Treatment of AIDS/ARC Patients on an Inpatient Psychiatric Unit

Jay Baer MD, Kris Holm RN, Susan Lewitter-Koehler RN, MS

As more individuals develop AIDS or ARC, an increasing number of reports has appeared in the literature documenting the neuropsychiatric syndromes that befall them, including psychosis, depression, and dementia (1-5). Early reports of the appearance of these individuals on inpatient psychiatric units (6-8) illustrate the tremendous stress clinicians experience while working with this population.

Following the lead of the dedicated AIDS unit established by the medical service in mid-1983, the Department of Psychiatry at San Francisco General Hospital centralized the treatment of AIDS and ARC patients on their psychiatric units. Although only 7 of these patients had been treated between July 1984 and June 1985, clinicians anticipated greater numbers of patients in the near future. Administrators and staff hoped that the centralization would help one group of mental health clinicians develop expertise in this field and reduce the strain felt by psychiatric staff from other units when they intermittently cared for AIDS patients.

The AIDS/ARC program began in July 1985 on a locked, inpatient unit which treats patients admitted from the community, the emergency room, other medical units, and from San Francisco county jails. A task force helped plan the special program and guided its integration into the existing ward program.

Patient Management

Of the 15 cases seen during the first 12 months of the program, eight were hospitalized following a suicide attempt or because of escalating suicidal ideation. Three were assaultive or threatening assault, and four were deemed incompetent to provide self-care in the community due to psychotic symptoms. All but one of the last group were hospitalized involuntarily. Standard short-term mental health holds (5150, 5250, etc.) for dangerousness to self or others or grave disability were utilized. One patient went on to permanent conservatorship. Mental health courts generally upheld these holds, despite initial debate over whether AIDS-related behavioral disturbance was medical rather than "mental" illness. The most difficult ethical dilemmas involved the involuntary hospitalization of suicidal patients.

Diagnostic assessment has been challenging, often requiring CT scan of the head and lumbar puncture, frequent consultation with other medical specialists, and neuropsychological testing in addition to standard procedures. Patients' diagnoses of AIDS or ARC were all established prior to admission although one ARC patient was discovered during the hospitalization to have Kaposi's sarcoma of the oral mucosa and therefore was reclassified as an AIDS patient.

Five of the patients received diagnoses of reactive depression; recent stress led to intense but transient suicidal behavior that resolved rapidly in the hospital. For four others, HIV brain injury appeared to be the primary cause of psychiatric disorder; whatever behaviors led to admission, dementia was soon apparent and rapidly progressive. For one, drug ingestion was the primary cause of symptoms. For the remaining five, however, it was impossible to decide whether the psychiatric disorder was reactive or caused by the HIV brain disease. In these cases, patients had subtle evidence of brain insult (for example, minor deficits on neuro psychological testing) that did not advance rapidly. None of the fifteen patients had a specific, reversible central nervous system infection.

Twelve patients were given neuroleptics which were useful in decreasing psychotic symptoms, severe anxiety, and agitation. We tended to use lower dosage ranges with AIDS and ARC patients compared to the general population of psychiatric patients. Two patients developed urinary retention on haloperidol (3 and 20 mg respectively) but tolerated thiothixene up to 25 mg/day without this difficulty; one of these patients developed muscular rigidity that was unresponsive to anti-parkinsonian agents. In the majority of patients, however, standard anti-parkinsonian agents (for example, benzotropine 2 mg twice a day or diphenhydramine 50 mg twice a day) were either not required or worked effectively.

Two patients tolerated and responded well to antidepressants; doxepin 300 mg/day and trazadone 300 mg/day respectively. Although medications were selected to minimize side effects (for example, Tricyclic with high anticholinergic activity like amitriptyline were avoided). Four depressed patients refused them altogether or after only a few days, complaining of multiple side effects. Interestingly, all patients whose primary problem was depression showed significant symptomatic improve...
an Inpatient Psychiatric Unit

continued from cover

ment in the first week of hospitalization, thereby illustrating the importance of psychosocial intervention in the treatment of depression in AIDS or ARC.

