

# **The Triply Diagnosed Person: HIV Infection, Mental Illness and Alcohol/Other Drug Use Disorders**

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**Carolyn Licht, PhD, Psychologist**  
Columbia University Medical Center  
Family Care Center of Harlem Hospital  
Department of Pediatrics, New York



## **Overview**

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- Statistics**
- Defining Who They Are**
- Diagnostic Issues**
- Treatment Issues**
- Conclusion**



## Current Reality & HIV Risk Factors

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- ❑ **33 million people globally live with HIV/AIDS**
  - Only 2 million actually receive HIV medications
  
- ❑ **Demographic**
  - Communities of color -African American & Hispanic
    - ❑ 77% of PLWAs are persons of color
  - Men who have sex with men
  - Increasingly women

## Demographic Risk Factors for HIV

(Rates of New Infections)

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- ❑ **CDC estimates 56,300 new HIV infections occurred in the US in 2006**
  
- ❑ **New Infections in 2005 by Race/Ethnicity**

■ African Americans	49%
■ Whites	31%
■ Hispanics	18%
■ Native Americans	1%
  
- ❑ **Women represent 27% of all new AIDS cases**
  
- ❑ **Native Americans ranked 3<sup>rd</sup> in rates (per 100,000) of new HIV/AIDS diagnoses, after blacks and Hispanics**

## Risk Factors for HIV continued

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- ❑ **Mental Illness**
  
- ❑ **Alcohol/Substance Use or Induced Disorders**

## Impact of Mental Illness

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- ❑ Nearly *half* of all Americans who have a severe mental illness do not receive any treatment
- ❑ Can interfere with HIV treatment adherence and self-care behaviors ( plus child care)
- ❑ Mental health problems may be associated with unsafe sexual and drug use behaviors
- ❑ Especially among people living with HIV, lack of treatment associated with increased
  - suffering
  - impaired quality of life
  - premature mortality



## **Triply Diagnosed Patients: Defining Who They Are**

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### **Majority**

**Alcohol / substance use disorders and HIV with comorbid depressive, anxiety, personality disorders.**

### **Minority**

**Recurrent psychotic disorders (schizophrenia, mania, depression with psychosis, psychosis NOS) with comorbid alcohol / substance use disorders and HIV.**

## **RAND HCSUS (Bing et al 2001) Study: 2,864 HIV+ Medical Patients**

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<input type="checkbox"/>	<b>Any Psychiatric Disorder</b>	<b>48%</b>
<input type="checkbox"/>	■ Major Depressive Disorder	36%
<input type="checkbox"/>	■ Dysthymia	27%
<input type="checkbox"/>	■ Generalized Anxiety Disorder	16%
<input type="checkbox"/>	■ Panic Attack	11%
<input type="checkbox"/>	■ PTSD (Vitiello, 2003)	10.4%
<input type="checkbox"/>	<b>Illicit Drug Use (not marijuana)</b>	<b>40%</b>
<input type="checkbox"/>	■ Drug Dependence	12%
<input type="checkbox"/>	■ Heavy Alcohol Use	8%
<input type="checkbox"/>	■ Problematic Alcohol Use	19%
<input type="checkbox"/>	<b>Triply Diagnosed</b>	<b>13%</b>

## Six Sides to a Rubix Cube

- 1. HIV/Medical
- 2. Mental Health
- 3. Alcohol/Substance Use Disorders
- 4. Family/Support
- 5. Environment
- 6. Life Stressors



## The Triply Diagnosed Person

### The Case of Ms. P

(49 Year-Old Hispanic Woman)

#### MEDICAL

- HIV/AIDS
- HCV/Cirrhosis/liver failure
- Diabetes Mellitis
- Hypertension
- Obesity
- Deep Vein Thrombosis
- Asthma
- Lipodystrophy
- MRSA / C-Diff Infections
- Poor Adherence

