

# FOCUS A GUIDE TO AIDS RESEARCH

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## Psychotherapy and the AIDS-Anxious Patient

Charles R. Tartaglia, MD and  
C. Richard Filsor, EdD

The threat of exposure to the human immunodeficiency virus (HIV) and the fear it inspires have forced people to develop a variety of coping mechanisms ranging from denial to substantial adaptation. If these coping efforts are successful, fear may subside to a level of reasonable caution or vanish altogether. If they are unsuccessful, however, fear may proceed unchecked, at times progressing to irrational levels and prompting actions that can be destructive and debilitating.

Among this group of AIDS-anxious individuals are those who respond to their fears by turning to the medical establishment, seeking evaluation, treatment and emotional solace from physicians. For a variety of reasons, physicians may refer these patients to mental health professionals, who must be prepared to deal with the issue of AIDS anxiety.

Over the past five years, we have evaluated and treated a number of such patients representing a varied but far from comprehensive cross-section of AIDS-anxious individuals. The majority have been gay or bisexual men, whose conditions have spanned the spectrum of the disease, from before HIV-antibody testing to terminal care. Distinctly absent from our treatment groups have been intravenous drug users, who have their own special problems and who do not as readily find their way into private medical referral channels.

Our interventions have included brief counseling, crisis management, ongoing individual psychotherapy over a few weeks to several years, and medication management.

This experience with several dozen such patients seen in individual psychotherapy provides the basis for a number of observations about the issues and psychodynamics of AIDS-anxious individuals and the conduct of therapy with such patients. There is always a risk of error in generalizing from the particular. Broad extrapolation from the groups we have examined must be undertaken with caution.

### Symptoms of AIDS Anxiety

Descriptions of the symptoms of AIDS anxiety can be readily found in the psychological and psychiatric literature and typically include panic attacks, phobic symptoms, generalized anxiety, morbid obsessions, anger, depression, persistent hypochondria, self-absorption and despair.

Virtually all the individuals we have seen have experienced serious disruptions of daily functioning that go beyond those attributable to physical dysfunction. Some have had problems at work including poor concentration, poor performance, withdrawal from co-workers, and frequent, occasionally protracted, absences. Others have suffered severe disruption of their social activities, and avoid their friends and acquaintances. Most have

spent some period of time withdrawn from the outside world, although they may exhibit a morbid interest in media reports about AIDS.

Frequently they have guarded their anxiety from all but their physicians, whose efforts to support are often unsuccessful and in some instances may even intensify anxiety. At times, doctor's visits have been avoided because of a fear of what might be discovered.

The most severe symptoms of AIDS anxiety have tended to occur early in the course of events — sometimes before seroconversion, most often upon testing HIV-antibody positive or being diagnosed with ARC.

### AIDS Anxiety among Gay and Bisexual Men

Gay and bisexual men represent the largest group at risk for AIDS anxiety and the one we most frequently encountered in our treatment experience. The situation of this group of patients can be best understood, in our view, as a confluence of several sets of factors: the character of AIDS itself, its effect on the gay community, and the psychological characteristics of individuals with AIDS anxiety.

*AIDS anxiety may progress to irrational levels and prompt actions that can be destructive and debilitating.*

For this discussion, AIDS can be characterized as a fatal disease caused by a sexually-transmitted virus whose incubation period can be as long as 15 years and which has incited more fear and social and moral stigmatization than any disorder in recent memory. Relevant factors about the gay patients we have treated for AIDS anxiety include: the common phenomenon of multiple sexual partners, the frequency of sexual practices that are closely associated with transmission of HIV, and most importantly, the prevalence of the virus in the gay community.

Finally, in an earlier descriptive study, we gained insight into the individual psychological characteristics of AIDS-anxious gay and bisexual men. We noted a tendency toward obsessionality, a pattern of chronic dysthymia (mood fluctuation) associated with prominent dependency needs, and a strong pressure to act in ways that were not always well advised. For example, patients would frequently seek reassurance from physicians, even when the reassurance did nothing to allay their anxieties. In addition, there was a tendency for some of these patients to define themselves first and foremost in terms of their sexual orientation.