Staff observed that lorazepam, already known for causing memory disturbance in normals, yielded a profound worsening of short-term memory when used to treat agitation in two demented patients. This led staff to prefer neuroleptics as the first drug of choice for this purpose, and to consider benzodiazepines only in the infrequent cases in which neuroleptics could not be tolerated.

An infrequent but important aspect of patient care has been the use of seclusion and restraints for violent AIDS or ARC patients. Staff have learned to exercise due caution when secluding or restraining an AIDS or ARC patient, and if necessary (for example, when a patient is biting or scratching) have worn protective coverings (gloves, mask, gowns). They do not routinely “cover up,” but they will do so if needed.

Illustrative Case

John was a 38 year old gay white man with no psychiatric history except episodic binge drinking and a two month history of AIDS (Pneumocystis carinii pneumonia). He was admitted after he became disruptive in an alcohol treatment program. Clinically, he appeared to be suffering an episode of bipoal disorder (mania) and exhibited insomnia, hyperactivity, pressured speech, flight of ideas, lability, grandiose and religious delusions, auditory and visual hallucinations, markedly impaired judgment and complete denial of his AIDS diagnosis. It was unclear if his symptoms were directly caused by HIV infection of his brain or were part of a reactive or “functional” disorder. A negative CT scan and lumbar puncture suggested the latter was the case. John improved moderately after treatment with antipsychotic medication; lithium was not used as John had recent renal complications of AIDS. He was released 10 days after admission, following a successful challenge of his mental health hold in Superior Court.

John was readmitted 10 days later after increasing fatigue and severely impaired judgment rendered him unable to provide food, clothing, and shelter. Treatment with antipsychotic medication was reinstituted. At first he continued to exhibit manic symptoms. On one occasion he became threatening and required seclusion. He repeatedly abused the telephone, calling 911 so the police would rescue him, burdening friends, and trying in order everything from plane tickets to brass bands.

After a few weeks, John’s clinical status began to change. Many of his “manic” symptoms diminished or disappeared; for the most part, he maintained his grandiose denial of his prognosis although this was punctuated by periodic lucidity and acknowledgement of his illness. He began to show signs of dementia: decreased attention to grooming and common etiquette, disorientation, failing short-term memory, wandering, and visual spatial recognition deficits. He had a number of medication complications although he was able to tolerate a neuroleptic and gradually required less of this. His dementia progressed rapidly, and he grew weaker and more in need of nursing assistance with basic activities.

John was placed on permanent conservatorship and no longer required acute psychiatric hospitalization after approximately two months although he remained on the unit for nearly six months until he could be placed in a residential program with 24 hour care. He died 10 days after discharge.

Impact on Milieu

The ward milieu has undergone several changes, and the planning staff has guided these by identifying specific areas that needed immediate attention. These included staff education and staff support, changes required of various inpatient disciplines, and the reactions of other patients.

Educational Needs

A series of specialized in-service trainings addressed the education needs of the staff with particular attention given to medical management, infection control, milieu management, and death and dying. Staff were allowed adequate time and opportunity to consider what this change would mean to them on a personal as well as on a professional level. Our experience indicates that these training and staff support exercises need repetition and revision to integrate the growing AIDS knowledge base and to orient new staff members.

In keeping with departmental practice regarding special focus programs on other units, staff were allowed to transfer to another unit if they were not comfortable working with the AIDS focus program. Two staff members chose to leave, but more joined the unit because of the special focus.

Changes for Inpatient Disciplines

From a nursing perspective, there are significant differences between caring for patients usually seen on an adult psychiatric unit and the AIDS and ARC patients who come to the unit. Working with these patients raises a number of issues not usually encountered in hospital psychiatry; for example, the nurse is required to attend to a multitude of physical problems, the quality of the nurse-patient relationship is intensified through additional contact, and the nurse must confront the issue of working with a life-threatening illness.

