

MODULE THREE

Assessment Issues and Strategies

A. Biomedical Issues

1. General Health Status and Current Treatment Regimens

- Many patients with HIV are living longer and are now developing other illnesses. Some of these are a consequence of HIV medications (e.g., lipodystrophy). Others are a direct effect of the virus in the body (e.g., renal disease, anemia, low testosterone or hypogonadism), as well as illnesses associated with aging (e.g., hypertension, diabetes, endocrine problems such as thyroid disease). Some manifest themselves through subtle or abrupt changes in mental status and require evaluation before defining them as a psychological or neuropsychological manifestation of HIV.
- When there are mental status changes, it is important to rule out any biological factors that can explain the change before it can be diagnosed as a psychiatric problem. This is important to avoid misdiagnosing medical problems which may be treatable and reversed. Biological causes may include:
 - a) HIV-related medical problems (e.g., neoplasms, opportunistic infections);
 - b) Non-HIV related illnesses that have CNS manifestations (e.g., tuberculosis, tertiary syphilis, traumatic head injury, acute drug-related psychosis, aneurysms and others);
 - c) Neuropsychological manifestations of HIV, (e.g., minor cognitive motor disorder, HIV-associated dementia, delirium, etc.);
 - d) Non-HIV related medical problems (e.g., thyroid disease, low testosterone and other endocrine problems, infections); or,
 - e) Side effects of medications (e.g., prescribed, over-the-counter) or herbal remedies, caffeine, use of alcohol and illicit drugs, all can manifest themselves as psychiatric symptoms.

After asking the patient about recent changes or events (e.g., new medications, new physical symptoms, substance use), it is useful to contact the primary provider to verify that there aren't other medical or biological issues that could explain the mental status changes.

- Current T-helper cell counts, viral load assays, and other markers of immune function should be identified as well as any significant changes in those indices over the past three months
- Medical history of HIV – Has the client had HIV for a long time or a short time? What symptoms and treatments have they had in the past?

What are their current symptoms and treatments? What is their response to current treatments?

- Medical history unrelated to HIV (e.g., TB, diabetes, hypertension, headaches, etc.)
- Medications being taken and those prescribed or recommended but declined. Side effects experienced in the present as well as those experienced in the past. Include drugs obtained on the street, herbal remedies, and complementary remedies given by non-medical providers.
- Adjunctive treatments, including chiropractic care, acupuncture, and spiritually based healing practices
- Self-care practices, including nutrition and exercise
- Names of all caregivers, medical and non-medical, including dentist, ophthalmologist, occupational therapist, physical therapist, visiting nurse, nutritionist, Christian Scientist practitioner, and clergy. Understand their roles and the client's choices. Are these persons well chosen, do they know about each other, do they work well together?
- When you feel sick, do you go to the emergency room, call your medical provider, or call someone else?
- How comfortable do you feel talking to your medical providers?
- How well do your medical providers explain your treatment options?
- Do you think your medical providers are sensitive to your pain (e.g., mental, emotional, physical, and spiritual pain)?
- How often do you see your medical provider for your other medical conditions? How often do you keep these appointments?

2. Neuropsychological Functioning

A. Overview of Research on Neuropsychological Sequelae of HIV Infection

- The majority of studies demonstrate conclusive evidence for neuropsychological impairment during the later stages of HIV and AIDS but there is considerable inconsistency regarding cognitive dysfunction in individuals during the earlier asymptomatic stages of the illness.

- The presence and extent of neuropsychological impairment during the asymptomatic stages of HIV illness remains unclear. There is wide variability among studies regarding the percentage of patients who actually exhibit cognitive dysfunction and the specific cognitive domains affected. Moreover, the clinical importance of statistically significant results when the magnitude of group differences is small (i.e., small effect sizes) is not clear (Reger et al., 2002).
- Some of the variability in studies of cognitive deficits among people with HIV disease has to do with the failure to control for numerous variables known to affect HIV neuropsychological functioning (e.g., age, education, depression, B12 levels, prior substance abuse, head injury, mental illness, IQ, etc.).
- White et al. (1995) qualitatively reviewed and summarized positive and negative findings of 57 studies assessing cognitive impairment in individuals at various stages of HIV. They found that studies that used large batteries were more likely to find impairment in HIV asymptomatic individuals, whereas variables such as battery type, sample size, or method of data analysis were less predictive of positive findings.
- Reger et al. (2002) examined the magnitude of neuropsychological impairment across three groups of HIV positive patients (asymptomatic, symptomatic, AIDS) in 10 domains of neuropsychological functioning using meta-analytic methodologies. Their work revealed that when comparing HIV groups to seronegative controls, effect sizes increased as a function of disease severity. In fact, all three HIV groups differed significantly from seronegative controls across most cognitive domains.
- Reger et al. (2002) found that when the literature is considered as a whole, motor dysfunction was not the most prominent impairment in asymptomatic HIV+ patients. The greatest effect at this stage of illness was in the area of language (naming). It is at the symptomatic stage that effect size was greatest for motor functioning followed by problem-solving and executive functions, information processing speed, and language skills.
- According to Reger et al. (2002), greater numbers of cognitive domains were affected in the AIDS patients with motor functioning and executive skills being most impaired (“executive skills” or “frontal lobe functions” includes such skills as problem-solving, sequencing, judgement, inhibition, and divided attention).

Patients with AIDS also displayed relatively large effects in the areas of information processing speed and immediate visual memory. Additionally, AIDS patients showed moderate effects in the areas of language and visual construction and yet relatively small effects in attention and concentration.

- The cognitive profile of patients in the later stages of HIV is thought to most closely resemble those with subcortical brain dysfunction. With advanced disease, HIV-infected patients become increasingly slow. This slowing takes two basic forms: (1) slowing of motor movements and (2) slowing of cognition, especially executive functions. Declines in memory and visual function, skills less dependent on subcortical anatomy, typically occur only in the most advanced stages of the disease.
- Although motor slowing typically arises from a central slowing associated with a subcortical dementing process, motor slowing may also be caused by myelopathy and myopathy, peripheral neuropathy, or simply the effects of physical illness.
- The relationships between HIV disease, neuropsychological impairment, and employment are not fully understood. Upon initial consideration, one would not expect that the subtle deficits observed in the early stages of symptomatic illness would interfere with occupational functioning. However, several researchers have found these deficits to affect employment status.
- A recent study by Van Gorp et al. (1999) found that among HIV+ symptomatic and AIDS patients, those who were unemployed were more likely to exhibit deficits on tasks of memory, set shifting-cognitive flexibility, and psychomotor speed than those who were employed.
- The use of highly active antiretroviral therapy (HAART) has been associated with improvements in cognitive performance (Sacktor et al., 2000a) and a decreased incidence of HIV dementia (Sacktor et al., 1999) as well as improvement in neuroimaging markers of HIV dementia (Sacktor et al., 2000b).
- One report from the Multicenter AIDS Cohort Study demonstrated declines of at least 50% in the incidence of HIV-associated dementia and CNS opportunistic complications (e.g., toxoplasmosis and primary CNS lymphoma) since the introduction of combination antiretroviral treatment in 1996 (Sacktor et al., 1999). However, there are emerging concerns that the incidence of cognitive impairment may increase again as

resistance to antiretrovirals increases and/or adherence to medications decline to the point where mutations of the virus begin to occur.

B. Diagnosis and Classification

- Diagnosis and classification schemes for HIV central nervous system disease have undergone many revisions.
- The Working Group of the American Academy of Neurology AIDS Task Force introduced one of the more widely used nomenclatures (Janssen et al., 1991). This system distinguishes two subclasses of HIV-related disorders, *HIV Associated Minor Cognitive/Motor Disorder* (MCMD) and *HIV Associated Dementia* (HAD).
- MCMD is diagnosed if patients display any two of the following six symptoms for more than a month: (1) impaired attention/concentration; (2) mental slowing; (3) impaired memory; (4) slowed movements; (5) impaired coordination; and (6) personality change or irritability or emotional lability ([Janssen, 1991](#)). MCMD is a diagnosis of exclusion. This means that a diagnosis is made only after proving no other cause can account for the clinical findings (e.g. signs, symptoms and lab results).
- MCMD symptoms can also be a consequence of delirium, where the individual is confused. However, in the case of delirium, the presentation would be more of a waxing and waning quality. Medical conditions, such as urinary infections and endocrine problems can also present like MCMD and thus a full medical evaluation is may be warranted with manifestations of MCMD-like symptoms.
- HAD is considered a "subcortical" dementia which means that intellectual functions, while slowed, remain good until very late in the process. The symptoms are often subtle and insidious in onset, with slowed decision-making most prominent. In early HAD, the patient may appear "depressed" with apathy, lethargy, and social withdrawal. Forgetfulness, loss of concentration, slowing of information processing along with visuo-constructive deficits, problems with coordination, walking/balance disturbances, weakness and tremor may be present. Early deficits generally include decreased attention and concentration, cognitive and psychomotor slowing, and memory impairment.

- In late HAD, patients may have problems with language, visual or spatial difficulties, in addition to disorders of movement and behavior. Patients can also present with psychotic symptoms, severe verbal memory loss, seizures and mutism. Walking/balance problems may be severe and the patient may be incontinent of urine and stool.
- HAD is a dementia of variable progress and duration. Some patients develop other systematic AIDS manifestations during the course of the dementia. Others have a more prolonged and relatively stable course. There are some patients who may compensate for cognitive loss, while others deteriorate rapidly to a severe vegetative dementia over a period of weeks. It is not possible to predict the clinical course for a given patient.
- Risk factors for the development of HAD include older age, CD4 cell count lower than 100 cells/mm³, high plasma viral load, and low hematocrit or red blood cells. Other risk factors include injection drug use (specifically cocaine), antiretroviral medication resistance, HAART regimens compromised by medications with poor penetration of the blood-brain barrier, co-infections (specifically cytomegalovirus, human herpes virus type 6, JC virus), wasting syndrome and gender (females increased over males). Likewise, delirious patients may be at higher risk for HAD after resolution.
- Delirium is a sudden and significant decline from a previous level of functioning not accounted for by a preexisting or evolving dementia. It is commonly underdiagnosed and should be differentiated from HAD.
- Delirium is characterized by a disturbance in consciousness with reduced ability to focus, sustain, or shift attention, with accompanying disturbances of cognition and perception. Delirium generally develops rapidly over a short period of time (usually hours to days) and follows a fluctuating course over the day.
- The etiology of delirium is often multifactorial. A diagnosis of delirium should initiate a full neurodiagnostic workup to exclude various general medical complications associated with HIV infection. Alcohol and substance-induced neuropsychiatric symptoms also need to be evaluated and treated. Other commonly associated features of delirium include disturbances of sleep, psychomotor activity, and emotion. Disturbances in the sleep-wake cycle observed in delirium include daytime sleepiness, nighttime agitation, and disturbances in sleep continuity.

- Delirium is often accompanied by disturbed psychomotor activity. The delirious individual may also exhibit emotional disturbances, such as anxiety, fear, depression, irritability, anger, euphoria, or apathy. There may be affective lability, with rapid and unpredictable shifts from one emotional state to another.
- While the majority of patients recover fully, delirium may progress to stupor, coma, seizures, or death, particularly if left untreated. However, in some patients with HIV, treatment of delirium may not improve cognitive function possibly because of underlying dementia.
- Although delirium may occur in patients with little to no previous cognitive impairment, it is most often caused by an organic insult (e.g., infections, metabolic, medications, alcohol/drugs) to the brain rendered vulnerable by HIV infection. Delirium is more frequent in patients with HAD. Similarly, previous delirium predisposes to recurrence of delirium.