AIDS, as a sexually-transmitted and fatal disease, establishes a real link between sexual behavior and risk. This, coupled with the uncertainty as to whether, when and in what ways the disease will manifest itself, provides a basis not only for rational fear but also for a patient's feelings of responsibility for his or her HIV infection. These fears of death and disability legitimately

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# AIDS Anxiety . . .

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occupy time and attention but do not seem to adequately account for the distress and dysfunction that we have observed among AIDS-anxious individuals. Other issues contribute to the phenomenon of AIDS anxiety.

One such issue is the significance of the role of sexual orientation in the definition of self. In the best-adapted individuals, it might be expected that sexual orientation would be experienced as one facet in a multi-faceted whole. For a number of AIDS-anxious patients, homosexuality seems to them to be the most important feature of their personality. This is understandable in light of the societal reinforcement of such a self view: that is, repetitive encounters with homophobia and reliance for support on the gay community, to which a shared gay identity is fundamental. With regard to AIDS anxiety, however, this emphasis on sexual orientation can become problematic. A conflict arises for men whose identities are keenly focused on their sexual behavior at a time when aspects of that behavior may be life-threatening. We found gay men from a variety of backgrounds and life situations who were dealing with these issues, including those who had been more integrated into mainstream society with straight as well as gay friends.

Moreover, many AIDS-anxious patients are ambivalent about their homosexuality and experience feelings of guilt and shame, which in some cases have not been acknowledged prior to their AIDS-anxiety. Attendant to this may be an expectation of punishment, a feeling reinforced by the social censure to which many gay people are subjected. Finally, they may feel simultaneously anger and resentment of other gays as sources of infection, and concern, regret and later shame about people with AIDS, for whose infection they feel responsible.

Shame and guilt about sexuality contributes to a serious loss of self-esteem and results in social withdrawal. This in turn permits an escalation of the existing depression, obsessiveness and hypochondria that characterize AIDS-anxious individuals. Social withdrawal also removes patients from their usual sources of pleasure and outside support, while limited activity diminishes their capacities to take constructive actions to meet their own needs. The resulting frustration further inflames existing anger — at themselves for their own helplessness and at others for failure to be constructively helpful to them — and increases anticipation of punishment for that anger.

## Treatment of AIDS Anxiety

At the outset of treatment, the distrust, depression and apprehension demonstrated by the AIDS-anxious patients we treated required our active engagement. Ruminations about disease and symptoms often required interruption in order for us to obtain a reasonable history. To counter this, it was fruitful to ask about the time of onset of symptoms and their meaning to the patient in relationship to life events that were occurring concurrently. Often there was initial resistance toward discussing these matters. In the end, gentle persistence and the demonstration to patients that the origin of their anxiety was broader than the real threat of AIDS were successful in stimulating patients' curiosity about themselves and their situations. In addition, the implication that a patient's psychological symptoms had a beginning seemed to stir the hope that they might also have an end.

In these cases, it was helpful to ask why the patient was feeling anxious and asking for help at that point in time. One patient discovered that a mid-life crisis was at the crux of his anxiety. This crisis, however, began at a time when media attention was focused on the epidemic. This encouraged his age-related anxiety to center on his vulnerability to AIDS.

Another important element of our work with AIDS-anxious individuals was the conscientious maintenance of therapist neutrality regarding certain matters, particularly sexual orien-

tation and behavior. Indeed, given the ambivalence expressed by some patients regarding their homosexuality, this neutrality may well have been the decisive factor in their abilities to acknowledge and speak of such conflicted issues, abilities that were essential to a full exposition of their affective states.

Our restraint from suggestions about what patients should and should not do, and our adherence to a policy of accepting, with concern and interest, whatever patients might offer, seemed to correspond to the fairly rapid development of their capacities to accept themselves, to think about their situation, and to reestablish more durable and adaptive coping styles. Last but not least, our neutrality seemed pivotal to our patients' capacities to trust us, a significant ingredient in their willingness to begin to trust others in their social and work environments. This led to a breakdown of social isolation and renewed access to accustomed sources of support.

