

# HIV: How to provide compassionate care

## Mitigate suffering by overcoming stigma, helping patients decrease risky behaviors

The prevalence of HIV in persons with untreated psychiatric illness may be 10 to 20 times that of the general population.<sup>1</sup> The U.S. Preventive Services Task Force has recommended HIV screening of all persons age 15 to 65 because 20% to 25% of individuals with HIV infection are unaware that they are HIV-positive.<sup>2</sup> Because >20% of new HIV infections in the United States are undiagnosed,<sup>3</sup> it is crucial to educate patients with mental illness about HIV prevention, make condoms available, and offer HIV testing.

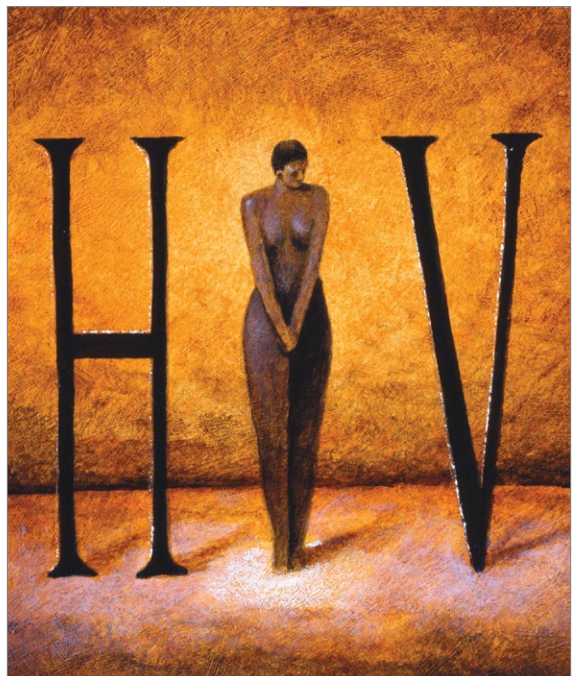
As psychiatrists, we have a unique role in caring for patients at risk for or infected with HIV because in addition to comprehensive medical and psychiatric histories, we routinely take histories of substance use, sexual activities, relationships, and trauma, including childhood neglect and emotional, physical, and sexual abuse. We develop long-term, trusting relationships and work with individuals to change behaviors and maximize life potential.

Increasing awareness of stigma, discrimination, and psychiatric factors involved with the HIV pandemic can lead to decreased transmission of HIV infection and early diagnosis and treatment. Compassionate medical and psychiatric care can mitigate suffering in persons at risk for, infected with, or affected by HIV.

### Preventing HIV transmission

AIDS differs from other complex, severe illnesses in 2 ways that are relevant to psychiatrists:

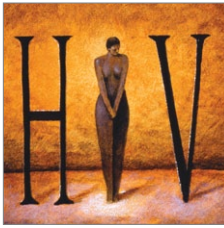
- it is almost entirely preventable



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## Helping patients who have HIV

### Clinical Point

Treating substance abuse can prevent HIV transmission by reducing needle sharing and related risky sexual behaviors



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Table 1

### Preventing HIV transmission: What you can do

Educate patients about risk behaviors and risk reduction

Offer confidential HIV testing and counseling

Refer patients to HIV clinicians for early treatment with antiretrovirals (ARVs)

Educate patients about condom use and make condoms readily available in emergency rooms, clinics, and psychiatric settings

Refer patients with substance use disorders for drug and alcohol detoxification, methadone maintenance treatment programs, rehabilitation, and/or 12-step programs

Refer patients for pre-exposure prophylaxis with ARVs for serodiscordant couples

- HIV and AIDS are associated with sex, drugs, and AIDS-associated stigma and discrimination (“AIDSism”).<sup>4-6</sup>

Unsafe exposure of mucosal surfaces to the virus—primarily from exchanging body fluids in unprotected sexual encounters—accounts for 80% of new HIV infections.<sup>7</sup> HIV transmission via sexual encounters is preventable with condoms. Percutaneous or intravenous infection with HIV—primarily from sharing needles in injection drug use—accounts for 20% of new infections.<sup>7</sup> Use of alcohol or other substances can lead to sexual coercion, unprotected sex, and exchange of sex for drugs or money. Hence, treating substance use disorders can prevent HIV transmission.

Early diagnosis of HIV can lead to appropriate medical care, quicker onset of antiretroviral (ARV) treatment, and better outcomes. Recent research has shown that pre-exposure prophylaxis with ARV treatment can prevent transmission of HIV<sup>8</sup>; therefore, becoming aware of risk behaviors and prevention can be lifesaving for serodiscordant couples.