C. General Neuropsychological Assessment Considerations

- Because most cognitive changes during the early stages of HIV are subtle, clinical mental status exams lack adequate sensitivity for reliable assessment.
- Cognitive slowing is the most widely observed feature of HIV-associated neurocognitive impairment (I. Grant et al., 1993). A person may initially report concentration problems, forgetfulness, and difficulty balancing a checkbook. Reaction-time tasks provide a valuable index of cognitive-processing speed because they are sensitive to cognitive dysfunction without ceiling effects.
- It is important to note that motor slowing, leg weakness, and loss of mobility can occur without any other cognitive or intellectual dysfunction (Worley & Price, 1992).
- Even minor cognitive impediments like those connected with *HIV-Associated Minor Cognitive/Motor Disorder* can reduce an individual's capacity to manage stressful situations and thus lead to more impulsive coping behaviors.
- In the case of *HIV Associated Dementia Complex*, concerns may eventually arise about home safety, wandering, confusion, and severe memory loss.

- The prospect of losing mental and sensory abilities is one of the most frightening aspects of HIV infection. Individuals with HIV infection are usually aware of the potential for neuropsychological impairment and may have known others who have experienced cognitive decline. People who expect to lose their mental faculties can become hypervigilant and monitor their day-to-day activities and their performance of even simple tasks. Normal forgetfulness and poor concentration can result from stress, yet when a person with HIV is forgetful, it may be attributed to HIV infection and misinterpreted as the beginnings of dementia.
- A detailed history about cognitive functioning from the patient's perspective is essential for diagnosis. A history should establish a baseline of cognitive functioning; identify whether the patient believes he or she has experienced cognitive slowing or memory loss; determine if the client uses compensatory strategies such as note taking or a reminder system; and assess whether there is peripheral nervous system involvement as indicated by pain, numbness or other symptoms in arms, hands, legs, or feet.
- Acute changes in functioning, either cognitive or behavioral, warrant referral for neurological and neuropsychological evaluation.
- Subjective complaints of cognitive problems are frequent and depending on the severity of problems, anticipated expense, and likely implications for treatment, should be followed by neuropsychological evaluation or screening.
- Standard psychological tests (e.g., IQ, academic achievement, personality) are insensitive to subtle changes in attention and speed of processing that can occur, and these tests do not assess learning and memory effectively.
- At late stages of disease, signs of neurologic involvement may be more evident on psychological testing (e.g., fund of knowledge or vocabulary preserved, with reduction in scores noted on timed measures) and can be an indication that further evaluation is necessary.
- Because differential diagnosis can be difficult, it is important to work with a neuropsychologist who is familiar with the neurobehavioral effects of HIV-1 at different disease stages.
- It is important to collaborate closely with primary care physicians and to refer to a neurologist, when warranted

D. Screening for Cognitive Impairment

- Among the symptoms that the mental health provider should notice and monitor over time are slowing in thinking or psychomotor speed and decreased spontaneity. Among the symptoms that can indicate acute illness are the onset of prolonged or severe headaches, seizures, and progressive muscle weakness evidenced as difficulty walking or abrupt changes in handwriting or other fine motor skills.
- A person with an HIV-associated dementia may have difficulty recalling a list of words or medication instructions but will often be able to recognize the correct information from multiple choices – indicating that the individual has learned the material but has difficulty retrieving it.
- Screening tests specific for detecting HIV associated cognitive impairment have been developed. For example, a five item test of memory, attention, psychomotor speed, and manual construction has been effective in detecting HIV-related dementia (Power, Selnes, Grim, & McArthur, 1995).
- Two common screening tests that are particularly sensitive to psychomotor slowing and memory impairment are *Trail Making A and B*; and, the *Symbol Digit Substitution Test*. *The Trail Making A Test* consists of an array of the numerals 1 to 25 distributed on a page. Clients connect one number to the next, in order, as quickly as possible. *The Trail Making B Test* includes both numerals and letters, and the client must sequentially alternate from a numeral to a letter, back and forth, as rapidly as possible. In the *Symbol Digit Substitution Test*, the client is shown a series of numerals paired with symbols. Applying this “key”, the client must write down as rapidly as possible the symbols associated with an array of numbers that are presented in a generally random order, within ninety seconds.
- Testing using all screening instruments must be conducted by individuals who are trained in the administration and interpretation of psychological tests and who understand and can interpret normative databases.

E. Differentiating HIV-Associated Cognitive Impairment from Other Conditions

- Delirium in people with HIV disease can be acute or chronic and it can be caused by a number of things including toxicity to medication, metabolic disturbance such as an electrolyte imbalance related to dehydration, high fevers, or undiagnosed infection. Delirium is different from HIV-related minor cognitive disorder or HIV-associated dementia in several ways. Delirium presents with an abrupt onset of confusion, dramatic attention difficulties, and a language impairment characterized by rambling, incoherent speech and writing. In contrast, HIV-related minor cognitive disorder and HIV-associated dementia usually appear more slowly over time and leave basic attention intact, affecting only the more complex attributes of divided and sustained attention.
- Concomitant opportunistic illnesses, past and present prescription and nonprescription drug use, sleep deprivation, poor nutrition, education, and socioeconomic status can also potentially influence neuropsychological screening and testing.
- It is important to note that some medications – including steroids or anticancer drugs – may have depressive effects.
- A client with a long-standing history of alcoholism may have clinically significant memory impairment, especially difficulty recalling information that he or she has recently learned. Substance-abusing clients may also have short-term memory loss and difficulty completing multi-step tasks. If the client is also HIV infected, it may be impossible to tease apart these potential sources of cognitive impairment.
- Although HIV-related psychosis may be caused by a late-middle or end stages of HIV-associated dementia, it can also arise from delirium, a coexisting schizophrenia-like disorder, or major depression. Symptoms of mania –including pressured speech, spending sprees, and sleeplessness have been reported in clients with middle and late stage HIV. Mania can also arise from use of or withdrawal from street drugs as well as central nervous systems disorders associated with PML, toxoplasmosis, and tumor.
- Depression potentially confounds neuropsychological testing by slowing or decreasing motivation and cognitive processing speed, attention, concentration, and motor functioning (Hinkin et al., 1992)

- It is important to note that those who are more depressed tend to complain of more cognitive failures than those who are less depressed, regardless of the objective level of their neuropsychological abilities (Van Gorp, Dilley, and Buckingham, 1998).
- Findings that suggest depression include:
 1. Clear evidence of changes in mood and affect, accompanied by vegetative signs;
 2. No evidence of decline in everyday functioning;
 3. Complaints of cognitive problems that are not obvious to others;
 4. Absence of impairment on neuropsychological testing;
 5. Impairment on testing that is “spotty” and not consistent with brain dysfunction (i.e., findings that are atypical of impairment when certain areas of the brain are not functioning properly);
 6. Ability to “rise to the challenge” and to perform better on harder sections of tests (e.g., Digits backwards better than forwards, Trail Making Test Part B better than Part A, delayed recall better than immediate recall).
- Findings that suggest cognitive impairment include:
 1. Apathy, but denial of changes in mood;
 2. Evidence of a decline in everyday functioning;
 3. Denial of cognitive problems that are observed by others;
 4. Cognitive impairment that is consistent with subcortical dysfunction (i.e., impairment in attention, reaction time, fine motor skills, recognition memory better than free recall) or focal dysfunction of another brain region;
 5. Deterioration in performance on harder sections of tests

3. Somatic Syndromes Associated with HIV Disease

- There are several HIV-related syndromes that have a direct impact on people's functioning and mental health well being. These include sleep disorders, pain, endocrine disorders, wasting, and medication side-effects. Some of the symptoms associated with them may be confused with psychiatric symptoms. Somatic syndromes are often associated with psychological distress and psychological distress may exacerbate somatic syndromes.

A. Sleep Disorders

- A significant number of patients with HIV/AIDS complain of sleep difficulties, which are sometimes overlooked. Sleep problems are associated with fatigue, mood disturbance, cognitive inefficiency, irritability, or impaired performance and increase the risk for depression, pain, and substance abuse.
- Even while asymptomatic, patients may experience difficulty sleeping. This may be due to anxiety, stress-related factors or disruption of sleep from direct virally mediated changes. Sleep difficulties may result from underlying conditions associated with HIV or its systemic complications (e.g., fever, pain, dehydration and poor nutrition). In more advanced disease, sleep difficulties are more prevalent and may be due to the dementia. HIV medications have negative sleep effects that further intensify the problem.

B. Pain

- Treatment of pain in HIV illness is particularly important and yet often neglected. Pain is widely reported by persons living with advanced HIV illness. The pain may be caused directly by HIV itself (e.g., neuropathies and myelopathies); by HIV-related cancer; by HIV medications (e.g., neuropathic pain associated with ddI and ddC, abdominal pain associated with most antimycobacterial agents), or by the direct effects of opportunistic infections (e.g., CMV colitis).
- Physicians tend not to ask about pain or focus on it and patients may be reluctant to acknowledge the extent to which pain interferes with their lives. Both patients and physicians may worry unnecessarily about “using up” pain medications because they may need treatment more urgently in the future. In fact, according to a statement by the Washington State Medical Association (1992), using strong opioids earlier during illness does not mean that later on they will be ineffective.
- Physicians often worry, as do patients, about the perils of addiction, even when patient’s are on their deathbeds. Patients often try to use as little medication as possible, preferring to wait until the pain gets “bad enough”. In fact, prophylactic use of analgesics to prevent pain onset usually requires less medication than treating existing pain and furthermore prophylactic use of analgesics maintains comfort far more effectively.
- Two issues occur in conjunction with the use of pain medication with drug users. First, pain is often undertreated because physicians

are afraid of promoting addiction and often fail to recognize that ex-addicts have increased tolerance for pain medication. Second, ex-addicts are particularly vulnerable to relapse after re-experiencing the physiological and psychological rewards of pain medication.

- Adequate assessment of pain is often not achieved because physicians and patients lack a vocabulary of pain. Words that describe different kinds of pain include: aching, shooting, gnawing, tender, numb, throbbing, stabbing, sharp, burning, exhausting, penetrating, and nagging.
- To assess pain, one needs to know the following:
 1. Pain duration: fleeting, intermittent, continuous?
 2. Cyclic patterns?
 3. What kinds of things ease the pain?
 4. What makes it worse?
 5. What medications or treatments have been tried?
 6. How effective have they been?
 7. How long does the relief last?
 8. How troubling are the side effects (if any)?
- If there are several types of pain, and/or several different locations, after describing one site, or one kind, the client should be asked about others that may be present.

C. Endocrine Disorders

- Endocrine problems, such as low testosterone and estrogen levels, can contribute to wasting, fatigue, mood disturbance, cognitive inefficiency, irritability, or impaired performance. Wasting can have similar consequences besides the impact of "showing" the illness (self-perception and outside "stigma").

