Mental Health Practitioners Need to Know About HIV and AIDS*. San Francisco: Jossey-Bass; 2000.
- Duffy V. The 14 crisis points of AIDS. *AIDS Patient Care* 1994;8:28-32.
- Folstein MF, Folstein SE, McHugh PR. "Mini-Mental State": A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975;12:189-198.
- Goldblum PB, Erickson S. *Working With AIDS Bereavement: A Comprehensive Approach for Mental Health Providers*. San Francisco: UCSF AIDS Health Project; 1999.
- Gonzales F. *HIV and Depression: Context and Care*. San Francisco: UCSF AIDS Health Project (in press).
- Goodkin K, Wilkie FL, Baldewicz TT, et al. HIV-1-associated cognitive-motor disorders: A research-based approach to diagnosis and treatment. *CNS Spectrums* 2000;8:49-60.
- Gordillo V, del Amo J, Soriano V, Gonzalez-Lahoz J. Sociodemographic and psychological variables influencing adherence to antiretroviral therapy. *AIDS* 1999;13:1763-1769.
- Kranzler HR, Rounsaville BJ, eds: *Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders*. New York: Marcel Dekker; 1998.
- Levitan SJ, Kornfeld DS. Clinical and cost benefit of liaison psychiatry. *Am J Psychiatry* 1981;138:790-793.
- Practice Guidelines for the Treatment of Patients with HIV/AIDS. *Am J Psychiatry* 2000;(Suppl).
- Sally J. Psychosocial issues of AIDS long-term survivors. *Families in Society* 1994;75:324-332.

Saravay SM, Steinberg MD, Weinschel B, Pollack S, Alovic N. Psychological comorbidity and length of stay in the general hospital. *Am J Psychiatry* 1991;148:324-329.

Shernoff M, Smith RA. *HIV Treatment: Mental Health Aspects of Antiviral Therapy*. San Francisco: UCSF AIDS Health Project; 2000.

Shor-Posner G. Cognitive function in HIV-1-infected drug users. *J Acquir Immune Defic Syndr* 2000;25(Suppl 1):S70-S73.

Tsevat J, Solzan JG, Kuntz KM, Ragland J, Currier JS, Sell RL, et al. Health values of patients infected with human immunodeficiency virus: Relationship to mental health and physical functioning. *Med Care* 1996;34:44-57.

Wilkie FL, Goodkin D, van Zuilen MH, Tyll MD, Lecusey R, Edwin T. Cognitive effects of HIV-1 infection. *CNS Spectrums* 2000;5:33-51.

Ziefert P, Leary M, Rinaldi J. *AIDS and the Impact of Cognitive Impairment*. San Francisco: UCSF AIDS Health Project; 1995.

Zweben JE, Denning P. *The Alcohol and Drug Wildcard: Substance Use and Psychiatric Problems in People With HIV*. San Francisco: UCSF AIDS Health Project; 1998.

# APPENDIX I

## INTERACTIONS BETWEEN HIV-RELATED MEDICATIONS AND PSYCHOTROPIC MEDICATIONS: INDICATIONS AND CONTRAINDICATIONS

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**RECOMMENDATION:**

**Practitioners should refer to the full prescribing information of all medications their patients are taking. Doing so is particularly important when changes in mental status or the onset of psychiatric symptoms seem to be linked chronologically to changes in medication or dosage.**

Most patients tolerate HIV-related medications without psychiatric or central nervous system side effects. However, when a change in mental status or the onset of psychiatric symptoms seems to be linked chronologically to changes in medications or dosage, it may be helpful to review the side effects described in the prescription literature.

**Few psychiatric drugs are fully contraindicated for concomitant use with HIV-related medications. Consultation with a psychiatrist experienced in the treatment of HIV-infected patients is warranted when implementing combinations that suggest use with caution or when possible dose adjustment is recommended.**

TABLE I-1 INTERACTIONS BETWEEN HIV-RELATED MEDICATIONS AND PSYCHOTROPIC MEDICATIONS: INDICATIONS AND CONTRAINDICATIONS			
Medication	Contraindicated	Use With Caution	Possible Dose Adjustment
Amprenavir	Alprazolam, diazepam, midazolam, triazolam, zolpidem	Fluoxetine and fluvoxamine may increase PI concentration and toxicity. Carbamazepine, phenobarbital, phenytoin, primidone, St. John's wort reduce level of PI, and concurrent use should be avoided. Avoid pimoziide if possible.	Carbamazepine, phenobarbital, phenytoin levels rise: monitor levels and adjust prn.

