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The Canadian Health Psychologist is produced by the Health Psychology section of the Canadian Psychological Association and distributed to all members of that section. It is designed to serve as a discussion forum for any issues of relevance to psychologists working in the area of physical health. The editor welcomes review articles, research and intervention reports, reports of events, letters, news of members, book reviews and announcements. Articles should ideally be no longer than 2500 words with about ten references. They should preferably include an abstract in English and in French. If possible, articles should be submitted on a computer disk.

The opinions expressed in this newsletter are strictly those of the author and do not necessarily reflect the opinions of the Health Psychology Section or of the Canadian Psychological Association, its officers, directors or employees. This is in no way affected by the right of the editor to edit all copy published.

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Le psychologue canadien de la Santé est produit par la section de psychologie de la santé de la société canadienne de psychologie et est distribué à tous les membres de cette section. Son but est de servir comme un agent de discussion pour des psychologues qui travaillent dans le domaine de la santé physique. Les articles revues, rapports de recherche et d'intervention, rapports d'événements, lettres, nouvelles des membres, des comptes rendus et des annonces sont le bienvenue chez le rédacteur pour soumission. Idéalement, les articles ne devraient pas dépasser 2,500 mots avec 10 références ou moins et, si possible, incluent un résumé en français et en anglais. Aussi, si possible, les soumissions devraient être présentées sur une disquette.

Les opinions exprimés dans ce bulletin son strictement ceux de l'auteur et ne reflètent pas necessairement les opinions de la section de psychologie de la santé ou la société canadienne de psychologie, ses officers, ses directeurs, ou ses employés. Le rédacteur a le droit d'éditer toutes soumissions.

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Les individus qui ne sont pas membres avec la section de psychologie de la santé s'abonner en envoyant 10\$ (payable à SCP Section de la psychologie de la santé).

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**THE CANADIAN HEALTH PSYCHOLOGIST/
LE PSYCHOLOGUE CANADIEN DE LA SANTÉ**
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Editorial/Éditorial

This issue of the Canadian Health Psychologist is the largest we have yet produced. The major part of it consists of a series of papers on psychological aspects of AIDS. These papers resulted, in part, from a special symposium on AIDS which was organised at last year's CPA conference in Charlottetown. They illustrate the wide involvement of psychologists in research into various aspects of AIDS and into caring for AIDS patients.

As a result of the special symposium a Special Interest Group of health psychologists working in the area of AIDS was convened. This group has now obtained funding from Health Canada to develop a special training package for psychologists. Some initial details of this work are contained in the article by Bruce Mills. In addition, further details will be made available at the I.U.P.S. Congress. This is a very exciting development and illustrates the increasingly important role that health psychologists are playing in healthcare.

The size of this special section required that other material in this issue was kept to a minimum. There is a brief summary of the work of the section over the past year. Further details will be provided at the I.U.P.S. meeting in Montreal.

Ce numéro du psychologue canadien de la santé est le plus grand que nous avons produit. La plupart de ce numéro se concernent avec les aspects psychologiques de SIDA. Ces articles sont le résultat du symposium sur le SIDA qui était organisé au congrès de SCP à Charlottetown. Ils illustrent la participation étendue des psychologues à la recherche sur les aspects variés de SIDA et au soin des gens souffrant du SIDA.

Par suite de cette symposium spéciale, un Groupe d'intérêt spécial sur le VIH/SIDA s'est assemblé. Cette groupe a obtenu des fonds de Santé Canada pour développer un paquet de formation pour les psychologues. Des détails préliminaires de ce paquet sont décrits dans l'article composé par Bruce Mills. En plus, des détails additionnelles seront annoncés au congrès d'U.I.P.S. Ceci est un développement excitant. Il démontre la contribution importante que les psychologues font à la santé.

Parce que la pièce spéciale était si grande, d'autres articles ont été réduits. Il y a un sommaire bref de la section durant l'année dernière. Plus de détails seront donnés au congrès d'U.I.P.S. à Montréal.

Michael Murray

Psychology and HIV/AIDS at The Toronto Hospital: A History of Clinical and Research Activities

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Over 12,000 cases of HIV infection, or approximately one third of the estimated total Canadian cases, have occurred in the Toronto area and the bulk of these cases have been distributed near Toronto's downtown core. The Toronto Hospital is the principal teaching hospital in the downtown area and it developed one of the first specialized clinics for AIDS care in Canada.