A third important element was our effort to become acquainted with our patients as fully as time and circumstances permitted. This helped them become more aware of the varied dimensions of their personalities and expand the excessively narrow self-definition as gay (self = gay only), to a broader one (self = gay plus other aspects). This entailed leading the patient to rediscover these dimensions, dimensions that he had recognized prior to his anxiety but which had become obscured by a focus on sexual behavior. To the extent that this succeeded, patients were able to appreciate themselves more fully and to restore a measure of self-esteem.

For the non-gay patient, similar issues — shame and guilt, concerns about social stigmatization, frustration and helplessness — pertained. In the cases of a woman with transfusion-related AIDS and the spouse of a person with AIDS, however, there was a strong sense of victimization, not seen with our other patients, and more prominent feelings of indignation and outrage. Nonetheless, the therapeutic posture just described served equally well in these instances.

In selected cases, psychoactive medication including anxiolytics, polycyclic antidepressants, neuroleptics, and hypnotics proved useful, although these were infrequently required and, except in the presence of major depression, were used only briefly as adjuncts to the psychotherapy.

## Effects of AIDS Diagnosis on Anxiety

When faced with a diagnosis of AIDS, reality-based issues emerge with increasing urgency. Physical discomfort and disability, including encephalopathic changes, become issues for, as well as impediments to, psychological treatment. Internal pressure to attend to unfinished business, often including reconciliation with estranged loved ones, becomes powerful and may involve the therapist as facilitator, consultant and mediator. The lessons learned in assisting patients with other fatal illnesses, such as cancer, are invaluable and therapists with clients dealing with an AIDS diagnosis would do well to acquaint themselves with the rich literature on the subject.

Despite the shifts in the issues patients face after diagnosis, problems maintaining self-esteem, retaining a clear sense of identity, finding meaning in day-to-day activities, holding on to important relationships, and preserving a sense of control persist, often require a therapist's assistance. As stated above, therapists have several techniques at their disposal: active engagement of the patient, understanding the meaning of symptoms (such as the fear of death or disability), and determining the patient's psychological characteristics and coping style. These techniques can help therapists in their efforts to provide care.

**Charles R. Tartaglia, MD**, is Assistant Professor of Psychiatry and Psychiatric Consultant to the AIDS Clinic at Georgetown University Medical Center. **C. Richard Filson, EdD**, is a psychologist and Clinical Instructor in Psychiatry at Georgetown University Medical Center.

## Diagnosis/Treatment/Prevention

# Depression, Cognitive Impairment and Response to Psychostimulants in HIV-Infected Patients

Francisco Fernandez, MD

Physicians have avoided using pharmacological treatments for AIDS patients with psychological disturbances for three reasons: a belief that psychotropic agents have adverse side effects; an historical bias against medical intervention for psychological symptoms; and a belief that the drugs may harm patients in poor physical condition.

Optimal care of those who suffer from HIV infection and secondary psychological disturbances, however, requires rapid recognition and management. Pharmacological treatments can be used to achieve qualitative and quantitative improvements in behavioral and cognitive functions and help the patient regain a more comfortable, competent and fulfilling life.

Formal neuropsychological testing is mandatory to accurately define psychiatric disturbances, and to assess appropriate pharmacological and clinical management. Test results will clarify not only whether the origin of the disturbance is organic or functional, but will also better define a patient's abilities to comprehend and comply with his or her treatment. Testing is especially helpful if there is an earlier baseline evaluation that allows for a comparison to determine whether any cognitive decline has occurred.

Because there is a wide range of cognitive dysfunction among HIV-infected patients, the selection of neuropsychological tests must consider a patient's stamina and ability to respond. Since HIV-related impairment is characterized as a subcortical dementing process, neuropsychological instruments that test memory (registration, storage and retrieval functions), psychomotor speed, and rate of information processing are essential.

### Use of Psychostimulants

Controversy has surrounded the therapeutic role of the psychostimulants since their formal introduction into general medical practice over 50 years ago. Some states have limited the therapeutic use of amphetamines, even for FDA-approved conditions, and have banned their production altogether. These actions were instigated to a large degree by the indiscriminate prescription of amphetamines for a variety of conditions and the dramatic rise in their illicit use during the 1960s.

Recent clinical and investigative experience with the psychostimulants, however, has demonstrated that they are both safe and useful when prescribed appropriately. Narcolepsy, nocturnal enuresis, post-cardiotomy depression, neurasthenia fatigue syndromes and secondary depression in medically-ill patients have all been treated successfully with psychostimulants in selected cases.