#### PSYCHIATRIC

- Past h/o sexual/physical abuse, DV
- Anxiety (PTSD, Panic Disorder)
- Bipolar depression
- Auditory/visual hallucinations
- Suicidal/homicidal ideation/attempts
- Severe memory and cognitive deficits
- Borderline personality traits

#### ALCOHOL/SUBSTANCE USE

- Benzodiazepine dependence
- Alcohol dependence
- Opioid dependence with past h/o IVDU
- Methadone Maintenance Therapy

## DSM-V-TR Diagnostic Impressions

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- Axis I:** Bipolar Mood Disorder Type I w/Psychotic Features  
Post Traumatic Stress Disorder  
Panic Disorder with agoraphobia  
Opioid Dependence (on Methadone Therapy)  
Benzodiazepine Dependence  
Alcohol Dependence  
r/o Dementia secondary to HIV/SA
- Axis II:** r/o Mental Retardation  
r/o Borderline Personality Disorder
- Axis III:** HIV/AIDS, HCV/Cirrhosis, Diabetes Mellitus, Hypertension, Obesity, Asthma, Lipodystrophy, MRSA and c-diff infections
- Axis IV:** severe stressors- chronic illness, multiple losses, legal history, no formal educational or vocational history, financial problems
- Axis V:** GAF 40

## The Stigma of the Triply Diagnosed Person

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- Human behavior**— unsafe sex, sexual violence, sex to obtain money or goods, and drug use and injection—drive the epidemic.
- Human reactions**— fear, denial, stigma, myths, unsafe sexual traditions, discrimination, indifference, greed, and ineffective responses—limit our ability to contain the epidemic.

## Diagnostic Dilemmas

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- What comes first, the chicken or the egg?**



## Focusing on Each Part of the Pie

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- HIV**
- Mental Illness**
- Alcohol and Substance Abuse**



## Differential Diagnosis of the Triply Diagnosed Person

Look for Underlying Biological Cause

1. **Medications:** HIV, psychiatric, other
2. **Substances:** Alcohol, drugs, herbal remedies, other
3. **Non-HIV Medical problems:** Vitamin deficiencies, metabolic disturbances, etc
4. **HIV-Related Illnesses:** CNS lesions, infections  
Non-CNS medical problems

and/or

**Psychiatric Syndromes**  
depression, anxiety,  
Personality Disorder

**Neuropsychiatric Manifestations of HIV:**  
Minor Cog Motor Disorder  
HIV Associated Dementia  
Other Cognitive Issues

## Differential Diagnosis continued...

- ❑ **Comorbidity of Substance Use and Mental Illness**
  - Co-occur at much higher than chance levels.
  - 51% of people with lifetime alcohol/substance use disorders met criteria for at least one other lifetime mental disorder, and vice-versa.
- ❑ **What Comes First? Possible Explanations:**
  - One disorder is a marker for the other.
  - Mental illness leads to self-medication with substances.
  - Substance use and withdrawal lead to symptoms of mental illness.
  - Mental and physical health are inseparable

## **The Mental Health Assessment**

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- Psychiatric History – individual and family**
- Developmental and Psychosocial History**
- Trauma History**
- Past/Current Danger to Self and Others**
  - **Suicidality and Potential for Violence**
- Alcohol/Substance Use Disorders and Treatment**
- Current Psychosocial Status**
  - **Housing, Financial, Legal, Social Support Resources**
- Cognitive Impairment or Literacy Issues**

