For debate

What is the role of the HIV liaison psychiatrist?

Bruce R Clark, Ian P Everall

In this article we review the field of HIV liaison psychiatry and illustrate the manner in which psychiatric care can contribute to the health and quality of life of this group of patients. To illustrate our discussion we review experience and findings in relation to affective illness, cognitive impairments, and personality disorder in HIV infection. We also highlight some of the areas where psychiatric care of people with HIV infection is unique from other types of psychiatric liaison work.

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A new disease brings with it the need for new medical specialisation for assessment and treatment. Human immunodeficiency virus (HIV) disease is no exception but full expertise in the area of mental health problems is lagging behind understanding and treatment for other areas of HIV care. Debate exists in relation to this as to whether there is a need to develop separate HIV liaison psychiatry services. Some sceptics would suggest that psychiatrists have little to offer HIV positive patients beyond compassion for the emotional consequences of the illness.

In this article we will debate the unique contribution that can be made to the assessment of HIV infected individuals from a specialised HIV liaison psychiatry service. The three major problem areas of affective illness, cognitive impairment, and personality disorder will be used to illustrate our discussion. We would argue that there are in fact specialised needs in this HIV infected population and that the input of psychiatric services with the relevant experience and knowledge is vital.

Are there special features of depression in those with HIV?

All studies to date reveal that depressive illness is the most common psychiatric problem in both asymptomatic and symptomatic HIV infection. Its prevalence appears to be approximately twice that of a normal community sample and it rises with disease progression.¹⁻³ This elevated rate is similar to that reported in other chronic illnesses. However, for medically unwell HIV positive patients this prevalence rises up to 40%,⁴ which is higher than that found in other age matched patients with a terminal disease.

Questions exist as to whether these high rates of psychiatric illness relate primarily to the viral infection itself or as a non-specific consequence of the effects of a terminal illness in the particular populations affected. We would argue that rather than decreasing the need for greater specialisation the capacity to meet the needs of some of the minority groups affected requires that they are understood in the appropriate context. This, therefore, involves not

only the sensitive appraisal of the symptoms with an understanding of the individual's pre-morbid history but also their assimilation into the broader medical picture by close liaison between the specialist psychiatric and medical personnel.

Suicidal feelings are undoubtedly common in HIV positive patients. Several studies support this, with relative risks of suicide in men with AIDS varying from seven times to 36 times that of an aged matched general population control.⁵ Likely vulnerable periods for suicidal thoughts and behaviour are notification of HIV positive status, development of an AIDS defining illness, or death of a partner or close friend.⁶ Homosexual men, substance abusers, and individuals with a diagnosis of personality disorder have a markedly elevated risk of suicide compared with the general population independent of HIV serostatus.⁷ While appropriately controlled trials to ascertain the contribution of HIV infection to these alarming statistics have not been done there remains little doubt that the HIV positive population is at markedly increased risk of affective disturbance.

These high rates of affective psychiatric morbidity may also be a reflection of a number of different factors including comorbid drug and alcohol use, the effects of physical illness and medication, or social factors including isolation, bereavement, marginalisation, and stigma.⁸ Homosexuals and injecting drug users have higher rates of depressive illness compared with the general population.⁹ This may be in part a consequence of prejudice both publicly, in society and at work, as well as personally by family or other personal acquaintances.¹⁰ Understandably, receiving notification of HIV infection may exacerbate such feelings of rejection and isolation.

Underdiagnosis rather than overdiagnosis of depressive illness has been observed in HIV medical clinics.¹¹ In fact, only 9% of patients in the WHO study who fulfilled research criteria for depressive illness were receiving antidepressant therapy at the time of assessment,^{2,3} but dramatic improvements in referral and treatment rates can be achieved by liaison services through the introduction of simple screening tools.⁶

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Can organic problems be overlooked?

For the specialist liaison psychiatrist, a degree of expertise in HIV related medical conditions and medications is vital. Symptoms of organic illness such as poor appetite and sleep, weight loss, and increased fatiguability are easily mistaken as signs of depressive illness. In these instances depressive symptoms respond to primary treatment of the underlying medical disorder, whereas, at other times the medications used to treat the physical complications of HIV disease may need to be tailored as they can exacerbate psychiatric disorders.⁷

Case note surveys showing a slight excess of bipolar affective disorder^{13 14} appear to consist of manic patients without the typical personal and family histories seen in HIV negative bipolar patients and may be secondary to medication, systemic illness, or even primary HIV related brain damage.¹⁵ Mania in these individuals therefore appears to be a late and ominous sign with death occurring within months.⁴ The management of such patients is clearly different from that of an HIV negative bipolar patient both psychologically and pharmacologically.