**TABLE I-1**  
**INTERACTIONS BETWEEN HIV-RELATED MEDICATIONS AND PSYCHOTROPIC**  
**MEDICATIONS: INDICATIONS AND CONTRAINDICATIONS (CONT'D.)**

<b>Medication</b>	<b>Contraindicated</b>	<b>Use With Caution</b>	<b>Possible Dose Adjustment</b>
Clarithromycin	None identified	St. John's wort may decrease level of clarithromycin.	Carbamazepine level rises: monitor level and adjust prn. Initial dose of benzodiazepines (i.e., alprazolam, midazolam) should be reduced, as clarithromycin may increase levels.
Delavirdine	Alprazolam, midazolam, triazolam	Fluoxetine, fluvoxamine and nefazodone may increase NNRTI level and increase toxicity. Carbamazepine, phenobarbital, phenytoin, St. John's wort can lower delavirdine levels: avoid concurrent use if possible. Avoid pimozone if possible.	Carbamazepine levels may rise: monitor and adjust prn.
Didanosine (ddI)	None identified	Gabapentin levels decreased by antacid: ddI should be given 2 hours before or after.	Methadone decreases ddI: consider increased dose.
Efavirenz	Alprazolam, diazepam, midazolam, pimozone, triazolam	Fluoxetine, fluvoxamine, and nefazodone may increase NNRTI level and increase toxicity. St. John's wort may decrease efavirenz levels and should be avoided.	Methadone levels decreased: may need to increase dose. Carbamazepine levels may rise: monitor and adjust prn.
Fluconazole	None identified	None identified	Carbamazepine and phenytoin levels rise: monitor level and decrease dose prn. Due to CNS effects, may need to decrease dose of benzodiazepines (i.e., alprazolam, midazolam, triazolam), methadone, or zolpidem. Levels of amitriptyline and nortriptyline may rise: monitor and adjust prn.

**TABLE I-1**  
**INTERACTIONS BETWEEN HIV-RELATED MEDICATIONS AND PSYCHOTROPIC**  
**MEDICATIONS: INDICATIONS AND CONTRAINDICATIONS (CONT'D.)**

<b>Medication</b>	<b>Contraindicated</b>	<b>Use With Caution</b>	<b>Possible Dose Adjustment</b>
Indinavir	Diazepam, midazolam, St. John's wort, triazolam, zolpidem	Fluoxetine, fluvoxamine, and nefazodone increase PI level and increase toxicity. Carbamazepine, phenobarbital, phenytoin, and primidone reduce indinavir level. Avoid pimozide if possible.	Carbamazepine level rises: monitor and lower dose prn.
Ketoconazole	Alprazolam, clonazepam, diazepam, midazolam, triazolam	None identified	Carbamazepine and ethosuximide levels rise: monitor toxicity and lower dose if necessary.
Lamivudine	None identified	None identified	None identified
Lopinavir/ Ritonavir*	Alprazolam, bupropion, clorazepate, clozapine, diazepam, estazolam, flurazepam, midazolam, pimozide, St. John's wort, triazolam, zolpidem	Fluoxetine, fluvoxamine, and PI levels may increase. Mexiletine levels rise and may cause greater cardiac/neurologic toxicity: use with caution. Phenobarbital and primidone levels may rise and PI level fall: avoid concurrent use if possible.	Desipramine levels may rise significantly: consider 50% lower dose. Meperidine and methadone levels decrease: may need increased dose. Carbamazepine, clonazepam, nefazadone, and sertraline: initial dose should be reduced 70%. Trazodone levels may increase: start low. Phenothiazines, SSRIs, and TCAs should have initial dose reduced by 50% and be monitored closely for toxicity. Valproic acid, phenytoin doses may need to be higher. Ethosuximide level rises: may need to lower dose.

\* Dose of ritonavir is lower than when used as a single PI, and the drug-drug impact of ritonavir may be less significant. However, as pharmacologic data are limited, at this time the same cautions and contraindications as with full-dose ritonavir are repeated.

**TABLE I-1**  
**INTERACTIONS BETWEEN HIV-RELATED MEDICATIONS AND PSYCHOTROPIC**  
**MEDICATIONS: INDICATIONS AND CONTRAINDICATIONS (CONT'D.)**

<b>Medication</b>	<b>Contraindicated</b>	<b>Use With Caution</b>	<b>Possible Dose Adjustment</b>
Nelfinavir	Diazepam, midazolam, St. John's wort, triazolam, zolpidem	Fluoxetine and fluvoxamine may increase PI level. Carbamazepine, phenobarbital, phenytoin, primidone may decrease PI: avoid concurrent use if possible. Avoid pimozone if possible.	None identified
Nevirapine	St. John's wort	Fluoxetine and fluvoxamine may increase NNRTI level.	Methadone levels lowered: may need higher dose. Carbamazepine levels rise, PI level may drop: avoid concurrent use if possible.
Pyrimethamine	Lorazepam increases risk of hepatic toxicity (monitor LFTs).	None identified	None identified
Rifabutin and Rifampin	None identified	None identified	Methadone level decreases, and higher dose may be needed. Carbamazepine, phenytoin, valproic acid levels may decrease: may need to increase dose based upon levels.

