

An HIV-Infected Psychiatric Patient: Some Clinicolegal Dilemmas

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The acquired immune deficiency syndrome (AIDS) crisis has raised many clinical and forensic dilemmas for the health-care system. Psychiatrists may encounter particular problems when evaluating and treating human immunodeficiency virus (HIV) infected patients. The authors present a case of an HIV seropositive, bipolar, intravenous drug abusing patient who participates in unsafe sexual practices to illustrate clinicolegal dilemmas involving dangerousness, involuntary hospitalization, confidentiality, and Tarasoff-like duty.

The acquired immune deficiency syndrome (AIDS) has raised a myriad of clinical and forensic issues.^{1,2} In the psychiatric area, most of these issues remain relatively undefined, as AIDS was only first reported in 1981.^{3,4} It was not until 1983 that a human retrovirus, human immunodeficiency virus (HIV), was established as the infectious agent of AIDS.⁵ The complexity of AIDS is perhaps best conceptualized by using a biopsychosocial model to delineate its clinical, legal, and sociocultural aspects.^{6,7}

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AIDS will continue to present a significant health problem for the foreseeable future, as currently no known cure or vaccine exists for AIDS. Moreover, AIDS is believed to be uniformly fatal. AIDS can be transmitted in several ways, including blood transfusion, sexual contact, shared intravenous paraphernalia, artificial insemination, and *in utero*.⁸ In the United States, from June 1981 to July 1987, 39,263 cases of AIDS have been reported to the Centers for Disease Control. Of these, 57% had resulted in death.⁹

In the United States, several groups have been identified to be at high risk for contracting AIDS. These include the male homosexual population, black and hispanic minority group members and intravenous drug abusers.^{1,10} So far, not included are those with major mental disorders. All these groups may be considered as disenfranchised from and stig-

matized by the majority culture, even before AIDS became a complicating factor.

A case of a mentally ill individual with HIV seropositive status will be presented to highlight the clinical and legal dilemmas raised by such individuals. The issue of mental compromise in patients with psychiatric disorders and concurrent HIV seropositive testing and its psychiatric-legal implications in terms of increasing the chance of infecting others or dangerousness to others will be addressed. The importance of early psychiatric intervention to help alleviate some of the problems brought about by AIDS in a psychiatric patient will then be discussed.

Case Report

Mr. B is a 27-year-old single white heterosexual male with a history of bipolar disorder and intravenous heroin abuse. He had been hospitalized psychiatrically several times for exacerbation of his bipolar disorder. He was involuntarily hospitalized in a psychiatric intensive care unit for wandering nude in public. Initially, Mr. B presented with pressured speech, uncooperativeness, psychomotor agitation, hostile mood, and labile affect. Soon after admission, his agitation began to subside, and he expressed themes of hopelessness and helplessness. He reported a 12-month history of dysphoric mood coincident with his discovery that he was HIV seropositive.

In addition, on the cognitive testing portion of the initial mental status examination, Mr. B exhibited difficulties in the following areas: simple calcula-

tions, short and long-term memory, naming common objects, abstracting proverbs, and temporal orientation. However, these cognitive deficits were not considered to be organically based, as they disappeared by the end of the hospitalization with treatment only with psychotropic medications.

Although the patient had some awareness of the different clinical states of the AIDS illness (including the asymptomatic HIV seropositive state, the AIDS-related complex (ARC) state, and full-blown AIDS) and was only HIV seropositive, he firmly believed that he was going to die soon from AIDS. As a result of his perceived imminent death, he did not care about what happened to him or others. He hid his drug abuse and HIV seropositive status from his family, fearing their disapproval and rejection. Prior to admission, the patient was "living in the streets" on a "day to day" basis. For the 12 months prior to admission, he reported having multiple sexual liaisons without the use of condoms, as that was "all there was left to do." He denied any IV heroin abuse during this time period. He did not inform any of his partners of his HIV seropositive status. He stated that although he did not want to intentionally hurt others, he "just didn't care." He was aware that by participating in unprotected or unsafe sexual behaviors he could infect others with the AIDS virus, possibly resulting in their development of AIDS and ultimately death. He explained that when he entered a manic phase, he became hypersexual and did not care about his actions or what others thought of him.

