CASE REPORT

MILIEU COMPLICATIONS OF THE PSYCHIATRIC INPATIENT TREATMENT OF THE AIDS PATIENT

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The authors anticipate that an increasing number of AIDS victims will be admitted to psychiatric inpatient units. The turmoil caused by the first AIDS patient admitted to the authors' psychiatric unit is described. The authors then discuss staff difficulties from the perspective of the forces unique to this inpatient unit and from the perspective of the group defenses that such a patient mobilizes in any setting. Recommendations are made for a flexible yet authoritarian leadership style when coordinating care for a patient who provokes so much staff anxiety.

Although there is profound psychological distress in the victims of acquired immune deficiency syndrome (AIDS), the psychiatric literature has not kept pace with the general medical literature which has been expanding logarithmically since initial descriptions of the illness in 1981. The devastating medical consequences of AIDS have typically made these patients the responsibility of internal medicine subspecialists. There is now pressure on psychiatric facilities to provide the full range of services to AIDS victims. Foci for psychiatric intervention not only include specific presenting problems such as suicidality or psychosis, but also include helping the patient understand AIDS, investigating and strengthening social supports, and clarifying the concerns of significant others.

There are times in the natural history of the disease when the psychiatric needs of the AIDS patient eclipse the medical needs. At these times, a patient may require admission to psychiatric inpatient unit. Although there have been reports of psychopathology associated with AIDS, we are unaware of any reports of the impact of an AIDS patient on a psychiatric inpatient unit. The following report details the hospital course of the first AIDS patient to be treated on our psychiatric ward. The admission criteria and treatment goals were routine, but the impact on hospital staff was dramatic and is the subject of this paper.

REPORT

The setting is a twenty-five bed psychiatric ward in a city general hospital. The hospital is publicly funded and is affiliated with a nearby medical center which provides housestaff and aca-

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demic support. The ward is responsible for admitting patients from the community with any psychiatric diagnosis requiring emergency hospitalization. The purpose of hospitalization is diagnosis, intensive treatment using somatic and psychotherapeutic means, and discharge to aftercare services within two to three weeks. At the time of this patient's admission, a new unit chief had been directing the unit for five months.

The patient was a thirty-six year old black female who came to the psychiatric emergency room due to a three-week history of auditory hallucinations telling her to poison her mother. She also complained that she was constantly bothered by family members who were ill with viruses and posed an infectious threat to her. She had a history of AIDS presumed due to heroin abuse and she also had a history of chronic paranoid schizophrenia. In the emergency room she was agitated, tearful, and was frequently incoherent although alert and oriented. Despite the absence of fever, the patient was admitted to the medical service to exclude the possibility that an occult CNS infection was causing an exacerbation of her psychosis.

After admission to the medical ward she began to hear voices telling her to jump out a window. She was begun on neuroleptic medication and placed on one-to-one nursing surveillance. Her medical workup showed no evidence of an active medical condition which could account for her psychotic exacerbation. Because of her acute psychotic state and the nature of her hallucinations, she was seen as too great a danger to herself to be discharged, transfer to a psychiatric inpatient unit was recommended.

Proposed admission was discussed in various Department of Psychiatry administrative meetings with emphasis placed on acceptance of this patient exemplifying the policy of the receiving unit being appropriate for any and all psychiatrically ill persons judged to be a danger to self or others. This policy coincidentally provides strong negotiating advantage in hospital-wide competition for the allocation of scarce medical resources (including the availability of medical consultants on psychiatric wards and vice versa). During the week prior to the patient's transfer, the unit chief distributed literature on AIDS and staff members' concerns, particularly about transmissibility, were discussed. The unit chief's discussions were supplemented by presentations by the Infectious Disease Department to the nursing staff. It was only after the patient's admission that widespread staff dissatisfaction with both the quality and quantity of this preparation was expressed. The patient group was also told in advance of the patient's arrival by an announcement in a ward community meeting. The announcement did not elicit either manifest or discernible latent anxiety from the patient group.

As soon as she arrived that afternoon, a veteran staff member announced that he had decided to take a two week vacation and if the patient were still here after two weeks, he would call in sick until she left. He explained that all the educational presentations were "bullshit," that "they really don't know what causes this or whether we can get it from working with her," and "if I come down with it, they'll say, 'He got it because he was a faggot.'" He summarized by saying, "This hospital doesn't care whether I get sick and I'm just looking out for my black ass."

The next day this staff member said that he would be willing to work with the patient if he could provide services to her in her room wearing a gown, mask, and gloves (as she had been approached in the general medical center). Rather than force this staff member to leave work in protest, the unit chief decided to allow this way of providing services if the staff member explained his reluctance straightforwardly to the patient. There was considerable acrimony which cut across supervisory and discipline lines about the unit chief's compromise with this staff member. The fact that this reluctant worker was in closer and more frequent contact with the patient than most other staff members went largely unnoticed.

In the coming days there was continual, argumentative discussion about this patient at staff meetings. A recurrent question was, "What are we doing for this patient, anyway?" The answer was that we were going to wait until she was no longer a suicide risk and had a safe place to live outside the hospital. The unit chief needed to insist that discussion in rounds i-