**TABLE I-1**  
**INTERACTIONS BETWEEN HIV-RELATED MEDICATIONS AND PSYCHOTROPIC**  
**MEDICATIONS: INDICATIONS AND CONTRAINDICATIONS (CONT'D.)**

<b>Medication</b>	<b>Contraindicated</b>	<b>Use With Caution</b>	<b>Possible Dose Adjustment</b>
Ritonavir	Alprazolam, bupropion, clorazepate, clozapine, diazepam, estazolam, flurazepam, midazolam, pimoziide, St. John's wort, triazolam, zolpidem	Fluoxetine, fluvoxamine, and PI levels may increase. Mexiletine levels rise and may cause greater cardiac/neurologic toxicity: use with caution. Phenobarbital and primidone levels may rise and PI level fall: avoid concurrent use if possible.	Desipramine levels may rise significantly: consider 50% lower dose. Meperidine and methadone levels decrease: may need increased dose. Carbamazepine, clonazepam, nefazadone, and sertraline: initial dose should be reduced 70%. Trazodone levels may increase: start low. Phenothiazines, SSRIs, and TCAs should have initial dose reduced by 50% and be monitored closely for toxicity. Valproic acid, phenytoin doses may need to be higher. Ethosuximide level rises: may need to lower dose.
Saquinavir	Diazepam, midazolam, St. John's wort, triazolam, zolpidem	Fluoxetine and fluvoxamine may increase PI level and toxicity. Phenobarbital and primidone can lower PI: avoid concurrent use if possible. Avoid pimoziide if possible.	Carbamazepine level rises (may need to lower dose prn) and PI falls when co-administered.
Stavudine	None identified	None identified	None identified
Zalcitabine (ddC)	None identified	Disulfiram and phenytoin may increase risk for peripheral neuropathy.	None identified
Zidovudine	None identified	Methadone and valproic acid increase zidovudine levels: monitor for toxicity.	None identified

Data are from 1) Klein R, Struble K. *The Protease Inhibitors: Background*. Food and Drug Administration, September 1996. 2) Preston SL, Stein DS. Drug interactions and adverse drug reactions with protease inhibitors. *Primary Psychiatry*. 1997;64:69. 3) *Physicians' Desk Reference*. Oradell, NJ: Medical Economics Company, Inc.; 1997.



## APPENDIX II

# HIV-RELATED CAUSES OF PSYCHIATRIC SYMPTOMS: DIFFERENTIAL DIAGNOSIS

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### Depression

1. Malnutrition, including deficiencies in vitamin A, B<sub>6</sub>, B<sub>12</sub>, and zinc
2. Systemic illness secondary to HIV infection such as anemia and metabolic abnormalities
3. Endocrine disorders such as hypotestosteronism and Addison's disease (secondary to HIV, cytomegalovirus)
4. Medications such as steroids, interferon, interleukin-2, zidovudine, vinblastine, vincristine, bleomycin, trimethoprim/sulfamethoxazole (TMP/SMX), ethionamide, isoniazid, efavirenz
5. Opportunistic infections and malignancies of the central nervous system (CNS) such as toxoplasmosis, cryptococcal meningitis, CNS lymphoma, cytomegalovirus encephalitis, herpes encephalitis, progressive multifocal leukoencephalopathy (PML)
6. HIV-associated dementia
7. Minor cognitive motor disorder

### Mania

1. HIV-associated dementia
2. Medications such as steroids, zidovudine in high doses, didanosine, zalcitabine, stavudine, lamivudine, ganciclovir, isoniazid, sympathomimetics (e.g., ephedrine, methylphenidate), antidepressants, clarithromycin, and efavirenz
3. Opportunistic infections and malignancies of the CNS such as toxoplasmosis, cryptococcal meningitis, CNS lymphoma, neurosyphilis and herpes
4. B<sub>12</sub> deficiency
5. Cocaine and/or amphetamine use

### Anxiety

1. Toxicity or withdrawal from various drugs such as alcohol, amphetamines, antidepressants, barbiturates, benzodiazepines, caffeine, cocaine, marijuana, methylphenidate, nicotine, opiates, or neuroleptic-induced akathisia
2. Medications such as  $\alpha$ -adrenergic stimulants, anticholinergic agents, antihypertensives (e.g., reserpine, hydralazine), isoniazid, cycloserine, isoproterenol, albuterol, steroids, theophylline, thyroid preparations

3. HIV medications such as acyclovir, interferon/interleukin-2, zidovudine, didanosine, zalcitabine, stavudine, lamivudine, and pentamidine
4. CNS opportunistic infections and malignancies such as toxoplasmosis, HIV encephalopathy, cryptococcal meningitis, herpes encephalitis, lymphoma, and neurosyphilis
5. Respiratory conditions such as chronic obstructive pulmonary disease, hypoxemia (in patients with active lung disease), pneumothorax, pulmonary edema, and pulmonary embolism; anxiety can also accompany subtle onset of *Pneumocystis carinii* pneumonia
6. Endocrine conditions such as carcinoid, hyperadrenalism, hypoadrenocorticism, hypercalcemia, hyperthyroidism, hypocalcemia, hypothyroidism, parathyroid disease, and pheochromocytoma
7. Metabolic conditions such as anemia, hyperkalemia, hyperthermia, hypoglycemia, hyponatremia, hypoxia, and porphyria
8. Cardiovascular disease such as angina pectoris, arrhythmia, congestive heart failure, hypovolemia, mitral valve prolapse, myocardial infarction, and valvular disease
9. Gastrointestinal conditions such as irritable bowel disease and peptic ulcer disease
10. Immunologic conditions such as anaphylaxis and systemic lupus erythematosus
11. Neurologic conditions such as akathisia, encephalopathy, infarction, ischemia, mass lesion, post-concussion syndrome, seizure disorder, and vertigo

