The Alcohol and Drug Wildcard: Substance Use and Psychiatric Problems in People with HIV

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UCSF AIDS Health Project Monograph Series Number 2
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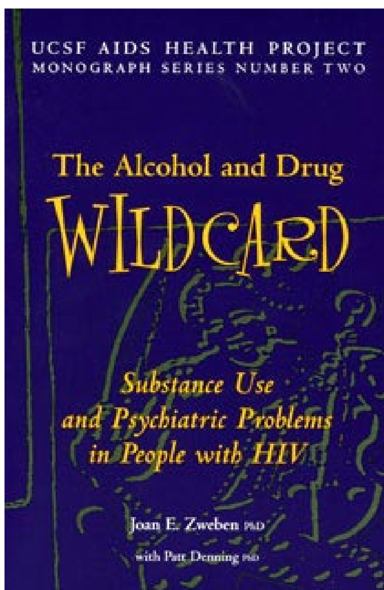
Evolving Approaches to Triple Disorders

Substance use often functions as the "wild card" in AIDS care, influencing the diagnosis of HIV-related and psychiatric disorders as well as the efficacy of medical and therapeutic interventions. Any amount of substance use, even that which falls short of meeting criteria for addiction, can have an impact on HIV disease and psychiatric conditions. The simultaneous combination of these three conditions, especially with increased substance abuse, presents mental health practitioners with the most complex clinical situation: treating a client with "triple disorders."



While each component of the triad contributes its own complexities to the mix, alcohol and drug use has the least predictable effect. In an effort to lay the foundation for optimal care in all three areas, this monograph focuses on the reduction or elimination of substance use. It pays special attention to assessment and diagnosis because distinguishing among the three conditions is crucial to treating them. It then discusses general treatment approaches for the client who suffers from all three conditions, defining and, in particular, examining the role of substance abuse treatment in responding to the needs of these clients.

As a preface, it is important to understand the historical relationship between substance abuse treatment and other health care. Treatment for alcohol and drug problems has evolved separately from psychotherapy and other mental health interventions. When traditional psychotherapeutic approaches were found to be ineffective for substance abuse, alternative treatments developed outside the mainstream of the mental health field. While initially effective and appropriate, this approach later resulted in an artificial separation of problems. For a time, this separation obliged individuals to seek help for their alcohol problems from one system, their drug problems from a second system, and their mental health problems from a third. Even though today many of the barriers to integrated care (often related to health insurance reimbursement) have been removed, the separation has left a legacy: mental health and medical providers outside the alcohol and drug treatment system are often unskilled to handle clients who use alcohol and drugs. At the same time, the stigma attached to addicted clients has perpetuated their isolation and discouraged the development of integrated treatment.

Basic training for mental health providers typically has not required competence in addressing alcohol and drug use. Thus, otherwise seasoned practitioners are often the least knowledgeable and skilled when it comes to the assessment and treatment of substance abuse. In most states, requirements for licensure and relicensure have begun to address this situation; but until material on alcohol and drug use is integrated into the core curriculum of psychiatrists, psychologists, and social workers, professional training will not produce providers who are competent to handle these problems.

Separate funding streams perpetuate barriers and fragmented care. Federal Ryan White CARE Act funding for HIV is separate from mental health and substance abuse treatment, and often does not foster integrated care. An agency wishing to integrate care faces many regulatory barriers in providing the services as well as fulfilling the daunting reporting requirements to account for the moneys.

As epidemiological studies and clinical realities have moved alcohol and drug

use into the foreground, medical and mental health practitioners have shifted from ignoring addiction to excluding substance abusers from care or requiring them to seek addiction treatment before receiving medical or psychiatric services. However, the addiction treatment system has been, and remains, ill-equipped to handle the influx of clients with concurrent substance abuse and mental health disorders, let alone the wave of clients that has developed since the advent of the AIDS epidemic.

While it is unknown to what extent the phenomenon of triple disorders occurs among people with HIV disease, some general conclusions can be drawn from a review of data regarding AIDS, substance abuse, and mental illness. For example, according to the Centers for Disease Control and Prevention (CDC), as of 1997, roughly 26 percent of the 633,000 adolescent and adult cases of AIDS were among injection drug users. From the studies on injection drug users (heroin and methamphetamine), it can be estimated that upwards of three-quarters of this population meets the criteria for mental health disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) of the American Psychiatric Association. Conversely, among seropositive gay men, drug use by routes other than injection is not unusual, and estimates of substance abuse or dependence among gay men approach 30 percent. The number of these men who also have mental health disorders is unknown. Suffice it to say that the phenomenon of multiple disorders among people with HIV disease is familiar to any clinician working in the field. Some larger agencies providing HIV services in the San Francisco Bay Area estimate that 80 percent of their clients have substance abuse issues.