## **Common DSM-IV-TR Diagnoses in HIV**

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- |   |   |
|---|---|
| <input type="checkbox"/> <b>Mood Disorders</b> <ul style="list-style-type: none"><li>■ <b>Major Depression</b></li><li>■ <b>Bipolar Disorders</b></li></ul>   | <input type="checkbox"/> <b>Psychotic Disorders</b>             |
| <input type="checkbox"/> <b>Anxiety Disorders</b> <ul style="list-style-type: none"><li>■ <b>Panic Disorder</b></li><li>■ <b>Generalized Anxiety Disorder</b></li><li>■ <b>Post Traumatic Stress Disorder</b></li></ul> | <input type="checkbox"/> <b>Cognitive Disorders</b>             |
|   | <input type="checkbox"/> <b>Axis II Personality Disorders</b>   |
|   | <input type="checkbox"/> <b>Adjustment Disorders</b>            |
|   | <input type="checkbox"/> <b>Alcohol/Substance Use Disorders</b> |

## Prevalence of Depression

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- Current Disorder**
  - **Major Depression: 29 – 36%**
    - Mellins, 2001; HCSUS, 2001, Atkinson et al 1988, Perkins et al 1994, Satz et al 1997
- Lifetime Disorder**
  - **Major Depression: 58%**
    - Mellins, 1997
- Depression can be the silent killer**
  - **HIV treatment failure**
  - **Suicide risk**

## Depression - Clinical Features

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- |  |  |
|--|--|
| <input type="checkbox"/> <b>Low mood</b>                           | <input type="checkbox"/> <b>Worthlessness/guilt</b>  |
| <input type="checkbox"/> <b>Loss of pleasure from activities</b>   | <input type="checkbox"/> <b>Thoughts of suicide</b>  |
| <input type="checkbox"/> <b>Appetite/weight change (5%)</b>        | <input type="checkbox"/> <b>Frequent thoughts of death</b>   |
| <input type="checkbox"/> <b>Insomnia/hypersomnia</b>               | <input type="checkbox"/> <b>Functional impairment</b>  |
| <input type="checkbox"/> <b>Psychomotor retardation/ agitation</b> | <input type="checkbox"/> <b>Rule out other causes</b> <ul style="list-style-type: none"><li>■ <b>medical condition</b></li><li>■ <b>medication</b></li><li>■ <b>alcohol/illicit drugs</b></li><li>■ <b>bereavement</b></li></ul> |
| <input type="checkbox"/> <b>Fatigue or loss of energy</b>          |  |
| <input type="checkbox"/> <b>Memory/concentration problems</b>      |  |

## **What's Unique to Depression and HIV?**

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- Symptoms of depression are also physical symptoms of HIV (e.g., weight loss, low energy)**
- Depressed mood can be triggered by HIV-related psychological stressors (e.g., grief)**
- Symptoms may have biological cause (e.g., hypothyroidism)**
- Psychomotor retardation or apathy of HIV dementia may be confused with depression**
- Symptoms can be first sign of HIV Neurocognitive Disorder**
- Symptoms may be due to substance use (e.g., alcohol & sedative-hypnotics)**
- Symptoms may be side effects of medications (e.g., HCV)**

## **Anxiety Disorders - Clinical Features**

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- Broad spectrum of symptoms, ranging from mild to pronounced**
- Mild symptoms may include stress, worry or fear (e.g., anxiety about HIV test)**
- More pronounced symptoms can include catastrophic thinking and panic symptoms - breathing problems, chest palpitations, muscle tension, nausea, headache, dizziness, etc.**

## **Anxiety Disorders: PTSD**

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- Symptoms must be associated with a specific traumatic event**
- Re-experiencing must be persistent and intrusive**
- Avoidance of stimulus, thoughts, and associations**
- Feelings of isolation and numbing**
- Recurrent intrusive flashbacks**
- Nightmares**
- Reliving experience**
- Intense distress to cues**
- Hyperarousal**
  - Disrupted sleep**
  - Anger outbursts**
  - Poor concentration**
  - Hypervigilance**
- Duration = one month**