### **Psychosis**

1. Toxic and withdrawal effects from drugs such as cocaine, amphetamines, alcohol, and sedatives/hypnotics
2. Medications such as steroids, DHPG, ciprofloxacin, antidepressants, and sympathomimetics
3. Opportunistic infections and malignancies of the CNS
4. B<sub>12</sub> deficiency
5. HIV-associated dementia

### **Sleep Disturbance**

1. Use of substances such as alcohol, cocaine, caffeine, amphetamines, and nicotine
2. Use of medications such as zidovudine, efavirenz, didanosine, zalcitabine, stavudine, lamivudine, protease inhibitors, DHPG, interferon/interleukin-2, TMP/SMX, dapsone, amphotericin B, fluconazole, acyclovir, steroids, isoniazid, and theophylline

**TABLE II-1**  
**NEUROPSYCHIATRIC SIDE EFFECTS OF SELECTED**  
**MEDICATIONS USED IN HIV DISEASE**

<b>Drug</b>	<b>Side Effects</b>
Acyclovir	Visual hallucinations, depersonalization, tearfulness, confusion, hyperesthesia, hyperacusis, thought insertion, insomnia
Amphotericin B	Delirium, peripheral neuropathy, diplopia
Lactam antibiotics	Confusion, paranoia, hallucinations, mania, coma
Co-trimoxazole	Depression, loss of appetite, insomnia, apathy
Cycloserine	Psychosis, somnolence, depression, confusion, tremor, vertigo, paresis, seizure, dysarthria
Didanosine	Nervousness, anxiety, confusion, seizures, insomnia, peripheral neuropathy
Efavirenz	Nightmares, depression, confusion
Foscarnet	Paresthesias, seizures, headache, irritability, hallucinations, confusion
Interferon	Depression, weakness, headache, myalgias, confusion
Isoniazid	Depression, agitation, hallucinations, paranoia, impaired memory, anxiety
Lamivudine	Insomnia, mania
Methotrexate	Encephalopathy (at high dose)
Pentamidine	Confusion, anxiety, lability, hallucinations
Procarbazine	Mania, loss of appetite, insomnia, nightmares, confusion, malaise
Quinolones	Psychosis, delirium, seizures, anxiety, insomnia, depression
Stavudine	Headache, asthenia, malaise, confusion, depression, seizures, excitability, anxiety, mania, early morning awakening, insomnia
Sulfonamides	Psychosis, delirium, confusion, depression, hallucinations
Thiabendazole	Hallucinations, olfactory disturbance
Vinblastine	Depression, loss of appetite, headache
Vincristine	Hallucinations, headache, ataxia, sensory loss
Zalcitabine	Headaches, confusion, impaired concentration, somnolence, asthenia, depression, seizures, peripheral neuropathy
Zidovudine	Headache, malaise, asthenia, insomnia, unusually vivid dreams, restlessness, severe agitation, mania, auditory hallucinations, confusion

Some data are from Grant I, Atkinson JH Jr. Neuropsychiatric aspects of HIV infection and AIDS. In Sadock BJ, Sadock VA, eds. *Kaplan and Sadock's Comprehensive Textbook of Psychiatry*. Philadelphia, PA: Lippincott Williams & Wilkins; 1999:308-336.



# APPENDIX III

## RATING SCALES

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### A. Memorial Delirium Assessment Scale

The Memorial Delirium Assessment Scale (MDAS) is a 10-item, 4-point clinician-rated scale (possible range, 0-30) designed to quantify the severity of delirium in medically ill patients. Items included in the MDAS reflect the diagnostic criteria for delirium in the *DSM-IV*, as well as symptoms of delirium from earlier or alternative classification systems (i.e., *DSM-III*, *DSM-III-R*, *ICD-9*).<sup>1</sup> Scores of 13 or above likely reflect the presence of delirium.

Scale items assess disturbances in arousal and level of consciousness, as well as several areas of cognitive functioning (e.g., memory, attention, orientation, disturbances in thinking) and psychomotor activity. Items were anchored with statements reflecting the severity or intensity of the symptom and were reviewed by experienced clinicians to ensure ease of administration and ability to generate accurate (reliable) ratings. The resulting scale, which requires approximately 10 minutes to administer (not including additional time necessary to establish rapport, review chart records, and speak to staff/family members), integrates behavioral observations and objective cognitive testing. When items cannot be administered, scores can be prorated from the remaining items to an equivalent 10-item score.