Since the early days of the AIDS epidemic, psychologists at The Toronto Hospital have been involved in clinical care and research with HIV/AIDS patients. Dr. Rosemary Barnes was one of the first Canadian psychologists to respond to the emerging AIDS crisis and her pioneering work helped to establish a precedent for psychologist involvement in multidisciplinary HIV clinics. In 1983, she began to provide psychological consultation to AIDS patients at The Toronto Hospital as well as to community groups. She also ran support groups for individuals with HIV infection. In addition to these clinical initiatives, she also took part in some of the earliest research into the relationship between mood and immune function in patients with HIV and she was involved with a community based research project about teaching safe sex practices. The project was very successful and 85 percent of the participants made positive changes in their sexual practices. In 1986, Rosemary left The Toronto Hospital to become Chief of Psychology at Women's College Hospital and she has since shifted to full-time private practice in Toronto.

I was hired at The Toronto Hospital in 1986. In 1988 I had an opportunity to design and initiate a group-based stress management training program for patients with HIV infection that taught a combination of breathing, meditation and self-hypnosis techniques. In 1989, Dr. Shelagh Emmott was hired as a full-time psychological consultant to the Immunodeficiency Clinic at The Toronto Hospital. In addition to providing general clinical service to HIV/AIDS patients, Shelagh also developed a specialized group-based cognitive therapy program to treat psychological distress in patients with HIV infection. As well, she has conducted clinical research in the AIDS area. For example, she worked closely with staff from Toronto's Hassle Free Clinic to develop a coping with HIV scale which assessed

capacity to cope with many domains of living with HIV. She also worked with Dr. Mary Fanning to develop an innovative HIV-specific quality of life scale.

Shelagh and I were both very interested in testing the efficacy of the treatment interventions that we had developed for treating psychological distress in persons living with HIV and related illnesses. This interest was further heightened by the recognition that many people living with HIV/AIDS at times feel a need for psychotherapy or counselling to help them cope with HIV-related distress and that these potential consumers of psychotherapy, and their physicians, were asking questions about which types of psychotherapy were likely to be beneficial and cost effective. Unfortunately, there were few clear answers to such questions in the late 1980's because very little research has been conducted on the usefulness of different types of psychotherapy for treating HIV-related distress.

During 1989 and 1990, Shelagh and I revised and pilot-tested our respective psychotherapy programs with the goal of submitting a research proposal to formally evaluate the efficacy of both interventions. I modified my original multi-method program and designed a stress management training program that was based exclusively on Mindfulness Meditation training and Shelagh further refined her Cognitive Behavioural Therapy program. The Psychology Department at The Toronto Hospital is very committed to clinical research and the Chief, Dr. Brian Shaw, provided crucial support and encouragement during this development phase of the grant. Dr. Don Layne, Vice-President of Research, also provided seed money for the pilot research.

In 1991, Shelagh Emmott and I were awarded funding by Health Canada to undertake a large psychotherapy outcome study which was designed to help provide answers for clients, clinicians, and policy makers who needed to know which types of psychotherapy could be effective for treating HIV-related distress. The project focused on two types of psychological intervention: Cognitive Behavioural Therapy and Mindfulness Meditation Training. Both of these types of therapy had been shown to be helpful for treating distress in general clinical applications and, on the basis of our pilot data, each therapy seemed promising as a treatment for HIV-related distress.

A standard, randomized, prospective clinical trial with three

month follow-up was used to test the effectiveness of the two types of psychotherapy. The control condition for the study was conventional medical treatment. A total of 243 men with HIV infection participated in the research. Two staff psychologists from The Toronto Hospital, Drs. Ron Davis and Christine Littlefield, led the cognitive therapy groups and two off-site psychologists, Drs. Ross Gray and Martin Rappaport led the meditation training groups. The group therapists followed a structured, manual-based protocol. Group treatment involved 9 weekly sessions of 2.5 hours each. Handouts and homework assignments were provided.

The results of the study indicated that both types of therapy, Cognitive Behavioural Therapy and Mindfulness Meditation, were effective at reducing psychological distress. Furthermore, this reduction in negative mood was stable at the time of the followup assessment, three months after the end of therapy. The two types of therapy did not differ in their degree of effectiveness.