D. Medication Side Effects

- Several HIV medications have mild to severe side effects (see Table 1). It is not uncommon for these side effects to be incorrectly attributed both by patients and clinicians to the disease itself. These side effects resemble mild to severe psychiatric complaints, which at times are also attributed to the disease. These side effects should be carefully evaluated and resolved by changing medications or offering alternatives. Side effects can have a negative impact on a patient's willingness to adhere to antiretroviral therapies.

- It is important to accurately determine all of the medications that a patient is taking including: prescription and over-the-counter medications, supplements, alternative remedies, and illicit drugs. Many antiretrovirals have overlapping toxicities with psychotropic medications and some of these interactions have a psychiatric component.
- Cytochrome P450 enzymes chemically oxidize or reduce drugs. There are more than 25 P450 enzymes in humans, several of them involved in drug metabolism. A substance can be a substrate, an inhibitor, or an inducer. A P450 substrate is a substance that is metabolized by one or more P450 enzymes. A P450 inhibitor inhibits the metabolism of a P450 substrate. An inducer increases the amount of a P450 substrate.
- Many psychotropic drugs and antiretroviral medications interact with Cytochrome P450 enzymes and interactions can produce either diminishing or multiplying effects of particular medications (see Klesmer & Badescu, 2002 for a review). Close monitoring of potential interactions between them is essential and requires close psychiatric and medical management. It is important to note that some psychotropic drugs are contraindicated for use with antiretrovirals and should be prescribed, if at all, with great caution.

4. Client's Understanding of and Response to HIV Diagnosis, Symptoms & Treatment

- Subjective interpretations and appraisal of symptoms as well as social reinforcement contingencies affect physical and psychological functioning based on an individual's unique illness schema. Thus, for clients with HIV, one must attend to the client's own conceptualizations of their symptoms, disease, and the responses from significant people in their environment because all of this may affect physical and psychological functioning as well as response to treatment and rehabilitation.
- If the client is not knowledgeable or forthcoming about their understanding of HIV disease and treatment, it is important to determine what might be the barriers?
- The client's expectations concerning HIV disease, its prognosis, and the procedures involved in its management should be assessed.
- It is important to determine the beliefs of the client and significant others concerning the nature and cause of HIV disease and whether important symptoms or the course of HIV can be controlled.

- Mechanic (1962) has referred to the manner in which people monitor their bodies, respond to symptoms, and decide on a remedial course of action as “illness behavior”. It is important to determine if illness is behavior is appropriate to the particular stage of the client’s HIV disease, or if there is evidence of amplification or discounting symptoms for any of a variety of psychological or social reasons or purposes?
- An important factor that is likely to influence how an individual acts on his or her symptoms is the value associated with a particular illness. HIV disease carries a great deal of social stigma in many communities, often because the disease is believed to result from immoral or socially undesirable behavior. The HIV infected individual may be perceived as responsible for or deserving of his/her illness.
- Because individuals with HIV are aware of the negative moral or physically threatening connotations associated with their illness, they may try to conceal symptoms from others or to ignore or deny symptoms, because an acknowledgment of the symptoms may entail stigmatization by his or her social group. Thus, an individual who lives in a culture or subpopulation that stigmatizes HIV disease, may be less likely to consult with significant others about their symptoms or to seek professional care.
- Because stigma can extend to members of an individual’s family, persons living with HIV may act not only to protect themselves but also to protect significant others from stigma.

5. Adherence to Treatment

A. General Considerations

- It has long been recognized that medication adherence is problematic for virtually all conditions and treatments, even when the regimen is simple and the patient is recognizably ill.
- Medication regimen’s for HIV illness is one of the most rigorous, demanding and unforgiving of any outpatient oral treatment ever introduced, and may be prescribed for some patients without any current symptoms.
- Because of the short half-life of the protease inhibitors currently available, each must be taken at intervals of either 8 or 12 hours around the clock, for years if not forever, either with meals or on an empty stomach. These drugs are combined with two or more additional antiretroviral drugs that may have different schedules for a total of more than 20 pills per day. Other medications, either

prophylactic or for symptomatic illness, also are prescribed, often increasing the number of pills in each daily regimen even further.

- Non-adherence is common among individuals treated with HAART. More than 10% of patients report missing one or more medication doses on any given day, and more than 33% report missing doses in the past two to four weeks (Catz et al., 2000; Chesney et al., 2000).
- Rates of non-adherence to HIV therapies are comparable to those in other chronic illnesses but in HIV near-perfect adherence is required to obtain successful treatment outcomes (Chesney, 2000).
- Partly due to non-adherence, HAART fails in approximately half of patients for whom it is prescribed (Valdez et al, 1999).

B. Determinants of Adherence to HIV Treatment

- Although most sociodemographic variables do not predict adherence behavior, studies have found that male sex, white ethnicity, older age, higher income, higher education and literacy correlate with adherence (Chesney et al., 2000; Gifford, 2000; Kleeberger, 2001).
- A number of psychosocial variables have been related to adherence, including depression and other psychiatric illnesses; active drug and alcohol use; degree of social support; social stability; self-efficacy; body image/weight concerns; patient ability to identify treatment regimen; and patient's understanding of the relationship between adherence and medication resistance (Ickovics & Meade, 2002).
- Side effects associated with HIV medications have been shown to negatively affect adherence. Unfortunately, side effects are common and often severe. Transient side effects include nausea, vomiting, diarrhea, and fatigue. More lasting side effects include metallic taste, oral numbness, peripheral neuropathy, metabolic disturbances, and new-onset diabetes.
- Patients report food restrictions, complex schedule and adverse side effects as the primary barriers to HAART adherence – not doses per day or pills per dose (Gallant & Block, 1998).
- Patient-provider relationship plays an important role in improving adherence to HAART. Specific aspects of the relationship that seem to be important are patient's perceptions of the provider's

confidence, affective tone of the relationship, trust, open communication, cooperation, willingness to include patient in treatment decisions, adequacy of referrals and overall satisfaction (Ickovics & Meade, 2002).

- It is important to note that one determinant of adherence may influence another. For example, depression or negative beliefs about the health care system may influence the patient's ability to trust the intentions and competence of a provider.
- Although simpler regimens are coming on the market, single-pill regimens will not be a panacea because so many other variables contribute to adherence.

C. Measuring or Assessing Adherence

- There is no gold standard to assess adherence. The ideal measure would be simultaneously unobtrusive, objective, and practical.
- Direct observation is routinely used in methadone clinics, in institutions such as hospitals and prisons, and in special programs for patients with active tuberculosis presumed to be potentially nonadherent.
- Blood and urine levels are less useful for compounds with short half-lives like protease inhibitors, where accurate determination of achieved serum levels requires multiple sampling before and at fixed intervals after dose.
- Some medications have physiological markers that indicate whether they have been taken. For example AZT causes an increase in mean corpuscle volume and uric acid levels rise when ddI is taken. Unfortunately, many medications have no markers and many factors can contribute to changes in physiological markers.
- Sumartojo (1993) noted that physicians' predictions of adherence are accurate less than half the time.
- Pill counts are often used to gauge adherence because they are easy and inexpensive. Unfortunately, counting medications like protease inhibitors constitutes a major practical hurdle because of the number of different pills involved, because of the number of times each pill has to be taken in a given week, and because different pharmacies dispense medications in different amounts for different periods of time. Even with microelectronic caps on

pill bottles that record the date and time pill bottles are opened, one cannot determine whether the pill was actually ingested, or whether food was or was not taken at the same time.

- Retrospective patient reports are widely used because of ease and feasibility, face validity, and empirically demonstrated utility. Overall, systematically elicited short-term recall (e.g., last three days) in a face-to-face interview setting can provide a fairly accurate picture of overall adherence (Ickovics & Meisler, 1997).
- Strategies to motivate patients to tell interviewers what is actually happening and not what they think the interviewer wants to hear have resulted in higher numbers of reports of nonadherence. Such strategies often include acknowledgement that many people miss doses and that the purpose of the assessment is to determine how best to assist the patient.

B. Psychological Issues

1. Prevalence of Psychological Disorders

- The HIV Cost and Services Utilization Study (HCSUS) provides the only national estimate of the prevalence of psychiatric and drug disorders among people with HIV disease (Bing et al., 2001). A nationally representative probability sample of 2864 adults receiving AIDS care in the United States was enrolled in the study in 1996. Subjects were asked to report on psychiatric symptoms and drug use during the previous 12 months. Nearly half of the sample screened positive for a psychiatric disorder. Additionally, nearly 40% reported using an illicit drug other than marijuana with more than 12% presenting with drug dependence during the previous 12 months.
- Many studies have, in fact, found a high proportion of women living with HIV to be experiencing depressive symptoms (e.g., Jones, Beach, Forehand, & The Family Health Project Research Group, 2001a; Moneyham, Sowell, Seals, & Demi, 2000). Depressive symptoms in women living with HIV have been associated with an increase in physical complaints (Jones, Beach, Forehand, & the Family Health Project Research Group, 2001b) and disease progression. Of concern is the finding that women with chronic depressive symptoms were twice as likely to die during a seven-year study as women with limited or no symptoms of depression (Ickovics et al., 2001).

2. General Assessment Considerations

- How has the client's pre-HIV psychological functioning changed with knowledge of infection and progression of illness? Symptoms of distress related to HIV may be superimposed upon problems that existed previously in the person's life. This means that clinicians should consider carefully the person's premorbid psychological history and determine the extent to which the current difficulties are related to anxiety and depression about having HIV or AIDS. How do reactions to one's HIV or AIDS status interact with previous challenges and problems in life? Knowing how the client coped with more remote problems may provide valuable information about how to assist the person in dealing with HIV-related issues.
- What psychological symptoms do the client attribute to HIV-related stressors?
- History of, and attitudes regarding, current or past experiences with mental health professionals, who may include substance abuse program counselors; past or current participation in twelve-step programs, such as Narcotics Anonymous or Positives Anonymous
- Use of psychiatric medications and psychoactive substances, either prescribed or obtained from street dealers.
- Emotional reactions to HIV infection are as diverse as the epidemic itself. Vulnerability to emotional distress is increased at critical junctures over the course of HIV infection (e.g., receiving HIV seropositive antibody test results; the initiation of treatment; the development of symptoms; increases in viral load; the onset of opportunistic illnesses; hospitalizations, first AIDS-defining conditions, and declines in immunologic markers)
- Simultaneous HIV-related events can be particularly distressing (e.g., people who learn they have advanced disease when they first find out they are HIV seropositive; pregnant women who test positive and must face their illness' while managing the potential risks posed to their unborn. In contrast, when events occur sequentially over a longer period of time, distress reactions may be of less clinical significance
- Mood states commonly associated with HIV-related coping range from momentary sadness and anxiety and anger to major depressive or full-blown anxiety disorders. In addition, because HIV infects the central nervous system, people with HIV can develop mood disorders associated with primary brain infections; these are classified as organic mood disorders. Distinguishing mood states directly related to HIV from those that underlie and are exacerbated by it is crucial to treatment.