## **What's Unique to Anxiety and HIV?**

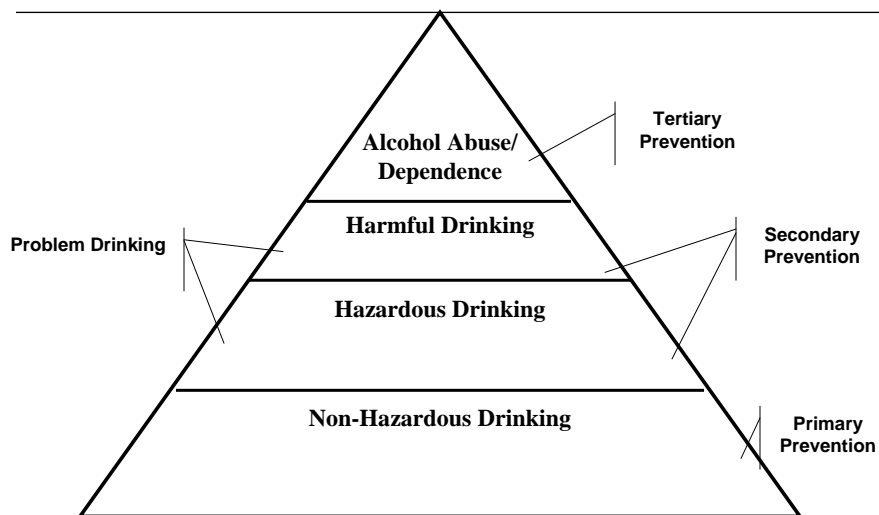
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- Pivotal points of living with HIV**
- PTSD symptoms may precede or be the result of the HIV diagnosis or be due to harm caused by others in response to HIV status**
- Anxiety can be a side effect of medication**
- Anxiety can be a symptom of HIV illness**
- Anxiety symptoms can indicate drug intoxication or withdrawal**
- Anxiety can indicate CNS lesions**

## Alcohol /Substance Abuse Disorders

- ❑ A maladaptive pattern of alcohol or substance use leading to clinically significant impairment or distress
- ❑ Significant behavior or psychological changes associated with intoxication (e.g., cognitive impairment, mood lability)
- ❑ Clinically significant distress or impairment associated with withdrawal

## Spectrum of Alcohol Problems



## **What's Unique to Alcohol Abuse and HIV?**

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- ❑ **Alcohol abuse complicates the clinical management of HIV-infected patients by:**
  - **Delaying or interfering with needed treatment**
  - **Causing cognitive and behavioral impairment**
  - **Reducing ability to practice safer sex**
  - **Mimicking psychiatric and biologic disorders**
  - **Increasing the risk of side effects from medications**
  - **Changing pharmacokinetics of prescribed drugs**
  - **Increasing risk of hepatic injury or fatal pancreatitis**
  - **Destabilizing psychosocial supports**

## **Adherence of the Triply Diagnosed Person**

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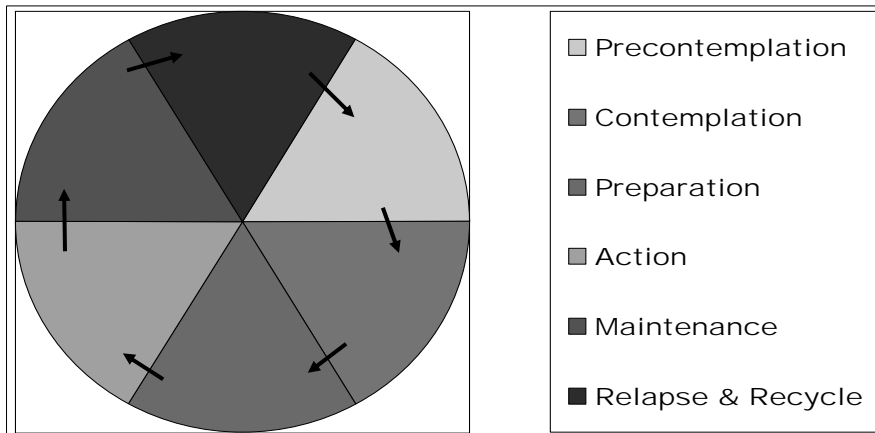
- ❑ **Substance use, depression, and other mental illnesses can undermine adherence - Treat these disorders!**
- ❑ **Most common referral question related to adherence is to rule out a psychiatric disorder- emotional/behavior/cognitive/substance/environment**
- ❑ **Consider adherence support factors:**
  - **Creating stable life conditions**
  - **Patient's readiness to adhere to HIV care**
  - **Individual/peer/family/spiritual support**
  - **Balancing harm reduction approaches with sensible limit-setting**