<sup>1</sup> Although the MDAS was developed prior to the publication of *DSM-IV*, the MDAS items were developed to be consistent with the proposed *DSM-IV* diagnostic criteria for delirium.\*

\* Tucker GJ and the *DSM-IV* Organic Disorders Work Group *DSM-IV*. Proposals for revision of diagnostic criteria for delirium. *Int Geriatr* 1991;3:197-208.

## Memorial Delirium Assessment Scale (MDAS)

**Instructions:** Rate the severity of the following symptoms of delirium based on current interaction with subject or assessment of his/her behavior or experience over past several hours (as indicated in each time).

### ITEM 1 - REDUCED LEVEL OF CONSCIOUSNESS (AWARENESS):

Rate the patient's current awareness of and interaction with the environment (interviewer, other people/objects in the room; for example, ask patients to describe their surroundings).

- 0: none (patient spontaneously fully aware of environment and interacts appropriately)
- 1: mild (patient is unaware of some elements in the environment or is not spontaneously interacting appropriately with the interviewer; becomes fully aware and appropriately interactive when prodded strongly; interview is prolonged but not seriously disrupted)
- 2: moderate (patient is unaware of some or all elements in the environment or is not spontaneously interacting with the interviewer; becomes incompletely aware and inappropriately interactive when prodded strongly; interview is prolonged but not seriously disrupted)
- 3: severe (patient is unaware of all elements in the environment with no spontaneous interaction or awareness of the interviewer so that the interview is difficult to impossible, even with maximal prodding)

### ITEM 2 - DISORIENTATION:

Rate current state by asking the following 10 orientation items: date, month, day, year, season, floor, name of hospital, city, state, and country.

- 0: none (patient knows 9-10 items)
- 1: mild (patient knows 7-8 items)
- 2: moderate (patient knows 5-6 items)
- 3: severe (patient knows no more than 4 items)

### ITEM 3 - SHORT-TERM MEMORY IMPAIRMENT:

Rate current state by using repetition and delayed recall of 3 words [patient must immediately repeat and recall words 5 minutes later after an intervening task. Use alternate sets of 3 words for successive evaluations (e.g., apple, table, tomorrow; sky, cigar, justice)].

- 0: none (all 3 words repeated and recalled)
- 1: mild (all 3 repeated; patient fails to recall 1)
- 2: moderate (all 3 repeated; patient fails to recall 2-3)
- 3: severe (patient fails to repeat 1 or more words)

**ITEM 4 - IMPAIRED DIGIT SPAN:**

Rate current performance by asking subjects to repeat first 3, 4, then 5 digits forward and then 3, then 4 backward; continue to the next step only if patient succeeds at the previous one.

- 0: none (patient can do at least 5 numbers forward, 4 backward)
- 1: mild (patient can do at least 5 numbers forward, 3 backward)
- 2: moderate (patient can do 4-5 numbers forward, cannot do 3 backward)
- 3: severe (patient can do no more than 3 numbers forward)

**ITEM 5 - REDUCED ABILITY TO MAINTAIN AND SHIFT ATTENTION:**

As indicated during the interview by questions needing to be rephrased and/or repeated because patient's attention wanders, patient loses track, patient is distracted by outside stimuli or overabsorbed in task.

- 0: none (none of the above; patient maintains and shifts attention normally)
- 1: mild (above attentional problems occur once or twice without prolonging the interview)
- 2: moderate (above attentional problems occur often, prolonging the interview without seriously disrupting it)
- 3: severe (above attentional problems occur constantly, disrupting and making the interview difficult to impossible)

**ITEM 6 - DISORGANIZED THINKING:**

As indicated during the interview by rambling, irrelevant or incoherent speech, or by tangential, circumstantial, or faulty reasoning. Ask patient a somewhat complex question (e.g., "Describe your current medical condition.").

- 0: none (patient's speech is coherent and goal-directed)
- 1: mild (patient's speech is slightly difficult to follow; responses to questions are slightly off target but not so much as to prolong the interview)
- 2: moderate (disorganized thoughts or speech are clearly present, such that interview is prolonged but not disrupted)
- 3: severe (examination is very difficult or impossible due to disorganized thinking or speech)

**ITEM 7 - PERCEPTUAL DISTURBANCE:**

Misperceptions, illusions, hallucinations inferred from inappropriate behavior during the interview or admitted by the subject, as well as those elicited from nurse/family/chart accounts of the past several hours or of the time since last examination:

- 0: none (no misperceptions, illusions, or hallucinations)
- 1: mild (misperceptions or illusions related to sleep, fleeting hallucinations on 1-2 occasions without inappropriate behavior)
- 2: moderate (hallucinations or frequent illusions on several occasions with minimal inappropriate behavior that does not disrupt the interview)
- 3: severe (frequent or intense illusions or hallucinations with persistent inappropriate behavior that disrupts the interview or interferes with medical care)

**ITEM 8 - DELUSIONS:**

Rate delusions inferred from inappropriate behavior exhibited during the interview or admitted by the patient, as well as delusions elicited from nurse/family/chart accounts of the past several hours or of the time since the previous examination.