2. Depression

- The proportion of people screening positive for major depression in HCSUS was five times greater than that obtained in general population samples.
- It is critical to distinguish between overlapping symptoms of HIV disease and depression to correctly assess depression in people living with *symptomatic* HIV disease. When paper-and-pencil depression screening instruments are used for this purpose, the somatic subsets of depressive symptoms should be removed from scoring and attention should be focused on the cognitive-affective subscales alone to improve the clinical utility of these instruments. According to Kalichman, Rompa, and Cage (2000), while the Beck Depression Inventory (BDI) offers a clearer separation of symptoms, it is the Center for Epidemiological Studies Depression Scale (CESD) that may be more sensitive to depression associated with the progression of HIV disease.
- Since the sensitivity of depression screening instruments is reduced when somatic symptoms of clinical depression are excluded from scoring, they should be used as only *one part* of a diagnostic assessment. Evaluation of daily functioning, the efficacy of coping skills, hopelessness, and suicidal ideation, among other aspects of a client's presentation, can serve to confirm or disconfirm a diagnosis of depression.
- It is well recognized that social supports insulate people from depression. Because HIV infection has thus far concentrated in groups that are often socially marginalized, individuals with HIV infection may be particularly vulnerable to depression. Those with stronger bonds to supportive networks and those with greater opportunities for secure relationships are likely to report less depression.
- Hopelessness and lack of perceived control over the course of HIV infection is related to the onset and course of depression among people living with HIV disease (Rabkin, Williams, Neugebauer, Remien, and Goetz, 1990; Kelly, Murphy, Bahr, Koob, et al., 1993)
- Symptoms of depression include loss of interest in usually pleasing activities or interests; insomnia; decreased energy; loss of appetite or eating more than usual – resulting in weight loss or gain; crying spells; suicidal ideation; loss of libido; and difficulty concentrating. It is important to note that several symptoms of depression may be due to HIV disease rather than mood:
 - a) Weight loss may be caused by wasting syndrome or other physical illness
 - b) Loss of appetite may be caused by gastrointestinal disease or nausea from medications

- c) Sleep may be affected directly by HIV disease and also by HIV-related medications
 - d) HIV-related cognitive impairment may cause psychomotor slowing and difficulty thinking or concentrating
 - e) Fatigue may surface either early or late in the course of HIV disease
 - f) Recurrent thoughts of death may arise as new physical symptoms amplify fears of mortality
- It is possible to confuse the apathy and blunting of affect caused by HIV-related cognitive impairment with depression. To differentiate between depression and cognitive impairment, look for persistent feelings of sadness and negative thoughts, which indicate depression, or more prominent and persistent cognitive problems such as memory loss or disorientation, which indicate cognitive impairment.
 - Alcohol and stimulant (cocaine or amphetamine) abuse, and sometimes opiate withdrawal, can also mimic symptoms of depression. A period of sobriety is usually necessary to distinguish whether treatment for depression, in addition to substance abuse, is necessary. The client who has not used drugs or alcohol in the previous month but who continues to meet symptom criteria for a major depressive episode merits treatment specific for depression.
 - Honn & Bornstein (2002) examined the impact of neuropsychological functioning on the relationships between stress, social support, and depression in 217 HIV-infected men. Results indicated that cognitive functioning did not contribute directly to depression, but contributed significantly to psychosocial variables (i.e., perceived stress, number of social contacts, perceived disability) that in turn affect levels of depression.

3. Mania

- In patients with no personal or family history of mood disorder, an acute episode of mania is often associated with substance use or direct HIV infection of the CNS, especially if it occurs late in the course of HIV illness. Opportunistic infections that can present as a bipolar disorder include: toxoplasmosis, cryptococcal meningitis, CNS lymphoma, neurosyphilis, herpes and B12 deficiency (Ellen, Judd, Mijch & Cochran, 1999).
- Differential diagnoses to consider include bipolar disorder (manic or depressed), substance induced mood disorder, schizoaffective disorder, personality disorder, HIV-associated dementia. Also, some medications can induce manic symptoms (e.g. steroids, some antiretrovirals, antibiotics, antidepressants, amphetamines).

4. Grief and Bereavement

- A positive HIV-antibody test result can lead to loss of employment, the threat of eviction, denial of health and life insurance, refusal of professional services, loss of health and dental care, disruptions to sexual relationships, and loss of a certain future.
- A common loss for many HIV seropositive people is the death of partners and friends due to AIDS. For example, Perry, Fishman, Jacobsberg, and Frances (1992) found that 55% of people with HIV infection in New York City to have suffered the death of someone because of AIDS. Although multiple losses occur frequently in high-AIDS-incidence areas, people who are HIV infected themselves suffer the greatest number of losses because HIV is spread through social-sexual networks or through drug-sharing networks that result in increased likelihood of people living with HIV/AIDS losing someone that they know.
- Bereavement is a well known, multidimensional source of stress, and multiple losses have multiple effects. Several researchers (e.g., J.L. Martin, 1988; Neugebauer et al, 1992; etc.) have observed demoralization, sleep disruptions, affective disturbances, intrusive thoughts, preoccupation with the deceased, and illicit and prescription drug use that increased proportionally with numbers of AIDS-related deaths. Bereaved individuals with HIV/AIDS may identify with the deceased in terms of their own mortality and deaths from AIDS may exacerbate fears of developing AIDS.
- Women living with HIV often contend with their own HIV infection while serving as the primary caregiver for their HIV-seropositive partner (although not unique to women with HIV), as well as while caring for their children. Having an HIV-seropositive child can further contribute to a sense of impending loss. Caring for her children and concerns about whom will care for them should she become ill are the most significant stressors for a woman with HIV (Hackl et al. 1997).
- Two factors appear important in determining responses to AIDS-related losses: the number of losses incurred over a period of time and the HIV status of the bereaved person. More losses in a short period of time result in greater distress and the distress appears to be greater among those living with HIV.
- Trends in psychological reactions to AIDS-related deaths have changed over the course of the epidemic. For example, Neugebauer et al. (1992) observed a pattern of decreasing adverse effects of loss over the second decade of AIDS among gay men in New York City. Neugebauer et al. concluded that the expanding scope of the epidemic has led to a gradual

normalization and expectation for death at young ages. Improved treatments, social and political mobilization against AIDS, increased availability of services, as well as reductions in social isolation and stigma may also buffer against emotional distress associated with AIDS-related losses at later points in the epidemic.

- Many people mourning HIV-related losses experience grief symptoms similar to those faced by other bereaved individuals (e.g., numbness, sadness, denial, preoccupation with the deceased, etc.). However, the unfortunate reality of multiple losses as well as stigma associated with AIDS, homosexuality, and substance abuse increase the likelihood that people suffering AIDS-related bereavement will experience prolonged or complicated grief reactions.
- Multiple losses often mean that the mourner does not have time to recover and grieve each loss separately. Stigma may make it difficult for the mourner to talk about their grief or garner support because the deceased, or the mourner's relationship to the deceased, is viewed negatively by others.
- Unlike many life-threatening illnesses, HIV disease has disproportionately affected young and middle-aged people and thus the premature quality of such deaths may increase the risk of pathological grief reactions in loved ones.
- Other factors that may increase the likelihood of pathological or complicated grief include: (1) being HIV-infected oneself; (2) poor social support; (3) excessive anger or guilt about the relationship with the deceased; (4) avoiding the pain of grief through overeating, substance use, or inappropriate sexual behavior; (5) experiencing high numbers of life stressors that result in the delay of grief reactions; and, (6) preexisting psychological disorders.
- Pathological or complicated mourning is best understood as an exaggeration or distortion of the normal process of mourning. Three variants of complicated mourning are widely discussed in the clinical literature: absent mourning, delayed mourning, and chronic mourning.
- Absent or delayed mourning refers to the lack of grief symptoms. This absence of grief may have to do with primitive defenses of denial and repression; it may have to do with the fact that there are so many things going on or so many recent losses that the mourner cannot create the "psychological space" to feel; or, it may have to do with the mourner's perception that they will be overwhelmed by grief or by fears of their own death and dying.

- Chronic mourning involves the undesired persistence of grief reactions, including shock, yearning, searching disorganization, and despair over a prolonged period of time. Even after an extended period of time, the loss continues to feel fresh and painful memories and thoughts may intrude into consciousness and disrupt occupational and social functioning.
- Although depression, anxiety, and stress are normal reactions to grief and often can be addressed through existing social support, professional intervention is necessary when grief reactions result in major depression, serious anxiety disorders such as post-traumatic stress disorder, or substance abuse. It is important to note that contrary to clinical lore suggesting that early intense grief is the normal and healthy response to loss, Zistook and Shuchter (1991) found that early intense grief reactions are associated with complicated mourning.

5. Anxiety

- The proportion of people screening positive for generalized anxiety disorder in HCSUS was eight times greater than that obtained in general population samples.
- HIV anxiety is associated with several HIV-related events including concerns about becoming physically disabled, rejected or isolated. Because HIV is transmittable, people with HIV often feel anxious about protecting others from infection while simultaneously feeling anxious about protecting themselves from rejection and isolation. Additionally, people with HIV disease may be attempting to cope with social losses, family conflicts, occupational transitions, financial uncertainties, and the uncertainty of the disease process. Under these circumstances, periods of anxiety are normal.
- Although there is a wide range in the amount of anxiety a person may experience – some people having by nature an “anxious temperament” – most people are able to respond psychologically and behaviorally to the stress of living with HIV disease and limit the impact of anxiety on the quality of their lives. Only a minority of people – those with anxiety disorders - suffer anxiety of an intensity and duration that causes prolonged impaired functioning. Generally, people with poor coping skills tend to be more anxious.
- Anxiety disorders include generalized anxiety disorder, panic disorder, agoraphobia, specific and social phobia, obsessive-compulsive disorder, acute stress disorder, substance-induced anxiety disorder, anxiety disorder due to a general medical condition, adjustment disorder with anxious mood, and post-traumatic stress disorder. Accurate diagnosis is helpful in

determining treatment, which varies somewhat between the different disorders.

- Loss of friends due to AIDS may serve as a salient reminder that HIV infection can lead to early death, further heightening anxiety.
- Death anxiety is greatest when HIV symptoms develop and increases with time (Catania, Turner, et al., 1992; Kurdek & Siesky, 1990). Impending physical decline and becoming dependent on others are closely associated with the dying process, and these concerns can supersede fears of death itself.
- Environmental cues such as AIDS-related newspaper articles, television news stories, public service announcements, and comments by friends can all provoke anxiety.
- Anxiety often manifests in a variety of autonomic and/or somatic symptoms that may mimic medical disorders. These symptoms may reflect involvement of numerous body systems. Some of the symptoms, besides anxiety, worry and fear, include chest pain/palpitations, breathing problems/choking sensation, muscle tension, nausea/vomiting/diarrhea, sweating profusely, flushing/tingling sensations, fatigue or headache/vertigo.
- Panic Disorder, a discrete period in which there is a sudden onset of intense fear associated with feelings of impending doom and some of the above symptoms, may be more common in HIV disease, as it can co-occur with depression, cocaine abuse (and other substances) and viral diseases.
- Post-traumatic stress disorder (PTSD) is characterized by the re-experiencing of an extremely traumatic event accompanied by anxiety symptoms and avoidance. PTSD is observed in some persons who receive HIV antibody test results. Some persons with multiple AIDS-related losses also experience it.
- Anxiety can also be a direct physiological consequence to a medical condition or substances/medications. A broad differential diagnosis should be considered including primary psychiatric disorders with associated anxiety (e.g., depressive disorders), neuropsychiatric disorders directly related to HIV infection (e.g., neurocognitive disorders and delirium), substance use or medications and other HIV-related complications (e.g. various medical complications and medication side effects). Knowing the course of HIV infection can assist the treating clinician in both anticipating and treating anxiety throughout the course of HIV disease.