Psychostimulants, which have some minimal analgesic properties of their own, may also be used as analgesic adjuvants. When given in combination with narcotic analgesics, psychostimulants add to the pain relief afforded by the narcotic agent alone. As a result, the dose of narcotics can be reduced significantly. This drug interaction is particularly important for those patients who do not experience adequate pain relief with narcotic analgesics alone or who are unable to tolerate their side effects, particularly sedation or stupor.

Psychostimulants, specifically dextroamphetamine, are also a useful adjunct in the management of certain seizure disorders such as myoclonic (muscular) and nocturnal seizures. Since some anticonvulsants are sedating, patients whose seizures require

large doses of anticonvulsants to be controlled may develop overwhelming sedative effects. In such circumstances, stimulants can also be used successfully to reduce sedation.

### Pharmacotherapy in HIV-related Depression and Dementia

Major depression is commonly diagnosed in HIV-infected individuals, although much less frequently than adjustment disorders. Unless such a diagnosis is accompanied by a rigorous mental status examination, however, it should be considered suspect since behavioral and emotional changes in patients with HIV disease may reflect any of a wide range of neuropathologic disorders. Knowledge of the medical complications of HIV disease is needed to evaluate complaints of depression and to differentiate among potential diagnoses.

Treatment of depression in HIV-infected individuals should follow standard clinical guidelines. However, the use of psychostimulants, specifically methylphenidate, in depressed HIV patients with cognitive impairment is growing. This agent effectively relieves the major signs and symptoms of depression without serious side effects and within hours of the first dose.

It is often difficult to distinguish the effects of HIV infection from those of a primary mood disturbance. In general, people who respond to psychostimulants exhibit apathy and a defeatist attitude that distinguishes them from chronically-ill patients, who lack the reserves but not the desire to go on with life. Psychostimulant treatment is highlighted by psychomotor activation, appetite stimulation and qualitative as well as quantitative improvements in higher cortical functions and affect.

In cognitively intact patients, psychostimulants may also be used to predict the clinical response to imipramine, desipramine and other noradrenergic agents. Methylphenidate and dextroamphetamine have also been given to patients with AIDS dementia complex, organic personality disorders, and organic affective disorders, and has sustained marked improvements in cognitive impairments as well as mood disturbance. Although interchangeable, methylphenidate is the slightly more potent of the two drugs.

### Conclusion

Several studies have now demonstrated the importance of stimulants in the treatment of depression and cognitive impairment secondary to HIV infection. Psychostimulant therapy has been responsible for improvement in higher cortical functions, self-esteem and self-sufficiency, and is remarkable for the absence of treatment-related side effects. When used appropriately, these drugs are both safe and effective, as convincingly demonstrated by their long-term success in the treatment of other disorders such as narcolepsy or childhood hyperkinesia.

Psychostimulants, like other potentially addicting agents, must be prescribed with caution to carefully selected HIV-infected patients. When prescribed for depression, however, instances of abuse have not been reported in published research.

In the quest for an improved quality of life for HIV-infected patients, further study is needed to firmly establish the role of pharmacotherapies in treating HIV-related psychiatric disorders.

**Francisco Fernandez, MD**, is the Chief of the Psychiatric Consultation Service at St. Luke's Episcopal Hospital in Houston.

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# BRIEFS

## Recent Reports

**AZT Overdose.** Clinicians from St. Luke's Medical Center in Chicago have documented in the *Annals of Internal Medicine* (July 1, 1988) a case of AZT overdose in a person with AIDS who attempted suicide.

Eight hours after he intentionally ingested 10 to 20 grams of AZT and unknown amounts of phenobarbital and triazolam (Halcion), a 26-year-old man presented to the emergency room with complaints of headache and nausea. Vital signs were normal. Physical findings included nystagmus (rapid eyeball movement) and ataxia (lack of coordination). The patient was admitted for observation. Ataxia and nystagmus resolved in 48 hours. Six weeks after discharge, the patient had no symptoms and a normal physical exam.