One of the most important ways to prevent HIV’s impact on the brain and CNS is to diagnose HIV shortly after transmission at onset of acute infection. If HIV is diagnosed very early—preferably as soon as possible after inoculation with HIV or at onset of the first flu-like symptoms—and treated with ARVs, the brain has less of

an opportunity to act as an independent reservoir for HIV-infected cells and therefore to develop HIV-associated neurocognitive disorders.<sup>9,10</sup> Table 1 outlines steps psychiatrists can take to help prevent HIV transmission.

### Psychiatric disorders and HIV

Psychiatric disorders and distress play a significant role in transmission of, exposure to, and infection with HIV (Table 2).<sup>4-6,11</sup> They are relevant for prevention, clinical care, and adherence throughout every aspect of illness.

Comprehensive, compassionate, non-judgmental care of persons at risk for or infected with HIV begins with a thorough psychiatric evaluation designed to provide an ego-supportive, sensitive, and comprehensive assessment that can guide other clinicians in providing care.<sup>12</sup> Setting the tone and demonstrating compassion and respect includes shaking hands, which takes on special relevance in the context of AIDSism and stigma. Assessing the impact of HIV seropositivity or AIDS is best done by asking about the individual’s understanding of his or her diagnosis or illness and its impact. For some persons with HIV, verbalizing this understanding can be relieving as well as revealing. It is a chance for the patient to reveal painful experiences encountered in the home, school, camp, workplace, or community and the anguish of AIDSism and stigma.

Pay attention to sensitive and sometimes painful issues related to sexual history and sexuality. Questions related to sexual history and sexuality in heterosexual men and women as well as gay, lesbian, bisexual, and transgender individuals—such as “What is your sexual function like since you have been ill?” “Do feelings about your sexual identity play a role in your current level of distress?” and “What kind of barrier contraception are you using?”—are included in the comprehensive assessment described by Cohen et al.<sup>12</sup>

Comprehensive psychiatric evaluations can provide diagnoses, inform treatment, and mitigate anguish, distress, depression, anxiety, and substance use in persons with

HIV and AIDS.<sup>12</sup> A thorough and comprehensive assessment is crucial because HIV has an affinity for brain and neural tissue and can cause CNS complications such as HIV-associated neurocognitive disorders (HAND), even in otherwise healthy HIV-seropositive individuals. See this article at CurrentPsychiatry.com for a discussion of HAND and delirium in patients with HIV.

Some persons with HIV and AIDS do not have a psychiatric disorder, while others have multiple complex psychiatric disorders that are responses to illness or treatments or are associated with HIV/AIDS (such as HAND) or other medical illnesses and treatments (such as hepatitis C, cirrhosis, end-stage liver disease, HIV nephropathy, end-stage renal disease, anemia, coronary artery disease, and cancer). See this article at CurrentPsychiatry.com for case studies of HIV patients with delirium, depression, posttraumatic stress disorder (PTSD), and substance dependence.

**Mood disorders.** Depression is common among persons with HIV. Demoralization and bereavement may masquerade as depression and can complicate diagnosis and treatment. Depression and other mood disorders may be related to stigma and AIDSism as well as to biologic, psychological, social, and genetic factors. Because suicide is prevalent among persons with HIV and AIDS,<sup>13</sup> every patient with HIV should be evaluated for depression and suicidal ideation.

**PTSD** is prevalent among persons with HIV. It is a risky diagnosis because it is associated with a sense of a foreshortened future, which leads to a lack of adequate self-care, poor adherence to medical care, risky behaviors, and comorbid substance dependence to help numb the pain of trauma.<sup>14,15</sup> Persons with PTSD may have difficulty trusting clinicians and other authority figures if their trauma was a high-betrayal trauma, such as incest or military trauma.<sup>14,15</sup>

In patients with HIV, PTSD often is overlooked because it may be overshadowed by other psychiatric diagnoses. Intimate partner violence, history of childhood trauma, and childhood sexual abuse are risk factors for HIV infection and PTSD. Increased se-

Table 2

**Psychiatric disorders that limit access to HIV prevention and care**

|   |
|---|
| Cognitive disorders (delirium, dementia)                                    |
| Mood disorders (depression, mania, bipolar disorder)                        |
| Posttraumatic stress disorder   |
| Substance use disorders (alcohol, amphetamines, cocaine, heroin dependence) |
| <b>Source:</b> References 4-6,11  |

verity of HIV-related PTSD symptoms is associated with having a greater number of HIV-related physical symptoms, history of pre-HIV trauma, decreased social support, increased perception of stigma, and negative life events.