- Milestones in the process of living with HIV are commonly associated with anxiety (e.g., new anxiety symptoms or the worsening of preexisting anxiety symptoms). Some of the critical milestones associated with anxiety include:
 - a) decision-making associated with HIV testing;
 - b) receiving news of HIV test results;
 - c) disclosing one's HIV infection to others;
 - d) negotiating safer sex;
 - e) fears of contagion;
 - f) the appearance of a first HIV-related illness (symptomatic stage);
 - g) maintaining antiretroviral treatment adherence and associated fears of failing treatment;
 - h) experiencing physical symptoms which signify illness progression (e.g., declining CD4 counts, increasing viral loads, development of antiretroviral resistance, the onset of an AIDS-defining illness, chronic pain syndromes); and,
 - i) awareness of functional disabilities or cognitive decline with disease progression).

6. Psychosis

- A psychotic disorder may occur at any time during the course of HIV infection and psychosis and HIV infection may co-occur due to chance. The onset of a psychotic disorder, such as schizophrenia, may precede HIV infection or the onset of AIDS.
- The likelihood of such co-morbidity has been demonstrated by several studies that found a substantial risk for HIV infection among severely ill psychiatric patients, including those with psychotic disorders (Cournos & McKinnon, 1997).
- One study found that psychotic HIV+ individuals had significantly higher rates of past stimulant and sedative/hypnotic abuse/dependence, suggesting that a past history of stimulant or sedative/hypnotic abuse/dependence is a risk factor for psychotic episodes in HIV-infected men. These men were also at risk for higher mortality (Prier, McNeil, & Burge, 1991).
- Several case reports have demonstrated the onset of a brief psychotic disorder following a severe psychological stressor in HIV infected patients. It is not known whether this reflects a greater risk of brief psychotic disorder in those with HIV infection, as compared to those without HIV infection. A variety of stressors-including personal or family illness, bereavement, disclosure of HIV seropositive status, medication

dilemmas, HIV testing, assault and child related problems-have been reported as precipitating factors for the onset of psychotic symptoms in patients presenting to an HIV service for psychiatric crisis.

- Psychotic symptoms may occur in the context of a cognitive disorder. Both HIV-associated dementia and delirium are important to rule out. Some medical conditions occur commonly in AIDS patients, and may predispose to psychotic symptoms in severe cases. These conditions can include pneumonia, dehydration and electrolyte disturbance (due to diarrhea), fever and infections, and may be associated with psychosis. A variety of opportunistic infections and neoplasms, and medications, including antiretrovirals, may increase the risk for psychotic symptoms. Substance use (alcohol, amphetamines, marijuana, cocaine/crack, hallucinogens, inhalants, PCP, sedative/hypnotics, and opiates) may predispose one to psychotic disorders, either as a direct result of intoxication or as a result of withdrawal.

7. Somatization & Hypochondriasis

- Typically, somatization refers to the tendency to amplify somatic symptoms of emotional distress and attribute them to physical illness in the absence of corroborating organic pathology. In HIV-related somatization, minor physical discomforts, nausea, or pain may trigger anxiety and heighten illness concerns or exacerbate the negative experience of relatively mild symptoms.
- Repeated body checking and palpating for swellings, discolorations, blemishes, and other bodily changes that are indicative of HIV-related illnesses can take on an obsessive quality.
- AIDS-related events, such as declines in immunologic markers, increased viral load, testing anniversaries, or illness among friends can serve as external cues for disease progression and contribute to somatization.
- Kessler et al (1988) found that HIV-seropositive gay men often underdetected recognizable symptoms of HIV-related illnesses, where only 9% to 14% of men who had medically diagnosed lymphadenopathy detected enlarged lymph nodes themselves. Similar underdetection occurred for fever and weight loss. Thus, not all patients with HIV infection become preoccupied with physical functioning and symptom checking. Many do not recognize actual illness symptoms because they lack awareness of their meaning or are unaware of proper methods of self-detection.

8. Anger and Guilt

- Anger is a common reaction to a life-threatening illness. Clients may focus on anger at the person who infected them, anger at the fact that they contracted HIV when others were less careful, anger at the government for not doing more to halt the spread of the epidemic, anger at the medical or pharmaceutical establishment for not doing more to develop and disseminate effective treatment.
- Guilt is a common reaction to sexually transmitted diseases. Self-blame, shame, and self-devaluation are among the first emotional responses to an HIV-positive test result (Chuang et al., 1992). These emotions often stem from beliefs about having engaged in behaviors that resulted in becoming infected, beliefs that HIV infection is a form of moral retribution or punishment, and beliefs about the social disapproval of others.
- Guilty feelings also arise in response to surviving when lovers and friends have died of AIDS. Guilt may arise when one is successfully treated for HIV/AIDS because many others fail. HIV-related guilt may fuse with internalized homophobia among men who contracted HIV through same-sex practices. Guilt is also enhanced by the social stigmas of drug-use behaviors.
- Guilt may arise from thoughts of having possibly infected others before or after testing HIV positive.

9. Sexual Functioning

- Sexual history, sexual self-concept, and sexual functioning play important roles in the overall adjustment of people living with HIV/AIDS.
- Substantial evidence shows that adolescents and adults who were sexually abused as children are at greater risk for HIV infection than those who did not experience abuse (Berenson, San Miguel, Wilkerson, 1992; Lodico & DiClemente, 1994)
- Wyatt et al.(2002) investigated history of abuse and other HIV-related risk factors in a community sample of 490 HIV-positive and HIV-negative African American, European American, and Latina women. Regardless of race/ethnicity, HIV-positive women had more sexual partners, more sexually transmitted diseases, and more severe histories of abuse than did HIV-negative women. Trauma history was a general risk factor for women, irrespective of race/ethnicity. The authors concluded that limited material resources, exposure to violence, and high-risk sexual behaviors were the best predictors of HIV risk.

- The success of HIV prevention messages for women may depend in part on addressing early sexual abuse, but few programs address the effects of abuse on sexual risk taking. Thus, recidivism to risky behavioral practices post-intervention may be an unintended consequence of the failure of prevention programs to include a full spectrum of skills that women need to cope with past experiences.
- There are numerous other sexual history factors that may have contributed to initial risks for HIV that carry over and affect the sexuality of people with HIV/AIDS (e.g., homophobia, commercial sex work, drug addiction, etc.). Because an individual's sexual history can be a source of guilt or shame, it is common for people living with HIV/AIDS to dissociate themselves from their sexuality or distance themselves from painful affects by anesthetizing themselves with alcohol or drugs during sex.
- Internalized AIDS stigmas and negative images of AIDS can become incorporated into one's sexual self-schema and persist for a long time because there are few opportunities for talking about these issues – even with therapists who are sometimes reluctant to discuss sex in an explicit way.
- Diminished sexual interest may be coincidental with depression or the disease process. Diminished interest can also arise from the association of sex with illness, disease, or death.
- Testosterone deficiency is frequently observed in HIV-seropositive men and is related to diminished sexual desire.
- Women living with HIV infection also experience a loss in sexual desire, with more than one third of women with HIV in one study meeting the diagnostic criteria for hypoactive sexual desire (Goggin, Engelson, Rabkin, & Kotler, 1997). For women, the loss of sexual desire seems less related to hormone levels than to fear of rejection, fatigue, relationship issues, and fear of infecting partners.
- In addition to hypoactive sexual desire, men and women living with HIV can experience other sexual dysfunctions as a consequence of HIV infection. For example, men may experience erectile dysfunction and women orgasmic dysfunction because of anxiety, distraction, or discomfort with sex (Hankins et al, 1997). Rosser, Metz, Blockling, and Buroker (1997) found that more than half of the HIV-positive gay and bisexual men in their study experienced negative effects of HIV on their sexual functioning including fear of sex and loss of erection.
- Across several studies with diverse populations, as many as half of men and women living with HIV infection report practicing unprotected

sexual behaviors that pose high risk for HIV transmission (Kalichman, 1998).

- Assessment of sexual risk taking involves examining a number of factors that have been associated with risk among seropositive men and women such as: relationship factors, economic conditions, emotional states, substance use, psychological control and behavioral inhibition, and willingness to disclose HIV status.
- Several studies suggest that unsafe sex is more frequent in primary relationships than in casual relationships (Doll et al., 1992).
- HIV seropositive men and women may engage in unprotected sex for money, drugs, or to meet other survival needs (Kalichman, Belcher, et al., 1998).
- Depression, anxiety, hostility, and fewer behavioral coping strategies all correlate with high-risk sexual practices among HIV-positive men and women (Kalichman, 1998)
- Alcohol and drug abuse are commonly associated with unprotected sexual behaviors among people living with HIV/AIDS (Kalichman, Kelly, et al., 1997)
- Impulsivity, high needs for sensation, excessive sexual-erotic ideation, manic episodes, and serious personality disorders all associated with high risk behavior among people living with HIV (Kalichman, Carey, & Carey, 1996).
- In the case of casual sexual partners, unsafe sex is more likely to occur with partners who are unaware that their partner is HIV infected, whereas condoms are used more frequently when a sex partner is known to be HIV infected (Wenger, Kusseling, Beck, & Shapiro, 1994)
- In many cases, unprotected sex occurs with another seropositive partner, posing no risk for new HIV infections. However, the risks in such cases are significant for re-infection with a more virulent or drug resistant variant of HIV. In addition, risks of co-infection with other sexually transmitted pathogens must be considered given the potential synergistic effects of viral infections in activating HIV.
- Use of protease inhibitors has also been associated with decreases in sexual interest and, among men, erectile dysfunction (Schrooten et al., 2001). When treating people living with HIV for sexual dysfunction, clinicians may seize this opportunity to discuss risk behaviors and attitudes regarding safer sexual practices prior to and during the resumption of sexual activity (Catalan & Meadows, 2000).

10. Quality of Life

- Most frameworks of health-related quality of life include sensory functioning, physical mobility, cognitive functioning, self-care and independence, degrees of pain and discomfort, energy level and emotional distress in their definitions of quality of life.
- Several variables have been significantly associated with quality of life in patients with HIV disease: (1) presence of symptoms; (2) stage of illness; and, (3) psychological distress (see Kempainen, 2001 for review).
- Questions that may be helpful in assessing a client's quality of life include:
 1. When did you find out that you are HIV-positive?
 2. How did you spend your time before you became HIV-positive? What was your typical day like back then? Who did you spend time with?
 3. Back then, how satisfied were you with your life?
 4. How do you spend your time now? What is your typical day like? Who do you spend time with?
 5. How satisfied are you with your life?
 6. How do you see yourself spending time in the future? What do you want a typical day to be like? Who do you want to spend time with? Are there people you would like to get to know better?
 7. How would you like to live your life differently in the following areas: job/career, education/training, social/recreation, spiritual, and volunteer work/advocacy? Would these things give you a greater sense of purpose in life? Would they bring you pleasure?
 8. If you were able to accomplish those goals, how satisfied would you be with your life?