- 0: none (no evidence of misinterpretations or delusions)
- 1: mild (misinterpretation or suspiciousness without clear delusional ideas or inappropriate behavior)
- 2: moderate (delusions admitted by the patient or evidenced by his/her behavior that do not or only marginally disrupt the interview or interfere with medical care)
- 3: severe (persistent and/or intense delusions resulting in inappropriate behavior, disrupting the interview or seriously interfering with medical care)

**ITEM 9 - DECREASED OR INCREASED PSYCHOMOTOR ACTIVITY:**

Rate activity over past several hours, as well as activity during interview, by circling (a) hypoactive, (b) hyperactive, or (c) elements of both present.

- 0: none (normal psychomotor activity)
- a b c 1: mild (Hypoactivity is barely noticeable, expressed as slightly slowing movement. Hyperactivity is barely noticeable or appears as simple restlessness.)
- a b c 2: moderate (Hypoactivity is undeniable, with marked reductions in the number of movements or marked slowness of movement; subject rarely spontaneously moves or speaks. Hyperactivity is undeniable; subject moves almost constantly; in both cases, exam is prolonged as a consequence.)
- a b c 3: severe (Hypoactivity is severe; patient does not move or speak without prodding or is catatonic. Hyperactivity is severe; patient is constantly moving, overreacts to stimuli, requires surveillance and/or restraint; getting through the exam is difficult or impossible.)

**ITEM 10 - SLEEP-WAKE CYCLE DISTURBANCE (DISORDER OR AROUSAL):**

Rate patient's ability to either sleep or stay awake at the appropriate times. Utilize direct observation during the interview, as well as reports from nurses, family, patient, or charts describing sleep-wake cycle disturbance over the past several hours or since last examination. Use observations of the previous night for morning evaluations only.

- 0: none (at night, sleeps well; during the day, has no trouble staying awake)
- 1: mild (mild deviation from appropriate sleepfulness and wakefulness states; at night, difficulty falling asleep or transient night awakenings, needs medication to sleep well; during the day, reports periods of drowsiness or, during the interview, is drowsy but can easily fully awaken him/herself)
- 2: moderate (moderate deviations from appropriate sleepfulness and wakefulness states; at night, repeated and prolonged night awakening; during the day, reports of frequent and prolonged napping or, during the interview, can only be roused to complete wakefulness by strong stimuli)
- 3: severe (severe deviations from appropriate sleepfulness and wakefulness states; at night, sleeplessness; during the day, patient spends most of the time sleeping or, during the interview, cannot be roused to full wakefulness by any stimuli)

Adapted by permission of Elsevier Science from The Memorial Delirium Assessment Scale by Breitbart W, Rosenfeld B, Roth A, Smith MJ, Cohen K, Passik S. *J Pain Symptom Manage*, Volume 13, pp 128-137, 1997 by The U.S. Cancer Pain Relief Committee.

## B. Center for Epidemiologic Studies–Depression Scale

The Center for Epidemiologic Studies–Depression Scale is a self-administered scale. Circle the number for each statement that best describes how often you felt or behaved this way during the past week. Each response should be scored from 0 to 3 on a scale of frequency of occurrence of the symptom. Possible range of scores is 0 to 60, with the higher scores indicating more symptoms, weighted by frequency of occurrence during the past week.

<b>During the past week:</b>	<b>Rarely or None of the Time (Less than 1 day)</b>	<b>Some or a Little of the Time (1-2 days)</b>	<b>Occasionally or a Moderate Amount of Time (3-4 days)</b>	<b>Most or All of the Time (5-7 days)</b>
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not get "going."	0	1	2	3

Reprinted from Radloff LS. The CES-D scale: A self-report depression scale for research in the general population. *Appl Psychol Measurement* 1977;1:385-401. Copyright 1977, West Publishing Company/Applied Psychological Measurement, Inc. Reproduced by permission.

# APPENDIX IV

## MENTAL HEALTH CARE RESOURCES IN NEW YORK STATE

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### NEW YORK CITY

#### *New York City Department of Mental Health, Mental Retardation, and Alcoholism Services (NYC DMHMRAS)*

- **LifeNet**  
**1-800-LifeNet (1-800-543-3638):**  
LifeNet is a clinically staffed 24 hour/7 days a week, crisis management, information, and referral network in New York City for mental health and substance use problems. It is an initiative of the Mental Health Association of New York City, Inc. and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services.
- **Bureau of Mental Health Services:**
  - **Bronx Borough Office**  
**(212) 219-5500**  
93 Worth Street  
New York, NY 10013
  - **Brooklyn Borough Office**  
**(718) 643-4620**  
16 Court Street, Suite 610  
Brooklyn, NY 11201
  - **Manhattan Borough Office**  
**(212) 442-5000**  
49-51 Chambers Street, Room 720  
New York, NY 10007
  - **Queens Borough Office**  
**(212) 219-5514**  
93 Worth Street, Room 815  
New York, NY 10013
  - **Staten Island Borough Office**  
**(718) 643-4620**  
16 Court Street, Suite 610  
Brooklyn, NY 11201
- **Bureau of Alcoholism and Substance Abuse Services**  
**(212) 219-5380; (212) 219-5383**  
93 Worth Street, Rooms 1203, 1205, 1207  
New York, NY 10013