Symptoms of acute AZT overdose in humans are presently unknown, but neurotoxicity has been previously reported<sup>1,2</sup>. Symptoms in these cases included headache, stupor, sustained seizure activity, cerebellar dysfunction and grand mal seizures.

In rats and mice, an AZT level of greater than 750 mg/kg body weight is the lethal intravenous dose. In this case, the patient ingested between 110 and 220 mg/kg body weight. The clinicians state that it is unclear whether his reaction was a result of AZT, phenobarbital or triazolam. It is interesting that although anemia and bone marrow suppression occur as a result of long-term AZT administration, no bone marrow toxicity was seen in this acute overdose.

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**Universal Precautions in Emergency Room.** Blood and body fluid precautions recommended to protect health care workers from HIV infection are being applied selectively and inconsistently, according to researchers from the Johns Hopkins University School of Medicine.

They report in the *New England Journal of Medicine* (June 23, 1988) that of 2275 patients who visited an inner city emergency room over six weeks and whose serostatus was unknown, 92 (4 percent) tested positive for HIV antibody.

While patients who were identified by emergency room personnel as having been infected with HIV were treated using precautions — gloves were worn, body fluids were labeled "infectious," and examining rooms were disinfected after use — all 2275 patients of unknown serostatus were treated with no such precautions.

Study investigators, who were not involved in patient care, collected excess sera, and demographic, risk-status and medical data from patients from whom blood had been drawn for medical reasons. Patients were divided into three groups: risk factor identified, risk factor assessed and not present, and risk factor unknown. Investigators did not influence the method of risk-factor assessment or whether risk-factor information was obtained at all.

During the study period, 2302 patients had blood drawn. Of these, 27 were known to be infected with HIV. Of the remaining 2275 patients, only 659 (29 percent) had risk factors

assessed to any extent. After assessment, 276 patients were found to have risk factors and 13 percent of these were found to be seropositive. Of the remaining 1999 patients, who were assessed as having no risk factors or who were not assessed at all, 2.8 percent were seropositive.

These figures varied depending on clinical condition. Of the patients who went directly into surgery upon admission to the emergency room, 4.6 percent were found to have been seropositive and were unrecognized as such.

The researchers concluded that, "Clinical variables and the current practice of risk-factor assessment are neither reliable predictors nor appropriate tools for the identification of HIV infection in emergency department patients. This study firmly supports the concept of 'universal blood and body fluid precautions.'"

**Legal Limits of AIDS Confidentiality.** In a comprehensive review of relevant laws, a University of Toronto law professor argues that public policy initiatives to protect people who are seropositive should focus on anti-discrimination legislation rather than confidentiality protection.

The premise of the review, published in the *Journal of the American Medical Association* (June 17, 1988), is that, "The law's protection of medical confidence is frequently illusory." The article details four areas of law — duty to warn, power to warn, criminal and police powers — and justifications for breaches of confidentiality that exist, not only in particular laws, but also under "transcending legal doctrines."

For instance, the duty to warn, established in a case of a mental health practitioner who failed to warn an identifiable victim of potential attack by a patient, requires patient/psychotherapist confidentiality to be breached when it helps to avert danger to others. The article states that this principle could be interpreted to equate the spread of HIV with violence and that physicians and related professionals have a legal responsibility "toward third parties they anticipate or reasonably should anticipate being harmed by their patients." HIV confidentiality legislation would probably be subject to this limitation, the review states.

The article goes on to detail in the other areas of law difficulties within confidentiality protection that render it unreliable. "Too much in the law itself compels, justifies and excuses disclosure of information," it states. The article concludes that the legislative effort is better devoted to anti-discrimination measures in such areas as employment, housing, education, insurance and access to medical care.

## Next Month

A person with AIDS may be the focus of pathology in a family. **Colleen McMillan, MSW**, of Mount Sinai Hospital in Toronto, will explore four areas of difficulty for families of gay men with AIDS: disclosure of homosexuality and AIDS, role differentiation, emotional cutoff and stress on partners.

**Sally Jue, LCSW**, of the AIDS Project Los Angeles, will discuss strategies for cross-cultural counseling and the significance of culture on beliefs about family, illness, death and dying, and sexuality.

## FOCUS A GUIDE TO AIDS RESEARCH

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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.

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