C. Social Issues

1. Stigma, Discrimination & Disclosure

- Assessment of the clients' experiences with stigma, discrimination, and disclosure is critical for understanding the context in which the client operates.
- HIV-related stigmatization constitutes an epidemic in itself- an epidemic of fear, prejudice, and discrimination. AIDS stigmatization is fueled by misinformation about risks of HIV transmission, by concern about even the most remote possibilities of contracting HIV, by prejudicial attitudes against groups most affected by the epidemic (e.g., men who have sex with men, people of color, injection drug users and their sexual partners), by anxiety associated with the sexual and drug-using behaviors that

transmit HIV, and by diffuse fears more generally associated with sickness and death (Herek & Glunt, 1988).

- Social stigmas can become a source of chronic stress for people living with HIV/AIDS. People who experience repeated acts of discrimination can become bitter, hostile, suspicious, and alienated. HIV-related stigma can contribute to anxiety, depression, and interpersonal distrust.
- People with HIV infection who internalize stigmas experience greater emotional distress. For example, people who view their situation as a punishment for their behavior or a pervasive contaminant of their life are likely to do worse than those who focus on less stigmatizing attributions.
- Women with HIV must often care for themselves and their children, some of whom may be HIV-infected. Because HIV progresses at a much faster pace in children, they usually require extensive care early in their lives. The HIV infected mother is therefore often dependent on others for her own care as well as the care of her children. The isolation that families with HIV endure due to stigma serves to further increase the stress and peril they face.
- Comer, Henker, Kemeny and Wyatt (2000) explored the relationship between disclosure, mental health, and ethnicity in a sample of 176 women. Among the African-American and European-American women in the sample, disclosure showed no consistent relations with measures of depressed mood, anxiety, reported pain, or psychological distress. Among Latinas, however, greater disclosure was related to higher levels of depression, psychological distress, and reported pain.
- The Comer et al. (2000) results for Latinas tend to support a stigma model, which suggests that disclosure is associated with poorer mental health, perhaps through a sense of shame or feelings of increased vulnerability to negative reactions from others. It may be that compared to other women in the study, Latinas are more isolated from the larger community in which they live and also more reliant on family for basic support and living necessities. If that is indeed the case, it is understandable that the risk of rejection is higher because they have fewer people to turn to for assistance. Alternatively, Latin American cultures conceive of self more in terms of interdependence and thus they may be more concerned about placing burdens on important others.
- Ridicule, violence, housing eviction, loss of insurance, denial of health and dental care, loss of supportive services, and loss of employment are very real consequences for people living with HIV.

- HIV/AIDS is included under the Americans with Disabilities Act, which prohibits discrimination against “otherwise qualified” individuals. However, laws and employment practices vary across states, and those who suffer illegal termination outside of high-AIDS-incidence areas usually lack adequate representation and advocacy.
- People with HIV/AIDS may not disclose their HIV serostatus to providers for fear that they will be refused services or suffer other forms of discrimination that do in fact occur. For example, Marks, Mason, and Simoni (1995) found that 21% of men in their study had not disclosed their serostatus to any providers and that 11% of their sample had been refused treatment.
- People with HIV infection are prone to disruptions in their most intimate relationships because disclosures of HIV status do in fact lead to abandonment and rejection at times. For example, Pergami et al. (1993) found that 27% of HIV-seropositive women experienced changes in their social networks following notification of HIV infection and that nearly 66% suffered severe disruptions to their sexual relationships.
- H.A. Turner, Hays, and Coates (1993) found similar relationship conflicts in the lives of gay men with HIV infection, particularly among family members who were previously unaware of their sexual orientation.
- Disclosing that one is positive can mean simultaneously coming out with one’s sexual orientation, sexual history, or drug use history. Threats of social isolation and discrimination may keep people from disclosing their HIV-infection status, often cutting off potential sources of social support and increasing emotional distress.
- Crandall and Coleman (1992) found depression and anxiety were highest for people who had not disclosed their HIV status to anyone. However, individuals who had gone completely public with their HIV status were also highly distressed. Selective disclosure to close and trusted confidants was related to the greatest degree of emotional adjustment.
- The drawback of selective disclosure of HIV infection is that it divides one’s world into those who know and those who do not. Living a “double life” can be stressful as it often necessitates structuring interactions to minimize risks of disclosure, hiding medications, and covering up symptoms. This type of secretive pattern has the potential for amplifying and reinforcing pre-existing patterns of shame-based hiding that developed as a result of one’s sexual orientation or drug use.

- Disclosure is often difficult for HIV-positive parents because they fear their children will suffer harm from stigmatization of having a parent with HIV/AIDS.
- Parents and guardians sometimes find it difficult to inform HIV-infected children of their serostatus. This reluctance to disclose the child's diagnosis may come from a desire to maintain a sense of normalcy, to circumvent feelings of despair in the child, or to avoid having to tell the child of the parent's serostatus.
- A study of HIV-seropositive women showed that relationship partners were more likely to react with anger and emotional withdrawal than were family members and friends (Simoni et al., 1995). Of women who disclosed to partners, their partner abandoned one in five.
- Other studies suggest that disclosure does not always lead to abandonment. It is unfortunately not known which relationship characteristics best predict positive outcomes and how long partners maintain their support. Fears of abandonment, violence, loss of financial support, and other harsh reactions may serve self-protective functions and likely interfere with disclosing to partners, particularly among women.
- In a sample of Hispanic black and non-Hispanic black women, Simoni et al. (2000) found that disclosure rates were positively related to social support and more adaptive coping strategies (i.e., spiritual resilience, constructive cognitions, and community involvement).
- Questions that may be helpful in assessing a client's social support include:
 1. Have you disclosed your HIV status to anyone?
 2. Is there anyone who knows about your status and helps you to deal with day-to-day needs?
 3. How often do you have contact with that person?
 4. Is your contact with that person limited, or is it ongoing?
 5. Is this person similar to you in terms of age, gender, ethnicity, and HIV status?

2. Family, Friends & Intimate Relationships

A. General Considerations

- There is no typical family of the person with HIV disease. In defining the family context of the person with HIV disease, one must consider a more inclusive definition that may or may not comprise the biological family but definitely does include those individuals who functionally form the system of support for the

person with HIV infection (e.g., partners, friends, neighbors, health care providers, case managers, etc.)

- It is important to assess the family structure of persons living with HIV. Some people living with HIV disease have relatively stable family structures with established patterns of relating in which members stay involved and connected over time. Others have families that change in composition at various points in the progression of the disease - people are involved for awhile, drop out, and then different people get involved. Members of some family systems are well acquainted with each other and have ongoing relationships independent of the person living with HIV disease. For some, families may consist of a group of people who, were it not for the person's illness, would otherwise have little reason for being together.
- Assessment of families should target members attitudes about HIV and its impact, perceived changes in familial roles and responsibilities, perceptions of burden and the broader emotional response of family members, perceptions of support within the family and from those outside the family, family members' reports on the availability of information about the illness, and family members' perceptions about their access to health care providers.
- Patients and families often report problems of communication within the family with regard to HIV disease and its sequelae. Persons living with HIV report a range of concerns: feelings of burden, guilt, and discomfort with growing dependence, on the one hand, or anger that family members do not appreciate the extent of the illness and expect too much, on the other hand. Families similarly report a range of concerns about the patient's response to HIV, their own behaviors on behalf of the patient, and his or her efforts to manage the illness and adapt to its presence.
- A particular challenge for many families is the need to maintain a reasonable frequency of pleasurable activity in the face of the demands of living with HIV.
- When persons are living with late stage AIDS, it is important to assess family members' feelings of loss, grief, and guilt as well as the extent of planning around finances and advanced directives for medical care.
- Assessment of the family's role in adherence or nonadherence to medical treatment is often important.

B. Serodiscordant Couples

- The situation in which one member of the couple is HIV seropositive and the other is seronegative is increasingly common, especially in light of new treatments that have resulted in increased willingness on the part of many HIV negative individuals to enter into relationships with people who are HIV positive.
- One of the issues to assess in serodiscordant couples is the extent to which the need for safe sex creates an obstacle in maintaining a sexual relationship that is satisfying to both partners? Issues and questions to be explored include: (1) Is there anxiety or disagreement about the perceived risk of unprotected oral sex without ejaculation?; (2) Is remaining seronegative after in engaging in potentially unsafe behavior considered a justification for not using condom?; (3) Does the seronegative partner avoid the expression of concerns or fears in an attempt to protect the seropositive partner?; (4) Has the fact that the relationship has lasted for some time without HIV transmission led to the belief that the chances of being infected are reduced?; (5) Do beliefs about the primary importance of vaginal or anal intercourse pose a barrier for engaging in behaviors that are less risky?
- The seronegative partner may feel that their emotional needs are less valid than their partner's needs and thus avoid "burdening" their seropositive partner with their concerns. The seropositive partner may avoid telling the seronegative partner about physical changes or worries in a similar attempt to avoid being a burden. The consequence of this mutual protection can be emotional withdrawal or disengagement.
- Serodiscordant couples may have difficulty talking about the future in the face of uncertainty associated with the long-term efficacy of new combination treatments.

3. Quantity and Quality of Social Support

- A number of studies have found a strong relationship between social support and both psychological and physical concerns of persons living with HIV (Namir et al., 1989; Ostrow et al., 1989; Zich & Temoshok, 1987). In general, social support often acts as a buffer when people are in distress and it positively affects psychological adjustment, perceptions of health status, and overall well-being.

- The assessment of social support of a person living with HIV should include both quantity and quality. Quantity refers to the number of sources of support available to an individual and quality refers to whether these supports are accessible and satisfying.
- When assessing the quality of social support, it is important to consider three different types of support: emotional support, informational support, and instrumental support.
- Emotional support is delivered through affection, comfort, and encouragement and results in positive effects on self-esteem, feelings of self-worth, and a sense of belonging. A specific need for emotional support identified by people with HIV/AIDS is physical contact. When touch is avoided it clearly communicates fear and distance.
- Informational support, such as advice or updating knowledge, may help people interpret, comprehend, and cope with HIV infection. Uncertainties about HIV infection and the rapid development of new treatments can cause an urgent need to keep up with new information. Seeking information promotes a sense of control and can lead to more realistic expectations about the course of illness and the effectiveness of treatments.
- Instrumental support involves practical assistance with everyday needs. For example, assistance with shopping, housework, or cleaning may be particularly important in later stages of AIDS. It should be noted that the needs for and the availability of instrumental support change over the course of HIV infection and thus must be understood in the ever changing context of a client's health status.
- Fatigue, diminished self-esteem, physical disability, and illnesses restrict the ability to establish long-term supportive relationships. Becoming ill therefore creates barriers to accessing social support even when it is available. When HIV leads to hospitalizations, disabilities, unemployment, and fatigue, social support often diminishes and people become increasingly isolated. Support networks are also lost to emotional exhaustion and an inability to deal with anticipatory loss. People with AIDS must therefore seek support from multiple sources and find ways to replenish support as HIV infection advances.

D. Environmental Issues

1. Case Management

- As HIV increasingly moves into communities of poverty, a disproportionate number of persons who are homeless, have mental and

addictive disorders, lack experience in accessing services, and/or who are in jails and prisons are affected. Given these trends, the need for case management becomes profound.