- **Bureau of Mental Retardation/Developmental Disabilities**

**(212) 219-5215**

93 Worth Street, Room 303

New York, NY 10013

***New York City Department of Health (NYCDOH)***

- **Bureau of Ryan White CARE Services**

**(212) 693-1440**

225 Broadway, 23rd Floor

New York, NY 10007

**NEW YORK STATE**

***New York State Office of Mental Health (NYSOMH)***

- **Customer Relations Service**

**1-800-597-8481; 1-800-597-9810 (TDDY)**

The customer relations service provides information and referral for mental health problems throughout New York State.

***New York State Office of Alcoholism and Substance Abuse Services (NYSOASAS)***

- **Substance Abuse Hotline**

**1-800-522-5353**

The substance abuse hotline provides information and referral for substance abuse problems throughout New York State.

# APPENDIX V

## SYRINGE ACCESS RESOURCES IN NEW YORK STATE

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### **EXPANDED SYRINGE ACCESS DEMONSTRATION PROJECT (ESAP)**

Pharmacies registered in New York State's Expanded Syringe Access Demonstration Program (ESAP) may now sell or furnish up to 10 syringes at a time to adults, 18 years or older, without a prescription. Under this program, health care facilities and health care providers (doctors and others who can prescribe syringes) may also furnish syringes.

Possession of syringes in accordance with the Public Health Law is legal. Persons legally possessing syringes are not subject to arrest or prosecution under the Penal Law.

To find syringe exchange programs or pharmacies participating in ESAP, call the New York State Department of Health HIV/AIDS Hotlines:

**English:** 1-800-541-AIDS

**Spanish:** 1-800-233-SIDA

**Deaf/TDD:** 1-800-369-AIDS

## **SYRINGE EXCHANGE PROGRAMS**

### **MANHATTAN**

#### **New York Harm Reduction Educators, Inc.**

1991A Lexington Avenue  
New York, NY 10035  
(212) 828-8464

#### **Positive Health Project**

301 West 37th Street, 2nd Floor  
New York, NY 10018  
(212) 465-8304

#### **Foundation for Research on Sexually Transmitted Diseases (FROSTD)**

369 West 29th Street  
New York, NY 10001  
(212) 924-3733

#### **Housing Works Syringe Exchange Program**

130 Crosby Street  
New York, NY 10012  
(212) 966-0466

#### **Lower East Side Harm Reduction Center**

25 Allen Street  
New York, NY 10003  
(212) 226-6333

### **BRONX**

#### **CitiWide Harm Reduction Program**

226 East 144th Street, 3rd Floor  
Bronx, NY 10451  
(718) 292-7718

#### **New York Harm Reduction Educators, Inc.**

903 Dawson Street  
Bronx, NY 10459  
(718) 842-6050

#### **St. Ann's Corner of Harm Reduction**

312-314 Cypress Avenue  
Bronx, NY 10454  
(718) 585-5544

### **BROOKLYN**

#### **Association for Drug Abuse Prevention & Treatment (ADAPT)**

815 Broadway  
Brooklyn, NY 11206  
(718) 782-5389

#### **Bushwick Community Service Society COMRADES IN A.R.M.S.**

1420 Bushwick Avenue  
Brooklyn, NY 11207  
(718) 455-6010

### **CENTRAL AND WESTERN NEW YORK**

#### **AIDS Rochester, Inc.**

1350 University Avenue, Suite C  
Rochester, NY 14607  
(716) 442-2220

#### **Kaleida Health/Project Reach**

777 Main Street  
Buffalo, NY 14203  
(716) 845-0172

### **LOWER- AND MID-HUDSON VALLEY**

#### **Urban League of Westchester, Inc.**

61 Mitchell Place  
White Plains, NY 10601  
(914) 428-5407

#### **Urban League of Westchester, Inc.**

10 Fiske Place, Suite 429  
Mount Vernon, NY 10550  
(914) 667-1010

# APPENDIX VI

## PERMANENCY PLANNING AND TRANSITIONAL SERVICES

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**NYSDOH AIDS INSTITUTE-FUNDED  
PERMANENCY PLANNING AND TRANSITIONAL SERVICES  
SOCIAL SUPPORT SERVICE PROVIDERS:**

**MANHATTAN**

**Beth Israel Medical Center**  
*Peter Krueger Clinic*  
317 E. 17th Street, 1st Floor  
New York, NY 10003  
(212) 420-2307