Fear of dementia is often one of the principal concerns of those with HIV and their caregivers¹⁶ requiring sensitive and skilled management. Minor cognitive impairments not meeting the criteria for a diagnosis of dementia are clearly demonstrable in patients with AIDS ranging from 5% of the newly diagnosed group to 60% in the late stage AIDS group.¹⁷

It is only recently that the true incidence of HIV associated dementia has become more clearly understood⁷ with estimates of between 7% of AIDS patients and up to 15% in a cohort followed to death.¹⁸ Detection of HIV associated dementia can take considerable psychiatric skill particularly in the early stages where the appropriate use of complex neuropsychometry is often necessary to detect subtle subcortical changes. Once present, dementia is associated with a poor prognosis¹⁹ with the Multicenter AIDS Cohort Study demonstrating a median survival of 6 months,¹⁸ although the potential impact of combination antiretroviral therapy has yet to be assessed. Earlier detection afforded by specialist services will not only allow this impact to be assessed more fully but helps to lessen the burden of what for patients is often the most devastating aspects of HIV infection.

Is there any effect of personality or lifestyle?

It has been suggested that there is an excess of borderline personality disorder in HIV infected individuals.²⁰ Estimates of the prevalence of personality disorder in HIV positive patients vary from 16% to 30%.^{21 22} Borderline personality disorder was found to account for 73% of all personality diagnoses made in HIV positive individuals in one retrospective study.²³ The characteristic features of this diagnosis broadly include mood instability, impulsivity, substance and alcohol misuse, deliberate self harm, low self esteem, and

unstable relationships. These can not only predispose the individual to maladaptive coping strategies, including risk taking with unsafe sex, drug and alcohol abuse,²⁴ but can also lead to the misdirected use of hospital time and haphazard follow up. Several studies indicate that personality disorder increases the risk of other comorbid psychiatric conditions.²⁵ Indeed, HIV positive men with personality disorders had more associated psychiatric symptoms than HIV negative men without personality disorder.²⁶ These authors suggest that personality disorder and HIV diagnosis are in some way synergistic in creating psychiatric morbidity. The assessment and treatment of comorbid psychiatric disorder together with the use of appropriate clinical boundary setting and regular supportive psychotherapy by liaison psychiatrists is effective not only in reducing mental health problems for the individual concerned but also in reducing the inappropriate use of medical and nursing staff time.

Drug users with HIV infection are a growing population of patients

The psychiatrist has many relevant skills to offer as the majority of HIV infected drug users suffer from other psychiatric disorders.^{27 28} Non-HIV related organic pathologies are also a significant problem which may in part explain the finding that 28% of HIV positive intravenous drug users will die before developing an AIDS indicator illness.²⁹ Questions exist as to the relative contributions of drug use and HIV to the neuropsychiatric impairments of these patients. The bulk of evidence suggests, however, that the high rate of psychiatric disorders seen in HIV infected drug users reflects the background rate of these disorders in drug users without HIV infection.

The triple diagnoses of HIV infection, illicit drug use, and psychiatric disorder can be very difficult to tease apart. This group of patients is notoriously difficult to engage and presentation to medical care is notoriously late.^{28 30} The provision of on site support for their substance misuse and psychiatric problems is known to be one of the most effective strategies for dealing with these problems,³¹ with treatment improving both their quality of life and reducing the spread of infection. Working closely with not only the physicians but also some of the non-statutory drug agencies caring for the individual is often the most fruitful. We would suggest the HIV liaison psychiatrist has much to offer with their experience of working with drug users often making them the key professional coordinating the efforts of the multidisciplinary team to deliver such an on site service.

Are there special considerations in starting treatment?

The commencement of psychotropic medication requires considerable expertise because of a number of important factors. Many drugs have side effect profiles which mimic the fea-

tures of physical illness, such as the gastrointestinal disturbance seen with many antidepressants. Drug interactions are similarly important to consider and recent developments in combination therapy for HIV disease have necessitated revision by our team of antidepressant prescribing on pharmacodynamic grounds. Further adjustments are inevitable as therapeutic developments progress. There is growing interest in the treatment of HIV dementia with antiretroviral agents, which have been shown to produce significant, albeit temporary, improvements in cognitive function.³² Timely use of psychotropic medication is still often necessitated for disturbed behaviour. Most commonly this is as a result of psychotic symptoms. Care and experience in the use of psychotropic medication is important as some individuals are particularly sensitive to the extrapyramidal side effects of neuroleptics.

Summary

The application of psychiatric skills in HIV positive patients is not only modified by the breadth of the mental health problems but also the unique way in which they are modified by factors such as comorbid physical illnesses, their treatments, and the experiences of the minority populations affected. A comparison often made is that of the psychiatric needs of patients under the care of oncology services where psychiatric services are often under-resourced. We would suggest that this is not a directly comparable group. The close personal experience of HIV positive patients of friends or partners who may have been similarly affected undoubtedly has a very powerful emotive effect on these individuals.

The practice of HIV medicine is constantly modified to keep pace with the rapidly developing research in this area. We would suggest that psychiatric services similarly need to undergo such a change. Continued specialist interest and research are therefore a necessity in order to maintain the psychiatric team in the centre of the multidisciplinary HIV health-care team.

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