- The Ryan White CARE Act has recognized the importance of case management and allocates a significant amount of its funding for case management. Unfortunately, some case managers have little time to manage their huge caseloads and in some areas there are no case managers. In such instances, the mental health providers must step into a more active case management role.
- Clients living with HIV often need a broad range of services including primary medical care, substance abuse treatment, financial assistance, housing, food, financial entitlements, clothing transportation, child care, dental care, and legal services.
- Patients living with HIV benefit when their mental health providers are actively involved with case managers in assessing the case management needs of clients. Once case management needs are identified, mental health providers are in an excellent position to further determine the client's capacity to follow through with potential referrals.
- If the client has a serious mental illness, HIV-associated dementia, poor communication skills, or is unfamiliar with the service delivery system, the mental health therapist should assist the case manager in assessing what types of support may be needed in order to help the client successfully access services. The client may need help figuring out public transportation systems, filling out forms, articulating his/her needs to service providers, figuring out who are the key gatekeepers for services and how to build relationships with them.
- Because persons with HIV often face a broad range of stigmatizing attitudes and actions when they attempt to access services, feelings of helplessness, hopelessness, and rage can take over. It is important to assess the extent to which such feelings interfere with accessing services and it is important to determine if the client requires advocacy on their behalf.
- Questions that may be helpful in assessing a client's current use of services include:
 1. Can you tell me about other services you use?
 2. What has it been like to use these services, now and in the past?
 3. How have these services benefited you?
 4. Do you have a case manager?
 5. How has he/she helped you?

2. The Health Care System

- It is important to assess whether the client accesses care through health maintenance organizations or traditional fee-for-service providers because such organizational factors might influence the number of primary physicians involved in the patient's care and the consistency of patient-physician contacts.
- The patient's ability to pay for health care is often an important consideration when one is evaluating the role of psychological factors in chronic illness. For example, insurance coverage can influence a patient's willingness to comply with recommended treatments, and compensation for related disabilities can exert an important effect on emotional adjustment, social and occupational functioning, and recovery rates.
- The health care system can throw up barriers to the effective participation of managing their illness. Transportation can be problematic, as can the fact that the potential cultural or demographic differences between patients and health care professionals may discourage patients from seeking needed treatment and from participating fully in their own care.

3. Immigration and the Psychology of Place

- As the HIV epidemic continues to spread in communities of color in the United States, especially in Asian American and Latino communities, issues relating to immigration status will continue to be important for AIDS service providers. Anti-immigrant sentiment sweeping the nation threatens immigrants with HIV/AIDS with disqualification from more and more essential health and social services.
- There are two critical issues raised by individuals with HIV about their immigration status. The first issue is whether their HIV status will prevent or, in a few situations, facilitate obtaining a more permanent immigration status. The second issue is whether their immigration status will prevent them from obtaining government benefits such as health and disability benefits.
- Although these immigration issues are often interrelated, it is important to discern which issues are of primary concern to an individual with HIV. In many cases, it may be easier and better to advocate for eligibility for certain types of benefits rather than seeking or waiting for a change in immigration status.
- An immigrant with HIV who recently found out about their HIV status may ask:

1. Will I get deported?
 2. Will I lose my immigration status?
 3. Can I work or get public benefits to help me if I need them?
 4. Will getting benefits make it hard to get another immigration status?
 5. If I can't work or get benefits, is there anything I can do to get another immigration status that will help me?
- According to Fullilove (1996) and others, the notion of place is a critical concept in understanding the environmental context of an individual, especially recently displaced people who left their homes or countries in search of work or a better life. Place refers to the immediate and intimate portion of a client's environment.
 - The psychology of place is based on the assumption that individuals strive for a sense of belonging to a place. This sense of belonging arises from the operation of three psychological processes: familiarity, attachment, and identity. Displacement ruptures these emotional connections. The ensuing disorientation, nostalgia, and alienation can undermine the sense of belonging in particular, and mental and physical health in general.

E. Spiritual Issues

- Winiarski (1997) expanded Engel's (1978) biopsychosocial model of assessment to include spirituality. Winiarski's decision to add spirituality to the model arose from the fact that many HIV-infected clients, in the course of their illness, reveal a desire to investigate their spiritual feelings. As Winiarski notes, a person diagnosed with a life-threatening chronic illness may come to realize that life is too short for trivialities. With crisis often comes a search for an anchoring, a deeper meaning.
- Winiarski recommends the following spirituality assessment topics:
 1. History of religious observance and current attitudes.
 2. Client's definition, explanation, and practice of spirituality.
 3. Are these beliefs comforting or a source of discomfort?
 4. Do the client's beliefs facilitate his/her capacity to deal with HIV or do they hinder it?
 5. With whom does the client discuss spirituality?
 6. What are the client's spiritual concerns?
- Unlike other life-threatening illnesses, HIV infection is associated with behaviors that are sanctioned by many religious institutions. People with HIV/AIDS may encounter reprehension rather than support when seeking spiritual guidance. Thus, it is not uncommon for individuals with HIV infection to seek new and alternative means of spiritual expression. It is important to assess whether a

client's new spiritual beliefs and practices create conflicts with long-standing beliefs forged during their early life.

- People with HIV/AIDS who have stronger spiritual beliefs often experience greater emotional adjustment (Somlai et al., 1996). Formal and informal religious practices may therefore provide a means of support that cannot be attained in other ways.
- Spiritual practices potentially provide multiple sources of comfort, including feeling connected to a higher power and the social support that can be gained from a spiritual community.

F. Substance Abuse Issues

1. General Considerations

- According to Zweben (1999), 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 can have an impact on HIV disease and psychiatric conditions. The combination of these three elements – substance abuse, psychiatric disorder, and HIV disease – presents mental health practitioners with the most complex clinical situation: working with “triple diagnosed” clients.
- Although problems in each area- substance use, psychiatric problems, and medical conditions - must be addressed, providers must prioritize treatment and define appropriate expectations for the client. A chronic amphetamine user, for instance, is unlikely to keep appointments for HIV-related care or to adhere to medication regimens and thus substance use treatment should be prioritized. On the other hand, a deeply depressed person may be unable to participate in the activities that promote sobriety, and a person with HIV-associated dementia may find himself or herself unable to maintain a previously well established sobriety.
- The most practical approach to distinguishing between addictive and other disorders is to establish an alcohol and drug free window for a circumscribed period of time and to observe the client's symptoms during this time.
- Clinicians need to understand how long after abstinence one can expect the effects of substance abuse to disappear. For example, among long-term methamphetamine users, psychotic symptoms may persist for months or years.

2. Provider Subculture and Systems Issues

- When traditional psychotherapeutic approaches were found ineffective to treat addiction, a number of alternatives developed outside the mainstream of mental health care. Although these new approaches proved to be productive, the process resulted in the artificial separation of psychotherapy and substance abuse treatment.
- Although many of the barriers to integrated care have been removed, they have left a legacy: (1) mental health and medical providers outside the alcohol and drug treatment system are often ill equipped to handle alcohol and drug use; (2) mental health practitioners often require substance users to seek addiction treatment before receiving mental health services but the addiction treatment system is ill equipped to handle the influx of triply diagnosed clients; and, (3) the addiction treatment system is largely organized for clients who understand from the outset that they need to do something about their alcohol and drug use and those who do not embrace this goal but who are interested in other kinds of medical, psychological, or psychosocial help often fall through the cracks.
- Providers are often confused about how to prioritize treatment tasks. For example, if a co-existing mental health disorder has a strong influence on a client's alcohol or drug use patterns, should that disorder be addressed first? Can a psychiatric disorder be effectively treated if a client continues to drink or use drugs?
- Medical, mental health, and substance abuse treatment systems each have its own goals, its own language, and its own set of assumptions that often remain unstated until conflict arises over how to address the needs of a particular client.
- Medical staff may label a former addict as “drug-seeking”-because he or she is using more pain medication than was prescribed – without taking into account the increased tolerance created by the drug addiction. On the other hand, medical staff may medicate an anxious patient as a way of decreasing office or telephone time spent reassuring them.
- Mental health providers often endorse a more holistic view and may be impatient with a physician's focus on a particular issue or symptom rather than on the general welfare of the client.
- Addiction counselors tend to be more comfortable making decisions and taking actions than the average psychotherapist, in part because the addiction treatment is usually highly structured, a feature that is objectionable to some psychotherapists.

- Most outpatient addiction treatment is abstinence oriented. Although total abstinence may be difficult to achieve, the goal itself does not usually vary, because abstinence is viewed as the foundation required before meaningful progress can be made on other issues.
- Psychotherapy, on the other hand, has a wider range of goals and less consistent priorities. Therapist may eschew abstinence as a goal in favor of a harm-reduction approach (Marlatt, 1998) and yet they may not be experienced with assessment or treatment using this model.
- Whereas addiction treatment makes alcohol and drug use the primary focus, mental health providers often explore underlying issues that can undermine sobriety by elevating anxiety before abstinence is firmly established.
- Frustrations may arise when addiction treatment providers have difficulty convincing mental health workers that a client's symptoms are typical of certain types of alcohol and drug use patterns rather than being "only" related to an emotional problem. On the other hand, mental health practitioners may object to what they see as a blanket labeling of a client as an addict when they believe the use is clearly initiated by emotional problems.
- Mental health workers may see refusal to treat someone who is actively using as abandonment, whereas some addiction treatment practitioners see continuing to provide treatment as colluding in perpetuating the addiction. Physicians, who are bound by an oath to treat everyone, have little understanding or patience for this conflict between mental health and substance abuse practitioners.

3. Assessment and Diagnosis

- According to Zweben (1998), interviewing a client about his or her drug and alcohol use history should include the following factors (for each drug): age at and circumstances of first use; date of last use; the typical patterns of use, including amounts, source of money to buy drugs, attitude of significant others toward use, and previous attempts to treat addiction. It is important to remember that mood has a strong influence on memory and thus can bias a client's reporting. For example, clients crashing from stimulant use will usually give a history consistent with depression; later, when their mood has improved, a different perspective will emerge. It is also important to ask about such issues as changes in work, mood, activities and sleep.
- One quick-and-dirty substance abuse screening method is the so-called CAGE questionnaire:

1. Have you ever felt the need to **Cut down** on drinking (marijuana ecstasy, GBH, crystal, Special K, etc.)?
 2. Have you ever felt **Annoyed** by criticisms of drinking (or your use of marijuana ecstasy, GBH, crystal, Special K, etc.)?
 3. Have you ever had **Guilty** feelings about drinking (or your use of marijuana ecstasy, GBH, crystal, Special K, etc.)?
 4. Have you ever taken a morning **Eye opener**?
- Because many clients are in denial about how drugs or alcohol are affecting their life, it is usually necessary to obtain collateral information (with the client's permission) from family, friends, or co-workers.
 - If it is clear that a psychological disorder coexists with addiction, it is useful-though often difficult-to determine which disorder is primary and which disorder is secondary. The primary disorder is the one that occurred first, and the object of this portion of the assessment is to establish the temporal relationship among clinical symptoms and other factors. For example, one might ask, "Can you tell me the first time you ever experienced depression? Were you also drinking at the time?" These distinctions are important because prognosis and treatment strategies follow the course of the primary disorder. For example, a person with a panic disorder who began drinking to reduce symptoms may be able to give up alcohol easily once the panic disorder is treated.
 - Zweben (1998) recommended the following assessment questions in attempting to make differential diagnoses between addiction-related and psychiatric-related disorders:
 1. Do episodes of substance abuse occur after an upsurge of psychiatric symptoms?
 2. Do psychiatric symptoms tend to occur only after episodes of substance use?
 3. Does substance abuse continue in the absence of psychiatric symptoms?
 4. Do the symptoms of mental illness return when psychopharmacological treatment for these symptoms is discontinued?
 5. Does the client's history suggest the development of a particular mental health disorder that was delayed or obscured by substance abuse?
 - It is important to remember that making personality disorder diagnoses in the context of substance use is particularly difficult. For example, of those voluntarily entering treatment, only a small number of clients will meet the criteria for antisocial personality disorder, despite the fact that

many may have anger management problems or engage in criminal activities such as drug dealing, prostitution, or stealing. Additionally, newly abstinent clients may temporarily appear narcissistic or grandiose.