In addition, the addiction treatment system is by and large designed for clients who understand from the outset that they need to do something about their alcohol and drug use. Those who do not embrace this goal but who are interested in other kinds of medical, psychological, or psychosocial help continue to fall between the cracks. Although harm reduction strategies are in widespread use among HIV providers, they are often presented as incompatible with abstinence-oriented substance abuse treatment, and discussions among caregivers become unnecessarily polarized. These interventions actually exist on a continuum, with harm reduction strategies producing many meaningful accomplishments and complete abstinence representing an end point offering the widest margin of safety and benefits.

Finally, when and where substance users have been able to access other forms of medical or mental health care, providers have been confused about how to prioritize treatment tasks. This has been one of the most confounding aspects of providing integrated care. For example, if a coexisting psychiatric disorder has a strong influence on a client's alcohol or drug use patterns, should that disorder be the initial priority? Will addressing it be enough to remedy the client's substance use problems? Can a psychiatric disorder be effectively treated if a client continues to drink or use drugs? Can a client achieve abstinence or even make progress towards abstinence if his or her psychiatric disorder is not confronted? How important is it to deal with psychodynamic factors in order to influence alcohol or drug use? These are the types of questions faced by providers seeking to treat HIV disease and mental health disorders in the context of substance use. This book offers a framework to guide clinicians in thinking through these issues.

Working with Clients with Multiple Disorders: A Balancing Act

Addictive disorders are characterized by behaviors that are compulsive, under intermittent or unpredictable control, and persist in spite of adverse consequences. Although the term "triple disorders" refers to people who meet these criteria as well as the criteria of a psychiatric disorder and HIV infection, clinicians should remember that alcohol and drug use can be a problem long before the person is considered to have an addictive disorder. Although there is no systematic data on this point, it is clear that people with severe mental illness in particular, can be exquisitely sensitive to the substances they use; the effects of moderate use on less severe psychiatric disorders, immune function, and HIV progression, however, are less clear. Alcohol and drug use also influences response to medication in ways that are often unpredictable, thus potentially undermining an otherwise viable treatment plan.

Clinicians who are not addiction specialists lack the detailed knowledge of drug effects that would enable them to identify adverse consequences quickly, particularly if symptoms are relatively subtle.

For example, alexithymia—the inability to identify or experience feelings—is present among people with a history of childhood trauma, but it is also common among marijuana smokers. Psychodynamically oriented therapists naturally gravitate to this dimension and often ignore other influences.

Marijuana use is particularly challenging for therapists because its effects are highly variable and more subtle than those of other drugs and its negative consequences can be difficult to demonstrate. In addition, the 1997 passage of the medical marijuana initiative in California (Proposition 215) will likely further complicate clinical intervention by normalizing marijuana use among clients with AIDS. For example, symptom relief in one area, nausea for instance, may be accompanied by negative consequences, such as increasing social withdrawal, that go unnoticed or are attributed to HIV progression. In addition, it may take as long as three months after a person stops using marijuana for drug-related difficulties in attention, concentration, and feeling to resolve. Until then, a practitioner may not be able to distinguish these symptoms from HIV-associated cognitive impairment or a pre-existing psychiatric disorder.

Clinicians also play a role in HIV prevention by addressing high-risk behaviors that may facilitate HIV transmission. Intoxicated individuals are much more likely to engage in unsafe sexual practices, including trading sex for drugs. Alcohol use is often underemphasized as a risk factor in sexual behavior. Injection use, well-known as a high-risk behavior, may be prevalent among amphetamine as well as heroin users. Armed with this information, clinicians have an opportunity to improve the well-being of clients and reduce danger to others.

Three case examples demonstrate the complex problems presented by clients with triple disorders and the ways they might present. These composite cases are included to help illustrate general concepts and issues that have proven to be confounding for clinicians. It is important to note, however, that actual clients do not often fall into such neat packages.

Mike: Benign Drug Use and Bereavement

The first case involves an instance of drug use in the context of bereavement that providers outside the addiction field might see as relatively benign.

Mike, an asymptomatic seropositive gay White man, had a 20-year history of heroin, cocaine, tobacco, and marijuana use. He held a responsible job and consistently met his work obligations. Three years ago, he stopped using heroin and cocaine and one year ago he quit smoking cigarettes. In the very recent past, after a year of Mike's devoted care, Mike's lover of 18 years died of AIDS. At that point, Mike relapsed and re-entered drug treatment.