PTSD also is associated with nonadherence to risk reduction strategies and medical care.<sup>14,15</sup> Diagnosis is further complicated by repression or retrograde amnesia of traumatic events and difficulties forming trusting relationships and disclosing HIV status to sexual partners or potential sexual partners because of fear of rejection.

**Substance use disorders.** Dependence on alcohol and other drugs complicates and perpetuates the HIV pandemic. Sharing needles and other drug paraphernalia is instrumental in HIV transmission. The indirect effects of alcohol and substance abuse include:

- the impact of intimate partner violence, child abuse, neglect, and/or abandonment
- development of PTSD in adults, with early childhood trauma leading to repeating their own history
- lack of self-care
- unhealthy partner choices
- use of drugs and alcohol to numb the pain associated with trauma.

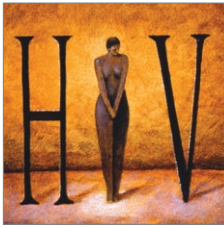
Persons who are using alcohol or other drugs may have difficulty attending to their health, and substance dependence may prevent persons at risk from seeking HIV testing.

Intoxication from alcohol and drug use frequently leads to inappropriate partner choice, violent and coercive sexual behav-

**Clinical Point**

**Every patient with HIV should be evaluated for depression and suicidal ideation**

See this article at  
**CurrentPsychiatry.com**  
for a description of  
cognitive disorders  
in HIV patients



## Helping patients who have HIV

### Clinical Point

Patients with AIDS are particularly vulnerable to extrapyramidal and anticholinergic side effects of psychotropics

Table 3

## Issues in HIV prevention and care throughout the life cycle

|  |
|--|
| <b>Childhood/adolescence</b>   |
| Health and sex education from elementary school through college can help prevent HIV transmission  |
| A sensitive, carefully timed, and phased approach is needed to disclose to children that they are HIV-seropositive   |
| How and when to tell children that a parent is infected requires sensitivity and care  |
| <b>Women of reproductive age</b>   |
| Pregnancy can be accomplished safely in serodiscordant couples through techniques such as sperm washing for HIV-seropositive men and use of a syringe or turkey baster for fertilization of HIV-seropositive women |
| Perinatal transmission of HIV is preventable with medical care and antiretroviral use through part of pregnancy, labor, and delivery   |
| An HIV-seropositive mother can transmit HIV to her baby through breast-feeding   |
| <b>Older adults</b>  |
| Older adults are vulnerable to HIV infection and are less likely to use condoms because they are not concerned about pregnancy   |
| Postmenopausal women are more vulnerable to HIV transmission because of thinning vaginal mucosa  |
| Some primary care physicians and gynecologists may not ask older patients about sexual activity  |
| Older patients may be diagnosed late and even after progression to late-stage AIDS   |

iors, and lack of condom use. Substance dependence also may lead individuals to exchange sex for drugs and to fail to adhere to safer sexual practices or use sterile drug paraphernalia.

### Treating persons with HIV/AIDS

Several organizations publish evidence-based clinical guidelines for treating depression, anxiety, substance abuse, and other psychiatric disorders in patients with HIV/AIDS. One such set of guidelines is available from the New York State Department of Health AIDS Institute at [www.hivguidelines.org](http://www.hivguidelines.org). As is the case with patients who do not have HIV, psy-

chotherapy and pharmacotherapy are common first-line treatments.

**Psychotherapy.** Patients with HIV/AIDS with psychiatric comorbidities generally respond well to psychotherapeutic treatments.<sup>16,17</sup> The choice of therapy needs to be tailored to the needs of individuals, couples, and families coping with AIDS. Options include:

- individual, couple, family, and group psychotherapy
- crisis intervention
- 12-step programs (Alcohol Anonymous, Narcotics Anonymous, etc.)
- adult survivors of child abuse programs ([www.ascasupport.org](http://www.ascasupport.org)), groups, and workbooks
- palliative psychiatry
- bereavement therapy
- spiritual support
- relaxation response
- wellness interventions such as exercise, yoga, keeping a journal, writing a life narrative, reading, artwork, movement therapy, listening to music or books on tape, and working on crossword puzzles and jigsaw puzzles.