G. Cultural Issues

1. General Considerations

- HIV/AIDS, like no other chronic illness, forces us to look at social issues and issues of difference. HIV/AIDS seems to have a way of “pushing every button” whether it be related to race, sex, reproductive choices, sexual orientation, death and dying, drug use, relationships, and many issues which are often at the heart of controversy. Winiarski (1997) notes HIV/AIDS “holds a mirror to the face of America and is not concerned about flattery” (p. 83). Thus, there is great potential for value conflict among clinicians working with clients living with HIV/AIDS. HIV/AIDS is a chronic illness which has greatly affected members of our society who have been “outcasts,” “minorities,” or “stigmatized.”
- Defining and clarifying the factors that influence the therapeutic relationship is necessary. Therapist self-exploration is a key component for a proactive approach to addressing these cultural factors in treatment. Key issues for therapists to consider include: helping relationships, communication styles, sexuality, reproductive issues, drug use, death and dying, and spirituality.

2. Family

- We all know the value of family and social support when dealing with a chronic illness, particularly one stigmatized like HIV infection. However, we often define family in terms of biological or marital relationship.
- For our clients family may include “non-blood kin” (Boyd-Franklin, 1989). These are often close friends of the family or people who are “like family” but not blood related. For homeless or runaway adolescents, family may become the youth with whom one shares an abandoned building as their home. Family may also include extended family members such as grandparents, aunts, uncles, etc.
- As therapists, we must understand how our clients define family and who is important in their lives. We may have to bend our frame for what family is and include “non-blood kin” as resources in the therapeutic process.

3. Helping Relationships

- Many cultures, both within and outside the United States, are unfamiliar with psychotherapy and counseling as it is taught in American universities and professional schools. Clients from other cultures often define helping or helpful relationships differently. Therapists may not be the first helpers clients seek. They may look to spiritual leaders for counseling and may continue to consult them even after consulting a therapist.
- Boyd-Franklin, 1989, points out that assisting a family with concrete needs or “real life problems” can be a means of joining with a family. A therapist’s interpretation of this behavior as resistance could be detrimental to forming a therapeutic alliance.
- Home visits: For many immigrant cultures, sharing meals is a source of bonding and a sign of accepting the host’s hospitality. For clients with HIV, sharing a meal gives one the opportunity to alleviate anxieties a client’s family may have about HIV transmission through casual contact. Clients may not discuss business until you are introduced to the family, share a meal or at least a beverage.

4. Communication Styles

- For effective counseling to take place, the therapist and client must be able to accurately and appropriately send and receive verbal and non-verbal messages to each other (Sue & Sue, 1990). Communication styles have a significant impact on face-to-face encounters, and culture is a powerful determinant of communication style, especially non-verbal communication.
- African-American clients may approach therapy with “healthy cultural paranoia” (Grier & Cobbs, 1968). This suspicion of a provider’s/system’s intentions has developed in response to generations of racism and discrimination in America. Many issues are considered private and not to be discussed outside the family. Clients may have learned, “What’s said in the house, stays in the house.” Initially, they may perceive the therapist’s questioning as prying into their “business” or family matters, such as drug use and sexuality, which are not normally discussed with strangers (Boyd-Franklin, 1989).

5. Sexuality

- Men who have sex with men represent a large percentage of AIDS cases in the United States. It is important to be aware of our own cultural and religious beliefs towards transgender, gay and bisexual people. If our

cultural and religious beliefs have strong biases regarding specific sexual orientations, we must address those issues.

- Cultural definitions of homosexual behavior vary. There have been several studies documenting a wide range of same sex behaviors for men that range from gay men defined as those who are effeminate, the “penetrated partner” or “bottom,” or dress as women or men who engage in all of these behaviors. These studies have also documented “masculine” men who are ‘tops’ or the penetrating partner being defined by their cultural norms as heterosexual. Many are married and have children. These same sex behaviors may not be considered homosexual or abnormal (Gant and Ostrow 1995, Carrier, Nguyen & Su 1992, Carrier and Magana 1991, Jue 1987).
- Most cultures also have strong beliefs and norms for male and female roles and relationships that may be in conflict with Western feminist or more egalitarian perspectives. However, HIV prevention strategies often encourage women to insist their male partners use condoms and to negotiate safer sex. In a culture where it is acceptable for women, the risk may be minimal. In Latino and Asian Pacific cultures, these behaviors may be viewed as insulting or inappropriate and could lead to verbal or physical abuse (Land 1994, Medrano & Klopner 1992, Amaro, 1995).
- In the United States, children become adults at the age of 18, yet laws vary on the age at which young people are “capable” of consensual sexual relations with an adult or other minors. Cultural norms also influence the “acceptable” age for sexual activity for young people. Our cultural norms and personal beliefs about sexual activity for minors may not coincide with our clients’ reality or their cultural belief systems.
- Many homeless youth engage in “survival sex.” Their sexuality becomes the means by which they sustain themselves and find a home for the night. They may even engage in high risk sexual behavior in order to get more money for their sexual favors. This behavior may cause some discomfort for therapists and force us to face the harsh realities of social issues such as ostracizing of gay youth.

6. Reproductive Issues

- The use of anti-retroviral treatments has reduced the risk of HIV-positive mothers transmitting the virus to their unborn babies. However, the long term effect of these drugs on infants remains unknown. Women need education so they can make informed choices about their reproductive choices and medical intervention during pregnancy.
- Despite the risks and possible complications, there are women who desire children with their HIV-positive partners in order to fulfill culture based marital obligations and personal desires, even if it means risking becoming HIV infected in the process.
- Pregnancy in HIV-positive women still carries some risk to both mother and child. Cultural and religious/spiritual beliefs may contribute to a woman's denial about the possible consequences to herself and her child should she continue a pregnancy without receiving HIV testing, information and good pre- and post natal care.
- Other cultural dilemmas arise when a woman with AIDS' health could be seriously compromised by a pregnancy, especially when the client's and therapist's views differ on abortion, the client's health and suitability for parenting, and whether or not to forgo Western medicine in favor of traditional or religious healing.
- Underlying these differences is the fundamental issue of whether the child's life under HIV circumstances is worse than not existing at all and whether the individual's procreative autonomy is valued higher than the impact that decision will have on others, including the child.
- Culturally based contraceptive choices also affect HIV risk reduction.

7. Drug Use

- It is important to examine our personal views towards drug users and whether we find some drugs more acceptable to use than others and whether we are therefore more accepting of clients who use these drugs rather than ones we view less tolerantly.
- Contrary to the total abstinence model, the HIV community often utilizes a Harm Reduction approach for treating drug users. Rather than deny services to clients still actively using drugs, many HIV agency providers will provide services along with risk reduction information. The goal is to modify the drug using behavior in ways that will reduce the risk of HIV transmission and enable the therapist to begin building a relationship with the client. This could eventually lead to abstinence or significantly reduced drug use but this is not the primary goal of the therapeutic

intervention. A risk reduction approach acknowledges that relapse could occur.

8. Death and Dying

- One of the areas that provokes some of HIV's greatest cultural challenges is death and dying. Quality of life versus longevity and control over the amount of pain and suffering the client endures can lead to intimate discussions about living with and dying of HIV related illnesses.
- Clients' coping mechanisms are often culturally based and may not always be compatible with the clinician's beliefs.
- Different cultures also have varying views on suicide and assisted suicide. Western culture has traditionally valued life over death, viewing life as sacred, while many Eastern cultures often view release from life as a goal to be sought (Albright & Hazler 1995). Suicide can be an honorable way to die. For some clients, it is an acceptable option that spares one's family from the shame of HIV and/or the undue burden of caring for the client in the later stages of illness.

9. Spirituality

- Spiritual and religious beliefs present unique challenges when therapists feel they are detrimental to our clients' well being. For example, how do we respond when clients that say they will trust God or traditional spiritual healers and rituals to cure them rather than seek conventional Western medical treatment? What if some practices such as the use of hallucinogenic drugs or animal sacrifice are illegal? Unlike most other issues clients bring to us, spirituality is based on faith and does not readily respond to logic or reality testing. Clients could question such interventions as religious intolerance or a direct challenge to their beliefs.
- It is especially important to suspend judgment when working with clients whose spiritual beliefs differ from our own. What is most helpful is learning as much as possible about the client's religious and spiritual beliefs and trying to frame interventions within the context of those belief systems.

H. Coping Skills

- Part of assessing a client's strengths is assessing their coping capacities.
- Lazarus and Folkman (1984) identified seven basic types of coping: self-control; cognitive escape-avoidance; behavioral escape-avoidance; distancing, planful problem-solving; social support seeking; and positive reappraisal.

- Lazarus and Folkman further grouped these coping strategies into two clusters: problem-focused coping and emotion-focused coping. Problem-focused coping includes thoughts and behaviors that actively seek problem resolution. Emotion-focused coping strategies are geared toward alleviating immediate emotional distress without directly confronting the source.
- Examples of illness-related problem-focused coping strategies include seeking information about the disease, calling others for help, and seeking medical advice and treatments.
- Examples of emotion-focused coping includes: selective ignoring, wishful thinking, blaming others, focusing on the positive, distancing, and acceptance.
- Both emotion-focused coping and problem-focused coping can be adaptive for people living with HIV. The key is applying the right strategies in the right situations. In general, problem-focused strategies are best when applied to situations and circumstances that are controllable while emotion-focused strategies are best in situations that cannot be controlled.
- In assessing a person's coping capacity, it is important to determine both the range of coping strategies in their repertoire and the extent to which they apply problem-focused strategies to situations and circumstances that are controllable and apply emotion-focused strategies in situations that cannot be controlled. Those who rely on just a few coping strategies and those who do not differentially apply coping strategies depending on the controllability of a situation fare less well.
- Additionally, people who cope well seem to be able to counter feelings of helplessness by focusing on small, discrete instrumental tasks that they can perform. Furthermore, they infuse these instrumental tasks with a sense of importance and thus derive meaning and satisfaction in everyday activities.
- People who cope well with chronic illness also display the capacity to put worries aside for circumscribed periods of time, note positive things going on in their lives, and enjoy themselves.
- Questions that may help in assessing a client's coping skills include:
 1. In the past, when you've had to face challenges, how did you respond? How did you cope? What personal strengths did you bring to the situation?
 2. How did you react when you first found out you were HIV-positive? How do you deal with it differently today than when you first found out?
 3. What do you do to make yourself feel better?
 4. What would make things more manageable for you? What has worked in the past? What hasn't worked as well?