This study showed clearly that two types of cost effective group psychotherapy can significantly reduce levels of psychological distress in men with HIV infection and related illnesses. The results further indicated that people living with HIV/AIDS can learn skills which help them to control the psychological effects of stress and reduce negative moods related to worries, anxiety and depression. The study was also important because it was the first randomized, prospective research which compared Mindfulness Meditation training against a potent, well validated intervention type, CBT.

In late 1995, Shelagh Emmott left The Toronto Hospital to work with Dr. Brenda Toner in the Women's Mental Health program at the Clarke Institute of Psychiatry. However, she has continued some involvement in the AIDS area. She is currently head of a CPA working group which is mandated to develop training materials and to provide training for mental health professionals who work with HIV/AIDS Patients.

Shelagh's replacement in the Immunodeficiency Clinic at The Toronto Hospital is Doug Saunders. In early 1996, he came to our department fresh from the University of Ottawa Clinical Psychology program. In addition to his thesis study of the factors contributing to effective adjustment to chronic pain, Doug worked with Vancouver-based massage therapist and counsellor Sequoia Thom Lundy, in developing a brief, body-oriented wellness training program for Persons Living With AIDS and HIV infection (PLWA/HIV), entitled Growing Positively Healthier.

The program combined relaxation training (simple breathing and stretching, progressive muscle relaxation, self-hypnosis and massage techniques), with exercises in meaningful living (emotional expression, meaning discovery, and goal setting) to

address issues of stress, future uncertainty and lack of control. The program was recently evaluated in a two year study of 200 participants from the National Capital and Greater Vancouver areas, funded by the (now disbanded) National Welfare Grants Division of Health Canada.

The results of the study were very encouraging. As a group, participants in the program showed significant improvements on standard measures of anxiety, psychological distress and wellbeing compared to those on a wait-list. Further analysis indicated that the impact of the program was most pronounced for those reporting the greatest distress. Slightly over 50% of this group showed clinically significant improvements. The results of this study suggested that this type of body-oriented wellness training has important potential for addressing the psychological needs of men and women who are coping with the a diagnosis of HIV/AIDS.

What does the future hold for Psychology's involvement with AIDS at The Toronto Hospital? Doug Saunders is now involved in additional work to expand his wellness program and identify the factors which contribute to success with the program. Doug and I are both interested in teaching techniques to HIV/AIDS patients to help them better cope with living this chronic, and usually life-threatening, infection and we will continue to develop and test psychological interventions. The Neuropsychologists at The Toronto Hospital will continue to provide assessment services for patients with HIV infection and brain dysfunction. As a department, we will also continue to provide specialized HIV clinical training to psychology predoctoral and postdoctoral interns.

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HIV Infection Survival Training Program: Building A Biopsychosocial Treatment Model*

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Abstract

Fifty HIV-positive individuals were trained in personal health skills workshops, including stress reduction and self-regulation, mood management, the organs and functions of the immune system, protected sex, relations with others, alcohol and recreational drug use, nutrition, and physical fitness. The workshops culminated in the development by each subject of written individualized self-care survival plans based on the workshop topics. Within 30 days pre- and within 30 days post-workshop participation, attitude, belief and behaviour measures were taken and will be repeated at 6-month, 12-month, and 18-month intervals. Clinical measures of immunocompetence and viral dormancy are simultaneously being gathered and include measures of CD4-CD8, antigen p24, viral load and symptomatology. The objective is to evaluate both subjective well-being effects and health outcomes of these interventions over time. By Fall 1996, 6-month follow-up data will have been gathered and analysis of these data will begin.

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HIV Infection Survival Training: Building A Biopsychosocial Treatment Model

While the prevalent belief among the general public, persons with HIV infection, and even the health care professional community, is that HIV infection is invariably fatal, some HIV infected people may remain well for long periods of time after infection (Kalichman, 1995; Kaiser, 1993). Much is quite well understood about the pathogenesis of HIV infection. Yet the variable course of HIV infection remains somewhat of a mystery: Why can some people harbor HIV for many years without obvious medical symptoms, while others rapidly develop opportunistic infection, dementia, and other secondary infections? It is generally acknowledged that a host of 'co-factors' are involved in determining the individual rate at which infection leads to collapse of the immune system (Gorman & Kertzner, 1990).