**Psychopharmacotherapy.** Accurate diagnosis and awareness of drug-drug and drug-illness interactions are important when treating patients with HIV/AIDS; consult resources in the literature<sup>18</sup> and online resources that are updated regularly (see *Related Resources*). Because persons with AIDS are particularly vulnerable to extrapyramidal and anticholinergic side effects of psychotropics, the principle *start very low and go very slow* is critical. For patients who are opioid-dependent, be cautious when prescribing medications that are cytochrome P450 3A4 inducers—such as carbamazepine, efavirenz, nevirapine, and ritonavir—because these medications can lower methadone levels in persons receiving agonist treatment and might lead to opioid withdrawal symptoms, discontinuation of ARVs, or relapse to opioids.<sup>18</sup> When a person with AIDS is experiencing pain and is on a maintenance dose of methadone for heroin withdrawal, pain should be treated as a separate problem

See this article at [CurrentPsychiatry.com](http://CurrentPsychiatry.com) for 4 case studies of HIV patients with psychiatric comorbidities

with additional opioids. Methadone for relapse prevention will target opioid tolerance needs and prevent withdrawal but will not provide analgesia for pain.

## HIV through the life cycle

From prevention of prenatal transmission to the care of children with HIV to reproductive issues in serodiscordant couples, HIV complicates patients' development. *Table 3* outlines concerns regarding HIV transmission and treatment at different stages of a patient's life.

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## Related Resources

- Academy of Psychosomatic Medicine HIV/AIDS Psychiatry Special Interest Group. [www.apm.org/signs/oap](http://www.apm.org/signs/oap).
- New York State Department of Health AIDS Institute. HIV Clinical Resource. [www.hivguidelines.org](http://www.hivguidelines.org).
- University of Liverpool. HIV drug interactions list. [www.hiv-druginteractions.org](http://www.hiv-druginteractions.org).
- Toronto General Hospital Immunodeficiency Clinic. Drug interactions tables. [www.hivclinic.ca/main/drugs\\_interact.html](http://www.hivclinic.ca/main/drugs_interact.html).

### Drug Brand Names

|   |                       |
|---|-----------------------|
| Bupropion • Wellbutrin, Zyban               | Nevirapine • Viramune |
| Carbamazepine • Carbatrol, Tegretol, others | Olanzapine • Zyprexa  |
| Clonazepam • Klonopin                       | Quetiapine • Seroquel |
| Efavirenz • Sustiva                         | Ritonavir • Norvir    |
| Escitalopram • Lexapro                      | Venlafaxine • Effexor |

### Disclosure

Dr. Cohen reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

- of distress in persons with human immunodeficiency virus infection. *Psychosomatics.* 2002;43(1):10-15.
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## Clinical Point

CYP3A4 inducers can lower methadone levels and might lead to withdrawal symptoms in opioid-dependent patients

## Bottom Line

HIV transmission and effective treatment are complicated by a high prevalence of psychiatric comorbidities, including depression and other mood disorders, posttraumatic stress disorder, substance use disorders, and cognitive disorders. With an increased understanding of the issues faced by patients at risk for or infected with HIV, psychiatrists can help prevent HIV transmission, improve adherence to medical care, and diminish suffering, morbidity, and mortality.

## Cognitive disorders in HIV and AIDS: HAND and delirium

One of the most complicated aspects of caring for persons with HIV/AIDS is the high prevalence of cognitive disorders at any age and at any stage of HIV infection. As psychiatric clinicians, we need to understand how to recognize and care for persons with HIV-associated neurocognitive disorders (HAND), delirium, and other cognitive disorders.<sup>a,b</sup>

### HAND

Every person with HIV infection should have a comprehensive evaluation for cognitive impairment at baseline and at least yearly to ensure early diagnosis and treatment of HAND. Cohen et al<sup>c</sup> provide a description of a comprehensive psychiatric assessment for HAND and other psychiatric disorders in persons with HIV/AIDS.

HAND is prevalent among young and older persons with HIV/AIDS and is the most common treatable cause of dementia in persons age <50.<sup>d</sup> It is important to diagnose HIV infection and begin antiretroviral treatment as early as possible to prevent the brain from becoming an independent reservoir for HIV. Antiretroviral treatment reduces the severity and slows

progression of HAND and can induce full recovery in some patients. HAND-induced memory impairment can lead to nonadherence with medical care and antiretroviral therapy. Direct observation therapy—during which a clinician watches while a patient takes medication—may be needed to assure adherence.