The care of the AIDS or ARC patient who is acutely depressed, however, is similar to the care for others hospitalized with depression. Nursing treatment involves helping those patients sort out feelings, get angry, be afraid, and receive validation of feelings about what lies ahead. Individuals with ARC have found the ambiguity of their diagnosis particularly stressful. Our depressed patients stayed in the hospital for a short time (less than two weeks), and a major focus of treatment was facilitating their use of community support services following discharge.

The patients with HIV-related dementia are the most difficult for the psychiatric nurse because their illness causes fluctuating cognitive abilities, steady physical deterioration, and death. They often need assistance with activities of daily living, for example, eating, ambulation, showering, and dressing. This increasing dependence differentiates these patients from others who gradually grow independent. Their physical status changes rapidly, presenting painful or life-threatening crises that need immediate attention; these can include respiratory difficulties, spiking fevers, and loss of bowel and bladder control. The patients often present with disfiguring signs of immune deficiency including oral candidiasis, disseminated Kaposi’s sarcoma, severe dermatitis, and an emaciated appearance which can increase ostracism by both peers and some staff.

Since dying is an isolating process and AIDS is a disease of isolation, the importance of touch cannot be emphasized too much. In psychiatry clinicians usually focus on transference and countertransference — psychological contact — and set limits on physical contact with patients. In this illness it is appropriate and often necessary to touch the patients in the course of giving care. Helping a person eat, simply holding a hand, or giving a massage can be therapeutic by decreasing the sense of isolation.

The occupational therapist has had to alter some of the ward activities to accommodate the AIDS and ARC patients. Their participation in such groups as cooking, grooming, and animal-assisted therapy has needed monitoring to assure compliance with infection control guidelines. The AIDS and ARC patients have required more individualized treatment planning due to their physical and cognitive deficits. However, it has been possible to incorporate their special needs into most of the group activities.

Disposition has proven difficult for some AIDS and ARC patients. For those who have improved or who have personal resources, a return to the community with follow-up care has been possible. Placement has been most difficult for demented patients who continue to have some type of behavioral dis-
turbance (wandering, oppositional behavior, grandiosity, etc.). Due to the lack of appropriate nursing home placement, one patient stayed on the ward for six months until his physical condition deteriorated and he could no longer wander. In our experience, most patients do not require a lengthy stay on an acute inpatient unit per se, yet they must remain there because of a lack of subacute psychiatric/skilled nursing facilities.

Impact on Other Patients
Non-AIDS patients on the ward have also needed special education and assistance with adjusting to the AIDS patients. The orientation handbook for patients has been revised to include a statement regarding the AIDS program. In addition, a handout explaining AIDS is available for all patients. A weekly health group for patients was begun to address the many questions raised by patients. Although this group deals with general health care issues, the primary focus is AIDS education. Group topics include what the disease is, how it is transmitted, who is at risk, and what constitutes safe sex. As needed, the staff provides more detailed and specific information.

Most of the AIDS patients have eventually joined the health group and shared with the others that they have AIDS. Some of the most poignant groups have been those that are “led” by our AIDS patients talking with other patients. If the person with AIDS does not choose to share his diagnosis with other patients, this information is kept confidential by the staff.

Not all of the other patients have reacted favorably to having AIDS patients on the ward. Some, particularly those with paranoid disorders, have become openly hostile and threatening. Some have incorporated AIDS into their delusions. Some have insisted that they be transferred to another unit or that the AIDS patients be sent away and “cured” before returning to the ward. The staff approach has been to reassure the non-AIDS patients, provide education, offer support, and allow them to express fears and concerns. With time, most have been able to tolerate being on the ward and have fewer concerns. Some have become interested and even protective toward their medically ill peers. Those who have been most vocal in their protests have usually used the AIDS issue to avoid some of their own problems. To deal successfully with this variety of patient reactions, staff emphasize that care of AIDS and ARC patients is important and part of the ward routine.

Conclusion
The introduction of an AIDS/ARC program into a pre-existing inpatient psychiatric unit has been challenging and rewarding. It has required consistent education and support for both staff and patients as well as innovations for all mental health disciplines. A look at the rapid increase in the number of the unit’s cases (19 since July 1, 1986, at a rate tripling last year’s) and the national trend suggests that more acute and subacute psychiatric/skilled nursing facilities must develop programs appropriate for patients with AIDS and ARC.