**The Family Center**  
66 Reade Street, 4th Floor  
New York, NY 10007  
(212) 766-4522 x65

**BRONX**

**Citizens Advice Bureau**  
2054 Morris Avenue  
Bronx, NY 10453  
(718) 293-0727 x161

**Leake & Watts, Inc.**  
1967 Turnbull Avenue  
Suite 40  
Bronx, NY 10473  
(718) 824-1978

**BROOKLYN**

**Haitian Women's Program**  
464-466 Bergen Street  
Brooklyn, NY 11207  
(718) 399-0200

**St. Vincent's Services**  
Positive Caring Program  
205 Montague Street  
Brooklyn, NY 11201  
(718) 422-3242

**LONG ISLAND**

**Planned Parenthood  
of Hudson Peconic**  
70 Maple Avenue  
Smithtown, NY 11787  
(516) 361-7526

**LOWER- AND MID-HUDSON VALLEY**

**Volunteers of America**  
50 Broadway  
Hawthorne, NY 10532  
(914) 741-2640 x14

**CENTRAL AND WESTERN NEW YORK**

**Center for Community Alternatives**  
115 East Jefferson Street  
Syracuse, NY 13202  
(315) 422-5638

**Child & Family Services**  
330 Delaware Avenue  
Buffalo, NY 14202  
(716) 842-2750

**NORTHEASTERN NEW YORK**

**Community Maternity Services**  
27 North Main Street  
Albany, NY 12203  
(518) 482-8836

**NYSDOH AIDS INSTITUTE-FUNDED  
PERMANENCY PLANNING AND TRANSITIONAL SERVICES  
LEGAL SERVICE PROVIDERS:**

**MANHATTAN**

**HIV Law Project, Inc.**  
841 Broadway, Suite 608  
New York, NY 10003  
(212) 674-7590

**Legal Action Center**  
153 Waverly Place  
New York, NY 10014  
(212) 243-1313

**Legal Aid Society  
Community Law Office**  
*AIDS Representation Project*  
230 East 106th Street  
New York, NY 10029  
(212) 426-3000

**BROOKLYN**

**Brooklyn Legal Services  
Corporation A**  
80 Jamaica Avenue  
Brooklyn, NY 11207  
(718) 487-1300

**South Brooklyn Legal Services'  
HIV Project**  
*Permanency Planning*  
105 Court Street  
Brooklyn, NY 11201  
(718) 237-5500

**QUEENS**

**Queens Legal Services**  
89-02 Sutphin Boulevard  
Jamaica, NY 11435  
(718) 657-8611

**LONG ISLAND**

**Nassau-Suffolk Law  
Services Committee**  
*Permanency Planning*  
1 Helen Keller Way  
Hempstead, NY 11550  
(516) 292-8100

**LOWER- AND MID-HUDSON VALLEY**

**Westchester/Putnam Legal Services**  
4 Cromwell Place  
White Plains, NY 10601  
(914) 949-1305

**CENTRAL AND WESTERN NEW YORK**

**Erie County Bar Association**  
*Volunteer Lawyers' Project*  
700 Statler Towers  
107 Delaware Avenue  
Buffalo, NY 14202  
(716) 847-0662

**Legal Services of Central  
New York, Inc.**  
*Permanency Planning*  
472 South Salina Street, 3rd Floor  
Syracuse, NY 13202  
(315) 475-3127, x113

**Volunteer Legal Services/Monroe  
Company**  
80 St. Paul Street, 6th Floor  
Rochester, NY 14606  
(716) 232-3051

**NORTHEASTERN NEW YORK**

**Albany Law School**  
*AIDS Law Clinic*  
80 New Scotland Avenue  
Albany, NY 12208  
(518) 463-8182  
School: (518)445-2393

**NYCDOH MEDICAL AND HEALTH RESEARCH ASSOCIATION OF NEW  
YORK CITY, INC. RYAN WHITE TITLE I FUNDED  
CUSTODY PLANNING AND TRANSITIONAL SUPPORTS:**

**MANHATTAN**

**Beth Israel Medical Center**

16th Street @ 1st Avenue  
New York, NY 10003  
(212) 420-2307

**Family Center**

66 Reade Street  
New York, NY 10007  
(212) 766-4522

**Iris House - A Center for Women  
Living with HIV, Inc.**

2271 Second Avenue  
New York, NY 10035  
(212) 935-7352

**New York Council on Adoptable  
Children, Inc.**

666 Broadway, Suite 820  
New York, NY 10012  
(212) 475-0222

**BRONX**

**RFCUNY/Health Force: Women &  
Men Against AIDS**

552 Southern Boulevard  
Bronx, NY 10454  
(718) 585-8585

**BROOKLYN**

**Bedford Stuyvesant Community  
Legal Services Corporation**

1368 Fulton Street  
Brooklyn, NY 11216  
(718) 636-1155

**Coalition for Hispanic Family  
Services**

315 Wyckoff Avenue, 4th Floor  
Brooklyn, NY 11237  
(718) 497-6090

**STATEN ISLAND**

**Seamen's Society for Children &  
Families**

25 Hyatt Street  
Staten Island, NY 10301  
(718) 447-7740



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