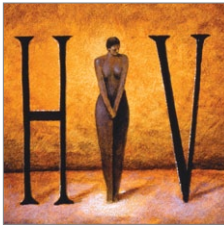
### Delirium

Delirium may be overlooked in persons with HIV and AIDS because it can be present in any age group, while in other illnesses it is more prevalent among older individuals. It also may be overlooked because it often mimics other psychiatric disorders. Hypoactive delirium may masquerade as depression whereas hyperactive or agitated delirium often looks like mania or psychosis. Delirium may be superimposed on HAND.

Establishing the cause of delirium is complicated by HIV-related and other medical conditions and treatments, but it is often possible to identify a cause in persons with HIV/AIDS. Delirium is almost always reversible when the cause is identified and treated.

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## Helping patients who have HIV

### Box 2

## Psychiatric disorders in patients with HIV: 4 case studies

### HIV-associated dementia (HAD)

Mr. A is a 37-year-old disabled investment banker with AIDS who was admitted to a nursing home when he was no longer able to care for himself or perform activities of daily living. During his initial psychiatric consultation, Mr. A denied being ill or needing care and wanted to return home. He had impaired memory, abstract thinking, and executive function; anosognosia; constructional apraxia on clock and Bender drawings; psychomotor retardation; and profoundly diminished intellectual functioning relative to his educational and occupational levels. He was incontinent of urine and feces. He was diagnosed with HAD.

Over 1 year in an AIDS nursing home, Mr. A responded well to treatment with antiretroviral therapy and gradually regained cognitive function. After 2 years of directly observed antiretroviral therapy, he was aware of his illness, kept track of his immune function and viral load, and was able to live independently and resume his work as an investment banker.

### Delirium

After being admitted to the hospital with chest pain, Mr. B, a 68-year-old married disabled attorney who has diabetes mellitus, hypertension, coronary artery disease, HIV, and hepatitis C, is referred for depressive symptoms. Psychiatric consultation revealed psychomotor slowing, confusion, disorientation to time and place, fluctuating levels of consciousness, and emotional incontinence, and no evidence of depression. He was diagnosed with hypoactive delirium. A comprehensive medical evaluation, including urine and blood cultures, was recommended and revealed a urinary tract infection with *E. coli* sepsis. Mr. B was found to have hypoactive delirium due to urosepsis.

### Depression and suicidal ideation

Mr. C is a 58-year-old married grandfather and disabled chef who is a long-term non-progressor with HIV (never treated with antiretroviral medications). He has been depressed and suicidal since his HIV diagnosis. Mr. C is followed in an ambulatory AIDS center and has oxygen-dependent chronic obstructive pulmonary disease with mild cyanosis and severe emphysema, pulmonary hypertension, rheumatic

heart disease, untreated hepatitis C, Paget's disease, and benign prostatic hypertrophy. When referred for care, he was addicted to cigarettes despite being dependent on oxygen. He has a long-standing history of major depressive disorder (MDD), recurrent, and suicidal ideation. Mr. C's suicidal thoughts rarely left him and are related to HIV stigma as well as depression.

Mr. C was diagnosed with MDD, recurrent, severe, with chronic suicidal ideation and active nicotine dependence. He engaged easily in weekly psychotherapy and agreed to attempt smoking cessation. He responded well to psychodynamic psychotherapy, family therapy, and venlafaxine XR, 150 mg, and quetiapine, 25 mg at bedtime. Bupropion XL, 150 mg/d, was added for smoking cessation and antidepressant augmentation. He responded to a recommendation to use jigsaw puzzles to keep occupied and prevent cigarette cravings but he refused nicotine replacement therapy.

Mr. C has been abstinent from cigarettes for 3 years and is acyanotic, although still oxygen-dependent. By participating in individual and family therapy, Mr. C was able to accept that he was not a burden to his family but a beloved, productive, valued member and a reliable caregiver to his grandchildren. Although he remains intermittently suicidal, he is adherent to medical and psychiatric care, is gradually working to develop a sense of meaning and purpose, and is less depressed.

### PTSD and substance dependence

Ms. D is a 38-year-old, divorced, unemployed woman with HIV who is pregnant and using cocaine. She was found to have posttraumatic stress disorder caused by early childhood trauma and intimate partner violence. She responded well to twice weekly psychodynamic psychotherapy and placement in a structured residential drug treatment facility for pregnant and addicted women and their children. She was escorted to her psychotherapy appointments, discontinued cocaine use, received antiretrovirals in direct observation therapy, and delivered a healthy, HIV-negative baby. She continued psychotherapy for 3 years and began to attain her goals before relapsing to cocaine use after discharge and becoming nonadherent to medical and psychiatric care.