In an intensive psychoimmunologic, retrospective study of long-surviving persons with HIV infection (Solomon, 1987), specific psychosocial characteristics were observed to be common among long-term survivors. These characteristics include a broad range of behaviours from enduring coping styles, active participation in health care, positive goal-directed behaviour, communication ability, involvement with other persons with HIV infection, and healthful interpretations of this life-experience (Solomon, 1989).

There is growing evidence that psychological factors associated with wellness, such as sense of self-efficacy, reduced social isolation, and reduced depression, have an influence far beyond the subjective experience of the individual. An improved understanding of the role of immunocompetence (Angus, Fisher, Vigilante, Jesdale, Flanigan, & Carpenter, 1993) and of biopsychoneurosociological factors involved with this competence, are receiving more attention (Feinberg, Elbeik, Sinclair, Colbert, Volberding, & Buchbinder, 1993; Detels, Visscher, Kan, Hennessy, Wu & Giorgi, 1993; Titus, & Brunswick, 1993).

The Survival Training Program has evolved from several sources. Since 1990, attention has been given to the growing literature concerning psychosocial factors involved with long term survival with HIV infection and other chronic illnesses. Fevens (1991) developed a theoretical model for HIV health empowerment training from which many of the features of the design of the Survival Training Program have been drawn. The work of Solomon (1964; 1987; 1989) Temoshok (1983; 1988) and Kemeny (1989; 1990) and the attention they have given to the psychosocial factors found to be associated with long term survival with HIV infection have also significantly influenced the development of this program. More recently we have been influenced by reports of the clinical work of Kaiser (1993), particularly his experience with health promotion initiatives for people with HIV infection conducive to viral dormancy.

The Survival Training Program evolved, also, from an examination of pilot study data (Gee, 1994) which surveyed alcohol and cigarette consumption and depression and social isolation among HIV infected people in Nova Scotia. A majority of respondents were young adult HIV infected males who were socially and sexually active, consuming alcohol and cigarettes and unlikely to be familiar with the risks associated with unprotected sex. For example, research has proven (Karchmer, 1995) that HIV positive individuals can be and often are reinfected by other strains of HIV than the one that originally resulted in their HIV positive status. These findings, and the knowledge that there were no health skills development programs for PHA's in Nova Scotia, prompted the development of the Survival Training Program in this setting.

Some of the findings of the pilot study results were communicated to study participants and based on these research findings we posed questions to them, such as: 1) If a person chooses to stop or drastically reduce their level of drinking and smoking would this contribute to their long term survival? 2) If a person learned to manage and master difficult feelings and moods, like anger and depression, would this contribute to their long term survival? 3) If a person came to believe that it was realistic to view HIV infection as a chronic illness rather than a death sentence, and got the tools to live with such a chronic illness, would this contribute to their long term survival?

Program Description

The Survival Training Program recruited HIV-positive individuals from Nova Scotia to participate in psychosocial health skills training. The training objectives were: a) to decrease consumption of alcohol and other recreational drugs; b) to increase protected sex practices; c) to improve knowledge, understanding and use of immune enhancing behaviours; and d) to provide concrete biological evidence of improved immunocompetence resulting from positive behavioural changes.

Eight Survival Training workshops were offered, each lasting 3 hours. Five to ten participants were involved in each series of workshops and all workshops were completed between Mondays and Fridays of a given week. The workshops covered the following topic areas: a) Psychosocial Factors Involved With Long Term Survival; b) The Human Immune System; c) Stress Reduction and Self Regulation; d) Mood Management; e) Alcohol and Recreational Drug Use; f) Protected Sex; g) Conversation About Relations With Others; and, h) Development of A Personalized Plan for Survival.

Trainers/facilitators for the workshops were identified from a broad spectrum of expertise within the community. A number of health care professionals with expertise in specific subject areas were recruited as facilitators. Other facilitators were HIV infected people from the AIDS Coalition of Nova Scotia who had

particular workshop content and facilitation skills.

Workshop participants were a mix of ages, gender, sexual orientation, and length of time since HIV infection (from 1 month to over 10 years) and included recovering injection drug users, and hemophiliacs.

Our initial program development struggle was between the idea of saturating participants with information and skills versus a focus on HIV-related attitude and belief change. We chose in favour of an emphasis on the latter to change attitudes and beliefs away from helplessness toward self-efficacy, away from HIV as a death sentence and toward HIV as a serious manageable chronic condition. We believe this supports the main message of the program. Namely, a focus on changes in attitudes and beliefs - a paradigm shift - that gives rise to health habits and self-care behaviour changes and has a beneficial effect on health outcomes.