## Treatment of the Triply diagnosed

- ❑ Treatment is extremely complex
- ❑ Appreciate the whole person!
- ❑ Integrated care is the best treatment option
- ❑ Share the work with a TEAM



## Creating Stable Change: Transtheoretical Model\*



\* Prochaska & Diclemente (1984)

## Patient-Provider Communication as a Collaborative Process

- ❑ **Build trust**
  - Get to know your patients - ask about their treatment goals
  - Be explicit about how you intend to provide treatment for the patient
  - Be consistent and respectful
  - Meet the patient “where they’re at”
- ❑ **Avoid shaming the patient in any way**
  - Address ongoing drug use or relapse in a non-punitive fashion
  - Avoid judgmental and stigmatizing language (“Drug Abuser”)
- ❑ **Provide positive feedback**
  - Improved clinical results when applicable
  - Adoption of healthful behaviors
  - Elimination or reduction of less healthful behaviors

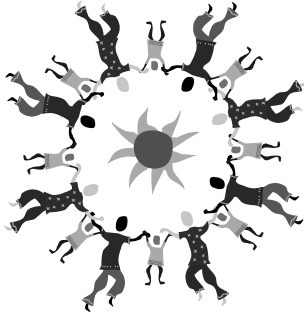
## Lessons Learned

- ❑ **Triply diagnosed persons can be very complicated medically and psychiatrically**
- ❑ **Need a team oriented and multidisciplinary approach:**
  - **Medical**
  - **Mental health and psychiatry**
  - **Substance abuse treatment**
  - **Case management**
  - **Outreach and/or home-based services**
- ❑ **Interventions need to be individualized**
- ❑ **“One-Stop Shopping” is the best option**
- ❑ **Communication is the key to success!**



## Final Thought

**HIV Does  
Not Discriminate  
People Do!**



**“I’m looking for a workaholic who feels the great job he does is compensation enough.”**



*“I’m looking for a workaholic who feels the great job he does is compensation enough.”*

## Training Topics

- THE TRIPLY DIAGNOSED CLIENT**
- NEUROPSYCHIATRIC ASPECTS OF HIV INFECTION**
- MENTAL HEALTH ISSUES FOR HIV/AIDS CLIENTS**
- HIV PREVENTION STRATEGIES**
- HIV AND POST-TRAUMATIC STRESS DISORDER**
- RECOGNIZING PERSONALITY DISORDERS AND HOW THEY CAN AFFECT HIV CAREGIVING**
- LEGAL/POLICY ASPECTS OF CARING FOR PEOPLE IN THE AIDS EPIDEMIC**
- MOTIVATIONAL INTERVIEWING WITH HIV CLIENTS**
- HIV AND CHILDREN/ADOLESCENTS**
- WORKING WITH SPECIAL POPULATIONS**
- SPECIAL TOPICS**
- ASK A PSYCHIATRIST**

## Contact Information

- To schedule a Psychiatric Consultation please contact James Satriano, PhD, at**
  - SATRIAN@PI.CPMC.COLUMBIA.EDU
  - 212/543-5591
- To schedule a Training Activity, please contact Dusty Hackler, MA, at**
  - DRA2107@COLUMBIA.EDU
  - 212/543-6537
- Visit us on the web at:**
  - [www.columbia.edu/~fc15/](http://www.columbia.edu/~fc15/)