Jay Baer, MD is the attending physician on Ward 7B at San Francisco General Hospital; Kris Holm is the acting head nurse for the unit; and Susan Lewitter-Koehler is a clinical nurse specialist.

References

Diagnosis/Treatment
AIDS Virus Targets Nerve and Lung Cells

Scientists have found that careful evaluation of patients with HIV infection — in addition to advanced laboratory techniques — makes it increasingly apparent that HIV may be the direct or indirect cause of a variety of organ dysfunctions. Some of these events may occur even without a diagnosis of AIDS as it is presently defined.

Three recent studies (JAMA, November 7, 1986) detailed the direct viral infection of macrophage and monocyte cells in AIDS patients, resulting in dementia, other central nervous system disorders, and lymphocytic interstitial pneumonitis. One of the studies documented the presence of HIV in the brain cells of AIDS patients suffering from severe dementia; another confirmed the presence of HIV RNA in samples of brain tissue from two patients with AIDS encephalopathy.

An editorial accompanying the three articles noted that “infection of macrophage/monocytic cells is likely to play a dominant role in the central nervous system as a mode of transmitting virus, as a productive reservoir of virus, and as the cell that initiates the disease process.” The authors observed that in the majority of patients with AIDS, neurological diseases, primarily dementia with subacute encephalopathy, have not been associated with opportunistic pathogens but rather with HIV itself.

A third study suggested that HIV plays a direct causal role in the development of lymphocytic interstitial pneumonitis (LIP) in AIDS patients. The researchers noted that LIP occurs in 50% to 78% of children with AIDS but in less than 5% of adults with AIDS.

Update on Viruses

Since June of 1986 at least five new human viruses have been discovered and announced in the medical literature and in the mainstream media. Scientists reported that they expect advanced laboratory research techniques to yield even more viral discoveries in the next few years. The reports prompt many individuals to wonder what personal risk each virus holds for them. Mental health care providers and AIDS educators are often asked by clients and patients to explain the new research reports. The following is a brief explanation of the recent viral discoveries.

LAV-II, discovered in West Africa last year by researchers from the Pasteur Institute in Paris, may pose the greatest threat to public health. Luc Montagnier, MD, the researcher who discovered the AIDS virus (which he named LAV but it is now known as HIV), discussed LAV-II at the International Conference on AIDS in Paris last June. His early studies indicated that the virus caused only rare cases of AIDS. However, during a November 1986 meeting of the American Association of Blood Banks, Montagnier revealed that new evidence indicated the virus may be a major cause of AIDS in West Africa. He and his colleagues isolated LAV-II in 63 people; of those, 11 have AIDS and 10 have ARC. The other have not developed any disease symptoms. The French researchers have isolated the new virus among residents of Western Europe as well. They noted that LAV-II apparently infects both men and women and could be transmitted by unprotected heterosexual contact and through the blood. The initial studies have not detected the virus in gay men or in I.V. drug users. Montagnier also observed that LAV-II often goes undetected during standard blood screening tests. Several American researchers cautioned that the French study — based on fewer than 100 individuals — was very limited.

continued on page 4
HTLV-IV, isolated by Dr. Max Essex of the Harvard School of Public Health, is different from LAV-II in that it does not appear to cause any human illness. Discovered in West Africa, HTLV-IV is related both to HIV and to a virus called STLV-IV which is found in monkeys. Although HTLV-IV can target and infect the same human blood cells that fall prey to HIV, HTLV-IV does not appear to have the same destructive effect. Essex theorizes that the newer virus may offer protection to those it infects from the more lethal HIV. He believes that HTLV-IV may be a missing link between the monkey virus and the AIDS virus, thus allowing scientists to study all three viruses and to determine why one is so deadly. The new virus may provide information helpful to the development of an AIDS vaccine as well.