The Research

The effects of this program are being evaluated through prospective pre- and post measures of attitude, belief, behaviour and clinical measures. Measures of attitude, belief and behaviour include measures of self-efficacy, mood, life satisfaction, participation in health care decisions, health locus of control, health care **habits**, compliance with medical treatment, and substance use and protected sex inventories. Clinical measures include biological indicators of immunocompetence (CD4-CD8; viral load; antigen p24; symptomatology). Data points were set at pre-workshop, within 30 days of post-workshop participation, 6 months, 12 months and 18 months.

The Research Questions

The following are the overall research questions with which the program evaluation is concerned: 1) Will persons with HIV infection gain increased knowledge related to long term survival as a result of their participation in the Survival Training Program (STP)? 2) Will participant awareness of health promoting choices be enhanced by participation in the STP program? 3) Will increases in knowledge and choice awareness among STP Program participants be sustained over time? 4) Will participant mood, beliefs, and attitudes related to long term survival improve after participation in the STP Program? 5) Will changes in knowledge, choices, awareness, mood, beliefs, attitudes and behaviour translate into changed behaviour associated with long term survival? 6) Will changes in knowledge, choice awareness, mood, beliefs, attitudes and behaviour translate into establishment, re-establishment or continuation of viral dormancy? 7) Will changes in knowledge, choice awareness, mood, beliefs, attitudes and behaviour translate into long term survival?

Current Status

The Survival Training Program has trained 50 HIV-positive participants from urban and rural Nova Scotia. The overall level of satisfaction, as evidenced in post workshop questionnaires completed by the participants for each workshop, has been high. Six-month post-test data collection across the spectrum of attitude, belief, behaviour and clinical measures will be completed later in the Fall of 1996.

The research subjects training phase of the program was completed at the end of March 1996. The program is undergoing a transition from a research project to an ongoing activity of the AIDS Coalition of Nova Scotia.

The evaluation of the effects of the interventions, based on 6-month post workshop data, will be completed toward the end of this year. Subsequently, 12-month and 18-month data will be collected, analyzed and reported.

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Childhood Abuse and HIV Vulnerability Among Gay Men: Implications for HIV/AIDS Work

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While research on the impact of childhood physical and sexual abuse in society continues to develop, few investigations have examined the implications of childhood abuse in the gay male community and its vulnerability to HIV infection and disease progression. The limited research available on the subject, as well as the experience of community-based AIDS organizations, however indicates profound implications for gay men's health. Preliminary evidence reveals high rates of HIV incidence among adult gay male survivors of childhood sexual abuse as well as a host of related psychosocial and sexual dysfunctions. Strategies at both the community and governmental levels need to encourage new research on abuse and HIV vulnerability and incorporate these insights into HIV/AIDS prevention, education and support programming.

The Social Context of Abuse for Gay Men

The physical and sexual abuse of children is now recognized as systemic, with consequential damage to the physical and psychological well-being of abuse survivors throughout their adult lives. Few studies to date, however, have examined the incidence of childhood physical and sexual abuse in the gay community, and almost no research has been conducted on the implications of such abuse for vulnerability to HIV infection. This is at least partly due to the fact that gay men's health issues are rarely viewed independently of their heterosexual counterparts, despite evidence that gay men face a broad range of unique physical and psychosocial health problems. Detailed research in this area is desperately required, particularly given preliminary evidence linking elevated levels of childhood physical and sexual abuse in the gay community with extremely high rates of HIV incidence (Veiel, 1995).

The available research indicates that an underlying history of abuse does have implications for uninfected gay men, impairing their capacity to protect themselves from HIV. For gay men who are already positive, a history of abuse may make it difficult to make empowered health decisions and choices. Some studies

place the incidence of sexual abuse at between 2.5% and 9% for men, but because they do not differentiate on the basis of sexual orientation the figures cannot indicate the incidence of childhood sexual abuse among gay men (Finkelhor, 1984). Estimates suggest that up to 25% of the gay male population are sexual abuse survivors, but many community AIDS workers suggest a much higher figure, especially among sero-positive gay men (Cameron and Proctor, 1986).

The problem of childhood abuse in the gay male community is compounded by prevailing societal assumptions around the development of "appropriate" gender roles in children. Boys who do not conform to socially mandated heterosexual (male) standards of development and behaviour are more likely to be targets of abuse, and those who exhibit childhood behaviour perceived as effeminate are often subjected to intense parental and social pressure to conform.