On the first day of his hospitalization,

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he was started on haloperidol and lithium carbonate. By the third day of hospitalization, his thinking became more organized. He also became more openly hostile, stating that his sexual life was his personal business, regardless of conduct. By the fourth day of hospitalization, he began to differentiate more realistically between his HIV seropositive status and the more medically serious ARC and AIDS states in terms of the immediate prognosis. On the fifth day of hospitalization, a judicially mandated probable cause hearing was held on the ward. The hearing officer held that there was sufficient legal basis for continuing Mr. B's involuntary hospitalization as a danger to others. Daily supportive psychotherapy provided him with some understanding of his psychiatric disorder and the nature of AIDS. He was also encouraged to discuss how his drug abuse and HIV seropositive status caused him further depression and social isolation. The patient eventually became more cooperative and agreed to seek help for his bipolar disorder, attend an AIDS support group, and obtain sexual counseling sensitive to the needs of HIV seropositive individuals.

The patient's physical examination, particularly the neurological portion, was unremarkable. His blood chemistries were within normal limits. Although a CT scan and electroencephalogram were ordered, they were not able to be conducted prior to discharge.

Methods

The patient's level of psychopathology was monitored daily with the administration of the Brief Psychiatric Rating

Scale (BPRS).¹¹ Ratings were completed by one of us (J.A.S.), who had previously been trained and validated on the BPRS. In addition to the BPRS, an attempt was made to follow the patient's level of dangerousness by rating him on the index of dangerousness (see Appendix), a scale specifically designed for Mr. B. The index's eight items attempted to elicit information related to the potential of unprotected sexual behavior and, therefore, the potential to infect others with the AIDS virus. These questions were rated on a Likert scale, with the higher the number indicating a greater level of dangerousness. The questions elicited information such as willingness and awareness of rationale for using condoms, expressed concern about infecting others with the AIDS virus, willingness to discontinue unprotected sexual behavior, and willingness to seek appropriate medical, psychiatric, and sexual counseling. The items of the index of dangerousness are answered from information gathered by rater interviewing of the patient from evaluation of the medical chart and by consulting with medical staff who participated directly in the care of the patient. In the present case, we inquired about the patient's mentation and behavior exhibited during the 24 hours prior to the formal rating interview with the patient. All interviews were performed in the morning.

Discussion

Psychopathology Mr. B's case involves a patient with a major psychiatric disorder who has tested HIV seropositive. Like his many past episodes of mania and depression, during this hos-

pitalization Mr. B presented with both manic behavior and depressive symptomatology. The results of the BPRS are presented in Figure 1 as a function of time. The results of the BPRS during the early part of the hospitalization indicate that his level of psychopathology was high. Complicating his preexisting psychopathology from the bipolar disorder was a reactive depression secondary to learning of the HIV infection and the possibility of developing the lethal AIDS. Possibly contributing to Mr. B's current psychopathology may be an organic mental disorder due to HIV involvement of the central nervous system (CNS). Given the patient's normal neurological examination and rapid improvement of his mental status with treatment, organic contribution was believed to be unlikely. Longitudinal follow-up of the patient will be needed to monitor any future CNS involvement.

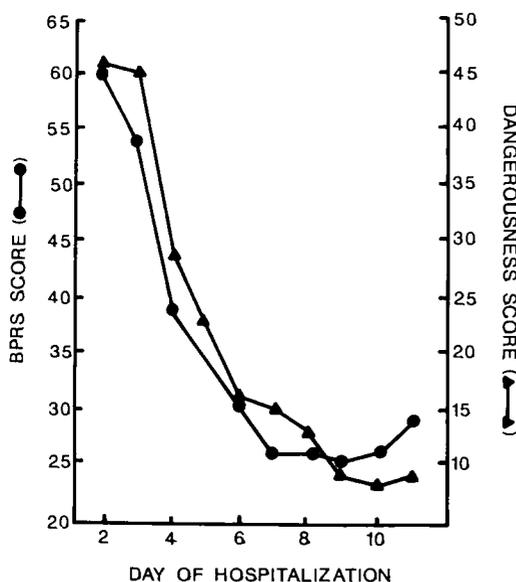


Figure 1. BPRS score and Index of Dangerousness score as a function of time.