When this occurred, Mike's HIV disease was stable. He had a good relationship with his primary care provider. His CD4+ cell count was 550 (slightly above the point where antiviral therapy is usually recommended) and he had no history of opportunistic infections. He and his doctor agreed that since he was doing so well and his CD4+ cell count was higher than 500, Mike would not begin antiviral therapy at that point. They also agreed that Mike would need to focus on maintaining his sobriety and seeking support for the loss of his lover.

Mike worked hard on his grief in his abstinence-oriented recovery group. He openly discussed two episodes during which he relapsed, using heroin and cocaine. Both episodes were clearly connected to mourning his loss and facing the daunting prospect of regenerating his social life. He was encouraged to pursue individual therapy, at least for a few months, to provide a supportive context for his grieving. Throughout this period, Mike smoked marijuana weekly, and although he acknowledged that this burdened his respiratory system, he was not willing to give it up. His therapist underlined the importance of open discussion about marijuana use, respecting her client's ambivalence about giving it up. She also began to watch for possible adverse consequences of drug use.

Mike's case illustrates a common dilemma: painful life circumstances and meaningful therapeutic accomplishments tempting the therapist to view the marijuana use as relatively benign. The therapist, however, should watch for a tendency towards social withdrawal, possible exacerbation of apathy, flat affect and low mood, and impairments of attention and memory. In addition, Mike's previous drug use history requires vigorous attention to any resumption of drug use, as his risk of relapse to other drugs is greatly heightened by his use of marijuana.

Sarah: Addiction and Depression

The second case describes a client who is engaged in problem drinking, possibly meeting criteria for an addictive disorder, and presents with symptoms suggesting depression as well.

Sarah was a forty-two year-old, seropositive, African American woman who lived with her daughter and two grandchildren. Until a month ago, she worked part-time as a cashier at a local liquor store. She presented at an outpatient mental health clinic saying, "because my daughter says I need to get some help; I'm not the same as I was." Sarah admitted to being upset much of the time, unmotivated to care for herself, and frequently argumentative with her daughter and grandchildren. She was fearful that she was developing dementia and complained that her memory was "shot." She said that she had been getting confused at work and had been making mistakes in taking orders and making change. As a consequence, Sarah's boss fired her. Sarah had no history of mental health problems.

Sarah had known about her HIV status for several years and believed her infection to be the result of unprotected sex with a boyfriend who used injection drugs. She was on zidovudine (ZDV; AZT) briefly four years earlier, but stopped because it made her feel sick. She said she had been hospitalized with pneumonia a year before coming to the clinic, but at the time of her visit she was feeling okay. She also stated that she had stopped taking her medication because she did not "believe in it." She had not seen a primary care doctor since stopping the ZDV and did not have one. When questioned, Sarah said she felt weak and sometimes unsteady on her feet, but she added that she would go "when the Lord is ready to have her" and that it was too much bother to go to the doctor all the time.

The clinic's intake worker further noted that Sarah complained of feeling tired all the time, had lost weight, was not interested in eating, and denied feeling sad. Sarah also admitted that she had a long history of alcohol use, beginning in her adolescence and including periods of moderate and heavy drinking. For two years up until coming to the clinic, she had been drinking five or six beers a day, and she considered this to be a bit too much. Sarah had experimented with other drugs in her teens but had not used any since.

During a mental status exam, Sarah was cooperative and able to give a coherent history but without a lot of detail, and she had to be prompted to explain her situation. Sarah came across as more subdued than angry or sad. She denied thoughts of suicide, repeating only her belief that she would "go when the Lord calls her." While Sarah was able to perform adequately on memory tasks and simple calculations, she approached such questions in a deliberate way, speaking slowly and appearing uncertain of her answers. She frequently said, "I don't know" in response to questions, but was able to answer after some encouragement.

Sarah's case is a good illustration of the overlap between the effects of substance use and the symptoms of depression. Sarah's symptoms may be explained in a number of ways—a fairly common situation in such cases—and the intake worker had to sort through the various possibilities. One way of putting the story together is that Sarah was experiencing an adjustment disorder with depressed mood, or perhaps a major depression as a response to her HIV disease, her unemployment, and her conflicts at home with her daughter and grandchildren. Another way to understand Sarah's symptoms is to consider the effects of her alcohol use. Alcohol is a central nervous system depressant that can certainly lead to dysphoria, lack of energy, and sleep disturbance. It is also possible that Sarah was underestimating her use and that some of her "confusion" was actually the result of intoxication.