Male children who depart from culturally inscribed assumptions surrounding masculinity and male identity frequently incur the anger and disapproval of parents and siblings, a reaction that can take the form of physical, verbal or sexual abuse (Filequeiras, 1994). These abusive home environments are part of a social context that make gay youth more likely to end up on the street; youth service providers in the US estimate that between 20 and 40 percent of homeless teens are gay, lesbian or bisexual (Burke, 1985; Filequeiros, 1994). Gay youth also attempt suicide in disproportionately high numbers, a reflection of how powerfully stigmatized homosexuality remains in North American society (Friedman and Downey, 1994).

Cultural stereotypes of men as the "dominant" sex also contribute to the under-reporting of abuse, both as children and adults; research indicates that males are less likely to report or acknowledge childhood abuse than females because it is psychologically more difficult for them to acknowledge a situation in which they were victimized and dominated (Finkelhor, 1984). The absence of a supportive social environment for gay men makes the possibility of acknowledging the abuse even more unlikely.

Adolescents who were sexually abused as children are 10 times more likely to share needles, and homosexually active adolescents are 7 times more likely to have been raped as children than heterosexuals (Lodico and DiClemente, 1994; Cunningham et al, 1994). In one study, 60% of adolescents identified in family practices as having histories of abuse were bisexual or homosexual (Johnson and Shrier, 1986).

Psychosocial Impact

Depression and reduced self-esteem are frequent long-term consequences of abuse, contributing to subsequent problems with obsessive-compulsive behaviour, alcohol and substance abuse and revictimization (Allders and Benjack, 1991). Among gay men, the pain from abuse is compounded by the social marginalization and exclusion faced by the gay community at large, resulting in a range of psychosocial and sexual dysfunctions. The sense of isolation gay male survivors feel can be compounded by an HIV diagnosis. Gay men with histories of abuse struggle with internalized problems of self-esteem and often experience substantial difficulty in establishing their self-worth and negotiating social and sexual boundaries. A recurring pattern among survivors of abuse is self-loathing and a willingness to blame themselves for the abuse and its psychological consequences.

Many survivors express difficulty in asserting their own wishes or desires in a sexual context and may seek out abusive relationships as adults. Sexual boundaries can become blurred, with survivors frequently not in control of the dynamics of sexual interaction. Abuse not only has a profound impact on the psychological health of the child, it also impairs the adult's ability to fully develop personal and emotional potential, thereby contributing to the cycle of revictimization.

How a history of abuse affects the health promotion of HIV positive gay men is a complex question. Gay men's health curriculums do not exist, and the limited sex education programs currently offered do not address abuse in the uninfected gay community, let alone the HIV positive population. Except in rare cases, HIV positive gay men have not received harm reduction messages tailored to their unique needs, and HIV/AIDS programs have not been designed to account for the experiences of gay men with histories of sexual abuse. An overall assessment of family health strategies is required before substantive changes in dealing with gay men's health issues can occur. The historic pattern of abuse does not occur in a vacuum: it extends from the family, to the community, and the broader social environment.

Epidemiological patterns reveal that women and young gay men are most vulnerable to HIV, and constitute the largest proportion of the newly infected. The second wave of AIDS also includes an increasing number of individuals who have multiple diagnoses: people struggling with mental illness, IV drug use, and alcohol and substance abuse. The likelihood that HIV

positive gay men will be disproportionately represented in these populations, particularly given the context of childhood sexual abuse, is strongly supported by the available evidence. The disinhibiting effect of alcohol and/or drugs has already been shown to increase the likelihood of high risk sexual behaviour, particularly given the mediating psychological factors of the abuse survivor: "Poor self-esteem is a behavioural modifier for both excessive substance use and risky sex, and depression will underlie and motivate both," (Veiel, 1995).

Confronting Abuse: HIV/AIDS Health Promotion Programming

The current social and epidemiological context of HIV/AIDS necessitates a fundamental re-evaluation of health programming for gay men at both the government and community levels. Childhood abuse is an important consideration when examining why gay men are at times unable to protect themselves and have problems negotiating safe sex or other harm reduction strategies. We need to look critically at the HIV/AIDS harm reduction messages and programs directed at HIV positive gay men: thrusting condoms into the hands of gay men does little to reduce their vulnerability to HIV infection. Much of the current AIDS education approach assumes that individuals are able to change their behaviour if condoms are available, that gay men are able to assert themselves in sexual situations, and that sexual partners will respect their needs.