This patient exemplifies how preexisting psychopathology combined with his depressive reaction to his discovery of HIV seropositivity may complicate and compromise the clinician's ability to identify a dementing process secondary to AIDS. This is especially true since both the clinical depression and AIDS dementia may present with apathy, dysphoric mood, cognitive deficits, and impaired judgment.

This case also raises the question of how a major psychiatric disorder such as a bipolar disorder, mixed type, as manifested by dysphoric mood, hypersexual behavior, and impaired judgment may further predispose an individual to engage in unsafe sexual activity that increases the chance of HIV transmission to others.

Dangerousness An indication of the level of dangerousness secondary to his potential to infect others with HIV is presented in Figure 1 as a function of time. The results indicate that the general level of psychopathology, as expressed by the BPRS and the level of danger as rated by the index of dangerousness, covary closely with each other across time. The close association of psychopathology and the level of danger is consistent with the view that the behavioral risk of infecting others with HIV may in part be due to psychopathology. The results do not support the notion that nonpsychopathological behavior alone may be the cause of irresponsible and/or dangerous behavior in this patient. Hence, these results indicate that serious psychopathology may predispose HIV seropositive individuals to act irresponsibly with behaviors which may re-

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sult in infecting others with the AIDS virus. The present discussion regarding the danger to infect others with the AIDS virus by a psychiatric patient may not be generalizable as it is based upon an open single case without controlling for rater bias. We emphasize that the index of dangerousness is only a preliminary tool and is yet to be validated.

There are several potential problems with interpreting the daily ratings of the index of dangerousness in this case. Some of the index's items are more likely to be valid in that they directly measure the patient's ability to understand a set of concepts regardless of whether this takes place via learning or by ability to recall prior knowledge which was previously made inaccessible by the exacerbation of mental illness. This is the case for items such as Number 3 which tests for basic knowledge about AIDS spectrum conditions. Other items are also more likely to be valid in that they are not only dependent on statements made by the patient but also on exhibited behavior. For instance, Item 5 measures the patient's hypersexual behavior as observed by the psychiatric staff. However, there are several items which may depend not only on improved cognitive ability but specifically on the individual's motivation to learn. We acknowledge that insofar as the patient may be motivated to learn socially acceptable answers in order to be released from involuntary status, an item may therefore not measure a true decrease in dangerousness. Furthermore, a gap likely exists between the knowledge gathered by the patient with prosocial intentions and his ability to

engage in safe sexual practices. Nevertheless, the results suggest that major psychopathology may predispose HIV seropositive individuals to engage in sexual behaviors which may infect others with the AIDS virus.

We emphasize that our results indicate that in this patient although the acute level of dangerousness may decrease with clinical intervention, the issue of chronic dangerousness remains less well defined. The difficulty in understanding chronic dangerousness depends largely upon the multiplicity of the milieus in which the patient may live. Measuring dangerousness even when using a valid scale for behaviors and mentations expressed in the milieu of an inpatient psychiatric ward may not be a valid measure of dangerous behavior in other ecological settings. Even if we assume that a large part of an individual's psychopathology is under control with appropriate treatment, many uncontrollable environmental factors may affect the degree of danger an individual exhibits regardless of mental illness. Estimating levels of dangerousness secondary to unsafe sexual practices will likely suffer from the same deficiencies in assessing dangerousness secondary to physically violent behavior.¹² Nevertheless, it is possible that a chronic degree of dangerousness may be minimized if the patient is willing and able to continue receiving psychiatric and medical treatment and has an adequate social support system. This is a theme to which we will return later in the discussion.