Finally, the intake worker considered how much of Sarah's presentation could be explained by advancing HIV, focusing in particular on complaints of confusion, difficulty with cognitive function, and Sarah's daughter's assessment that her mother had changed. The intake worker questioned whether these symptoms were the consequence of depression or signs of cognitive impairment caused by HIV's effects on the brain. She leaned towards a diagnosis of depression, recalling that Sarah complained of memory problems and frequently said she "could not remember" things, yet with encouragement was able to perform adequately on tests of cognitive function.

Sorting through these factors and formulating an appropriate treatment plan requires serious detective work. In Sarah's case the intake worker wisely appreciated these complications and consulted with her agency's psychiatrist. Noting that Sarah's medical care had been essentially non-existent since she had pneumonia, the psychiatrist strongly suspected that Sarah's pneumonia was an opportunistic disease that occurred later in the course of HIV disease, by which time Sarah's

immune system had been significantly damaged. The psychiatrist also suggested that before any further decisions were made, Sarah needed to see an internist to evaluate her HIV disease. She noted that, given the progressive nature of HIV disease, HIV's well-known predilection for attacking the brain and nervous system, and Sarah's complaints of sometimes feeling unsteady on her feet, Sarah could have been suffering from early HIV-associated dementia. The interim treatment plan focused on providing support and encouraging Sarah to eliminate alcohol consumption in order to better evaluate her cognitive and mood symptoms over time. She was assigned to a therapist who was not an addiction specialist but was reasonably proficient at addressing mild to moderate substance use. It was made clear to Sarah that if she were unable to discontinue drinking, she would need to consider entering addiction treatment.

Carlos: Impulsivity and Emotional Problems

A challenge of another sort is presented by the client who is impulsive and has several other problems, including poverty, lack of work skills, and little social support.

Carlos was a 33-year-old Hispanic gay male who presented for drug treatment a year after he had been diagnosed with HIV. He said he had been hospitalized three times for "emotional problems" and described himself as an alcoholic and a methamphetamine user. He admitted to thinking about suicide and attempted suicide in the past. He stated his CD4+ cell count was "about 600" and that he had diarrhea, mouth sores, skin problems, and difficulty healing.

Carlos reported that he was hyperactive as a child, remained so as an adult, and wanted to get on Ritalin or Dexedrine to manage this problem. He recounted a long history of poor self-esteem, concentration problems, learning disabilities and head injury. Carlos described his father as a heroin addict who had been repeatedly physically abusive and reported being sexually abused by an older boy when he was about eight years old.

At the time he presented for treatment, Carlos was on crutches because he had attempted to jump off a bridge but fell before he could get to the top. His goals were to obtain psychological testing to qualify for supplemental security income (SSI); to receive help for his anxiety and depression; and to get on "some kind of medication so I can stay calm and function." Carlos lived in the home of an elderly gay man with whom he traded sex for living space. For the previous ten years, he had been unable to work because he could not maintain a routine. He laughed, "I can't even clean my own room." His dream was to have a job and a place of his own.

Carlos had a number of difficulties that presented challenges for his therapist. He had a history of impulsive, self-destructive behavior in which alcohol and drugs likely played a major role. His childhood history suggested the presence of an independent psychiatric disorder, possibly attention deficit/hyperactive disorder. These problems made it unlikely that Carlos would be able to maintain stable employment. Treatment would likely focus on getting Carlos into a residential drug treatment program where he could receive support and a trial of psychopharmacology for his long-standing problems with anxiety and depression.

Carlos's behavior reflects an important phenomenon: the use of methamphetamine in the gay and bisexual male community prevalent in some urban areas. Individuals report that methamphetamine temporarily boosts their energy levels and feelings of attractiveness, intensifies sensations and emotions, and provides the means for episodes of prolonged sexual behavior that were impossible without it. The drug is often consumed under circumstances that exacerbate the risk of HIV transmission: in bathhouses, at sex clubs, and during sex work.4 As methamphetamine use spreads across the country, it and its accompanying high-risk sexual behaviors are a key focus of prevention efforts.

[2d Subhead] An Interplay

As these scenarios suggest, the interplay of the three conditions—psychiatric problems, HIV, and substance use—produces a separate entity, all the more challenging because the many interactions among the components are poorly understood. One condition, by itself, may not be severe, but when combined with symptoms of the other two, it can create a critical situation. For example, a person with HIV-associated cognitive impairment may be only slightly impaired in his or her daily life; but if substance use or a psychiatric disorder limits his or her ability to cope, this minor condition could have increasingly harmful effects. ■