Among the new viruses are two that have yet to be named. The first (temporarily designated SBL 6669 V-2) was described last year by molecular biologist Flossie Wong-Staal, MD of the U.S. National Cancer Institute. She reported that Swedish scientist Dr. Gunne Bieberfield of the National Bacteriological Laboratory in Stockholm had sent her blood samples, taken from West African immigrants to Sweden, that revealed a new virus, different from HIV and the others. She did not theorize on what the new virus may mean for Western nations. Although this virus and LAV-II apparently cause AIDS, scientists believe that the majority of AIDS cases in the world result from an HIV infection.

The second unnamed virus was discovered by U.S. government researcher Shyh-Ching Lo, MD. He announced in the American Journal of Hygiene and Tropical Medicine that the new virus has been found only in AIDS patients. He and other scientists observed that there were three possible roles for the new virus: (1) it may be an important co-factor in the development of AIDS; (2) it may lead to opportunistic infections in people with compromised immune systems; and (3) that it may have no effect at all.

Human B-Lymphotropic Virus, or HBLV, is a new herpes-like virus that only infects B cells, those cells that produce antibodies to defend against foreign agents in the body. Robert C. Gallo, MD and his colleagues at the U.S. National Cancer Institute, described their discovery in a recent issue of Science (October 31, 1986). Gallo commented that all of the known herpes viruses cause disease; he expected that HBLV would be no exception. While a few reports in the media linked HBLV with the recent outbreak of a chronic illness of uncertain origin in West African immigrants to Sweden, that revealed a new virus, different from HIV and the others. She did not theorize on what the new virus may mean for Western nations. Although this virus and LAV-II apparently cause AIDS, scientists believe that the majority of AIDS cases in the world result from an HIV infection.

The second unnamed virus was discovered by U.S. government researcher Shyh-Ching Lo, MD. He announced in the American Journal of Hygiene and Tropical Medicine that the new virus has been found only in AIDS patients. He and other scientists observed that there were three possible roles for the new virus: (1) it may be an important co-factor in the development of AIDS; (2) it may lead to opportunistic infections in people with compromised immune systems; and (3) that it may have no effect at all.

Human B-Lymphotropic Virus, or HBLV, is a new herpes-like virus that only infects B cells, those cells that produce antibodies to defend against foreign agents in the body. Robert C. Gallo, MD and his colleagues at the U.S. National Cancer Institute, described their discovery in a recent issue of Science (October 31, 1986). Gallo commented that all of the known herpes viruses cause disease; he expected that HBLV would be no exception. While a few reports in the media linked HBLV with the recent outbreak of a chronic illness of uncertain origin in Nevada, Gallo cautioned that there currently is not enough information to link the virus with that or any other disease.

Gallo commented that these viruses appear to cover a broad spectrum, some being infective and some being weak. He also said (New York Times, November 20, 1986) that he believed scientists would determine in 1987 why one virus causes disease while another does not.

**FOCUS**

**A REVIEW OF AIDS RESEARCH**

**SUBSCRIPTIONS/CORRESPONDENCE**

The amount of research information now appearing in the medical and lay press staggers most AIDS health care and service providers. The goal of *FOCUS* is to place the data and medical reports in a context that is meaningful and useful to its readers.

**Next Month**

Until the recent U.S. Surgeon General’s report on AIDS, most public concern about children and AIDS focused on whether school children with the illness should be allowed in the nation’s schools. Now public health officials, school administrators, youth counselors, and parents have begun to look at the risk of exposure for young people as a result of sexual experimentation and drug use. In the United States nearly 1.2 million young women become pregnant each year, and 85% of reported sexually transmitted diseases (STDs) occur in persons 15-30 years old. The same activities that caused all of these pregnancies and most of these STDs can also expose individuals to AIDS.

In the February issue of FOCUS, Marcia Quackenbush, MS, MFCC, Coordinator of the Youth and AIDS Prevention Program for the UCSF AIDS Health Project, will assess the impact of AIDS on youth — from grade-school children to street youth and young adults. Quackenbush is also the co-author of “Teaching AIDS: A Resource Guide on Acquired Immune Deficiency Syndrome.”