The patient's mental disorder led to a clear compromise in his ability to assess

the nature and consequences of being HIV seropositive. His recent irresponsible behavior of unprotected sexual activity and not informing his partners of his HIV status cannot easily be explained by a lack of education regarding AIDS. Clinicians who had seen him prior to this exacerbation of his bipolar disorder reported that he possessed a comprehensive and rational understanding of AIDS spectrum disorders. This uncaring and irresponsible attitude may in part be due to his depression, whether from his bipolar disorder and/or his reaction to positive HIV testing. The contribution of his mania increased his risk of not being able to have responsible sexual activity and increased his degree of danger to others.

Involuntary Hospitalization Mr. B's behavior also raises other legal issues. First, the issue of whether this patient qualified, as a result of a mental disorder, as being a danger to others under existing California involuntary hospitalization or civil commitment laws after the period of initial involuntary evaluation remains unclear. Individuals who are HIV seropositive likely represent some degree of continual danger to others because HIV infection persists for years,¹³ and the physiological potential to transmit the AIDS virus to others probably does not change. In applying involuntary hospitalization or civil commitment standards to such individuals, at least in states such as California, a certain level of imminence is generally required. However, there is no clear demarcation of the level of imminence needed to trigger the involuntary hospitalization or civil commitment thresh-

old. In general, progression to AIDS after initial viral infection takes at least several months and perhaps several years.¹⁴⁻¹⁶ Hence, any realistic level of imminence in this respect is difficult to meet. Nevertheless, a significant percentage of those who become HIV seropositive from this patient could develop AIDS and ultimately die. So the imminent danger of the infection process itself could be considered as sufficient to meet the involuntary hospitalization or civil commitment threshold, even though those who develop AIDS may die years after HIV infection. Currently, it remains legally unclear whether the ability to transmit the AIDS virus in a psychiatric patient represents a viable psychiatric-legal danger under involuntary hospitalization or civil commitment statutes. The infecting process itself would necessarily be considered the dangerous act. Current California statutes do not address this conundrum raised by HIV seropositive individuals who have active major mental disorders and as a result engage in high risk activities that increase the likelihood of the AIDS virus transmission. Therefore, until legislation or case law concerning this issue clarifies this matter, it will remain the subject of debate and uncertainty.

Confidentiality and the Duty to Warn and Protect The providing of an individual's personal medical history to others without the patient's consent has traditionally been viewed as a violation of confidentiality. This right has been breached when society's welfare outweighs the individual's right to privacy. Since the nineteenth century, in order to encourage treatment of communica-

ble diseases, patient confidentiality was emphasized. In recent years, however, communicable diseases have been considered a valid reason to violate confidentiality by notifying public health officials in order to prevent the spread of the illness. In California, a specific statute¹⁷ prohibits the release of HIV antibody test results without the explicit written consent from the tested individual. This statute would seem to preclude notification under public health laws regarding communicable diseases, but this issue remains nebulous and case law or new statutes would be necessary to clarify this point. Since this patient was treated, the California legislature has enacted a statute permitting the physician to disclose a HIV seropositive test result to the spouse of a HIV seropositive individual.¹⁸ Since many individuals besides a spouse are at risk, this statute may be of limited value. On the other hand, there is no legal prohibition that would prevent involuntary psychiatric hospitalization of HIV seropositive individuals when indicated. However, patients in states like California could refuse to allow the HIV test result to be part of their records. It is unclear whether a psychiatrist would be permitted in such cases to use the test results as part of the basis for involuntary hospitalization. In Mr. B's case, he did allow the test result to be part of the record and indicated he knew the identities of several of his sexual partners. However, he refused to provide their names, therefore, rendering any possible third party notification impossible.

The issue of future harmful behavior adds psychiatric-legal confusion.¹⁹ The

psychotherapist's duty to warn and protect known third parties of a patient's foreseeable violent behavior based upon the *Tarasoff* cases,^{20,21} or so-called *Tarasoff*-like reporting duty, might be operative in those states which have not limited potential liability in situations of danger to others. In California, the recently adopted duty to warn and protect statute²² would not present potential liability in Mr. B's case since a specifically identified third party is not known. If a specifically identifiable person were known, it may still be unclear which requirement would take precedence: the requirement of confidentiality or the potential liability for the patient's dangerous action which could be eliminated by warning a potential victim and the police about a danger of the patient's infecting others, which could kill them in the future.^{20,21,23} In addition, the new California duty-to-protect statute still permits (but does not require) notification of the police or others even if a specific third party is not known. Psychotherapist discretion regarding warning or reporting is permitted.²⁴ even though there exists no potential liability for not reporting. It is unclear, however, whether the AIDS confidentiality statute could lead to potential liability for reporting. In states without an AIDS confidentiality statute, the legal responsibility of psychiatrists to take action may be even greater, particularly if there is no law to limit potential *Tarasoff*-like liability and a *Tarasoff*-like duty exists.

Since this patient was evaluated and treated, the American Psychiatric Association has adopted guidelines that attempt to deal with the HIV seropositive

patient.²⁵ These guidelines appear to emphasize breaching confidentiality, even though no obvious consideration was made that the transmission of the HIV virus primarily resembles a public health problem and not a true *Tarasoff*-like psychiatric situation. Notwithstanding this conundrum and legal uncertainties, a debate at the American Psychiatric Association annual meeting highlighted a multiplicity of ethical and clinical dilemmas faced by clinicians dealing with the HIV seropositive individual who persists in his or her high risk activities that increase the probability of HIV virus transmission.²⁶

Clinical Reduction of Dangerousness

Although the issue of dangerousness in potentially infectious HIV seropositive psychiatric patients must await further clarification through case law, the psychiatrist may, nevertheless, be able to offer some help in diminishing the dangerousness of these patients. First, the psychiatrist can provide clinical evaluation (diagnosis and prognosis of the mental disorder) of the HIV seropositive patient. For example, many patients with AIDS or AIDS-related disorders may go on to develop varying degrees of dementia secondary to HIV infection. Other patients may have preexisting major mental disorders of which this case is an example. Therefore, it is possible that these patients may need treatment tailored to their particular individual needs. For example, bipolar patients may need more intensive sexual counseling which will take into account their known proclivity to become hypersexual when in a manic episode. Major mental disorders such as AIDS-related demen-

tia, bipolar disorder, major depression, and schizophrenia may compromise the ability to exercise civil responsibility. Mr. B's case represents a patient suffering from a major mental disorder (bipolar disorder, mixed type) and exemplifies how psychiatric decompensation may lead to irresponsible behavior which constitutes a danger to others.

After initial clinical assessment, the next step is to provide effective clinical intervention. If the patient's dangerousness results from his mental illness and the patient is unable or unwilling to seek treatment for it, involuntary hospitalization may be instituted. In Mr. B's case, treatment with neuroleptics and thymoleptics decreased his psychiatric symptomatology and enhanced his ability to make responsible decisions. Thus, treatment reduced this patient's degree of dangerousness. Parenthetically, many individuals with bipolar disorder have poor compliance to recommended psychiatric treatment. Hence, the reduction in the level of dangerousness depends upon both the efficacy of the prescribed treatment and the patient's compliance to the proposed treatment regimen. Additional reduction in Mr. B's degree of danger may be obtained by psychotherapeutic intervention to address his apathetic attitude toward the potential transmission of the AIDS virus to others with unprotected sexual activity. Clarification of Mr. B's HIV seropositive status as less serious than AIDS helped him regain hope. He subsequently became more responsible in his attitude toward sexual behavior with others. In other similar cases, treatment of depressive symptomatology with medication and

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psychotherapy may reduce the level of danger.

Part of the difficulty in treating HIV seropositive patients, whether or not psychopathology exists, is that many of these individuals tend to be severely stigmatized by society. In Mr. B's case, we must consider his status as an HIV seropositive patient living within a society which is only beginning to address the serious realities of AIDS.²⁷ In addition, the patient belonged to a group whose drug-seeking behavior has society's disapproval. Homosexual patients have similar problems. Consequently, Mr. B found it very difficult to share his substance abuse and HIV seropositive status with others, including his family. A supportive network of family and friends could have provided support for him and reduced his sense of alienation. His status as a psychiatric patient further stigmatizes him and alienates him from society. Thus, individuals who suffer from a major mental disorder, who are infected with the AIDS virus, and who engage in drug abuse belong to three stigmatized groups and, therefore, are subjected to extremely high levels of psychological stress. Moreover, their coping abilities may be further compromised by their mental disorder and/or CNS involvement by the AIDS virus.

The mental health professional may be of further assistance to patients such as Mr. B by providing a biopsychosocial therapeutic milieu⁷ which takes into account his substance abuse, HIV seropositive status, and major mental disorder. For example, patient compliance with prescribed medication may be increased if the treating mental health professional

takes into account the many biopsychosocial stressors the patient is facing in a sociocultural-sensitive mode. This would be especially important in treating patients who are homosexual and/or minority group members.

Concluding Remarks By taking into account stigmatizing factors such as drug abuse, HIV seropositive status, and the existence of a major mental disorder, a more comprehensive and effective treatment regimen may be attempted. Such a treatment plan with a biopsychosocial approach appears to have the best chance for reduction of a patient's alienation toward society and decrease his likelihood of future harmful behaviors toward others.

Unfortunately, the mental health professional's legal duties in this area are presently unclear. A recent Los Angeles criminal case involving an alleged AIDS afflicted individual with a psychiatric history who may have irresponsibly infected others with the AIDS virus has received international attention and highlighted many clinicolegal dilemmas facing the psychiatric community.^{28,29} It is possible to be sued for taking action and also for not taking action. Even the most ethical course of action is often unclear, as what may be clinically indicated in other circumstances may not be feasible in these type of cases. There is a difficult choice between revealing information which may be harmful to the patient or concealing information which could lead to harm to others. The conflict between AIDS confidentiality statutes and duty to warn and protect statutes further complicates the issue, especially given the varying legal require-

ments with respect to AIDS in different jurisdictions³⁰ notwithstanding the American Psychiatric Association's guidelines,²⁵ which have no legal standing. In the present case, involuntary hospitalization provided a solution that was of benefit to both patient and society. However, it is unclear whether involuntary hospitalization represents a solution to these dilemmas insofar as it is unclear whether the threshold of danger to others is met in jurisdictions with stringent criteria. Statutes may need to be adopted to clarify these issues. Otherwise, mental health professionals will not know what course of action to follow when confronted with these difficult clinicolegal situations. It would be unfortunate if mental health officials would need to be sued in order for case law to clarify these clinicolegal dilemmas.

There may be no simple model to address HIV seropositive individuals who persist in activities likely to transmit the HIV virus. One psychiatric commentator recently proposed that the public health department take responsibility for this problem.³¹ Nevertheless, until more definitive public policy is elucidated, such proposals cannot be effectively used for our current cases. Presently, a thorough clinical and ethical risk/benefit analysis with consultation with other clinicians remains the soundest model clinically and ethically.

Appendix

Index of Dangerousness Likert scale 1 to 7

1. Patient agrees to always utilize condoms when engaged in sexual activities (1 = yes to 7 = no).

2. Patient fully understands that by engaging in sexual activity without condoms he may infect others with HIV (1 = yes to 7 = no).

3. Patient has a reasonable understanding of differences in prognosis regarding being HIV-positive and having AIDS (1 = yes to 7 = no).

4. Patient does not appear to care if he infects others with HIV (1 = no to 7 = yes).

5. Patient manifests hypersexual behavior (1 = no to 7 = yes).

6. Patient minimizes or denies his high risk sexual behavior (1 = no to 7 = yes).

7. Patient expressed desire to seek medical, psychiatric care, and sexual counseling (1 = yes to 7 = no).

8. Patient expressed sadness and concern for others suffering from AIDS (1 = yes to 7 = no).

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