AIDS educators talk about sexual behaviour in plain language, but rarely address the motivations and psychosocial dynamics that underlie high risk behaviour (Odets, 1994). We need to examine the social, political and sexual environments that increase vulnerability to HIV and be careful not to provoke harm with our assumptions. The discussion that needs to occur around the specifics of gay men's health issues will hopefully provoke a systemic re-orientation of HIV/AIDS prevention, education, support and care programming.

Sero-positive gay men who have survived abuse face isolation, chronic depression, and feelings of profound loss and hopelessness, thereby diminishing their capacity to assert control over their own health and make empowered health decisions. Many of those in advanced stages of AIDS face poverty and unstable housing in addition to a loss of independence, a situation which has additional impact on their psychological health and well-being. These factors significantly undermine the impact of HIV/AIDS programmes encouraging empowerment and self-care strategies.

Asking individuals with histories of abuse to take charge of their health, without the strategic programs, resources and supportive environments to enable this behaviour, may simply be asking too much. Seeking out and negotiating health care is often extremely difficult for survivors exhibiting dysfunctional and passive behavioural patterns. Accepting support can be equally difficult,

with most psychosocial support not adapted to the needs of HIV positive gay men. These factors make homosexuals highly vulnerable in care giving relationships. Physicians and other health and social service workers are often unaware of the implications that childhood abuse has for their patients and clients, and rarely integrate these issues into their standard medical workups and case management methodologies.

Revising Health Strategies

AIDS educators and care providers need to develop an awareness of abuse issues and reorient their policies and programs accordingly. All of the barriers to healthy sexual behaviour need to be examined, with special attention paid to the messages disseminated through HIV/AIDS harm reduction strategies. Community based AIDS workers need to be trained to recognize how a history of childhood abuse affects people living with HIV/AIDS and the community at large. Our work should acknowledge the social realities of the epidemic with research that investigates the effects of abuse at every level of the community. Federal and provincial AIDS strategies should also, as a central tenet of health promotion, mandate legislation that protects marginalized groups from the health-destroying effects of discrimination.

Progress can be made if gay male survivors of abuse are encouraged to step forward and share their experiences. Their stories must inform ongoing HIV/AIDS research and development strategies. Additionally, it will mean that expertise from other social science disciplines must be imported into the AIDS movement to create supportive environments that encourage survivors to tell their stories and to be heard. Public health policies will need to develop strategies that document the severity of the problem and its effect on survival and epidemiology. Failure to investigate and redevelop our knowledge of HIV/AIDS issues within the context of widespread childhood abuse in the gay population will undermine our own public health strategies.

Public health policy statements such as Population Health provide a framework for moving forward in recognizing the profound impact of health determinants outside the health care sector, and in identifying specific communities at higher risk for health problem (Strategies for Population Health, 1994). The devastation of the gay community by HIV and AIDS is only one indication of the profound effect social environment has on health. In addressing the 2nd Annual Home and Community Care for People Living with HIV/AIDS Conference, Harvard Professor Jonathan Mann noted, "in each society, those people who--before HIV/AIDS arrived--were marginalized, stigmatized and discriminated against--become those at highest risk of HIV infection (Mann, 1995). This knowledge has yet to be fully integrated in public health strategies, and sectors outside of health to date have given little heed to research which indicates

the "root causes" of illness are to be found in the social environment" (Mann, 1995). The social and economic costs of not addressing the social determinants of health need to be identified and communicated to policy makers at all levels in order to ensure the political response necessary to implement these changes.

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La démence associée au VIH et l'évaluation neuropsychologique

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Le virus d'immunodéficience humaine affecte le système nerveux central dès les premières phases de l'infection. Les changements observés ne sont cependant pas tous des signes de démence associée au VIH (DAV). Bien que les premières estimations soient aujourd'hui réévaluées à la baisse, le complexe de démence associée au VIH reste la complication neurologique la plus fréquente de l'infection (Navia et al, 1986a, Day et al, 1992). Outre les différentes infections opportunistes, la DAV est reconnue comme une complication distincte de l'infection au VIH. Le diagnostic de DAV est encore un diagnostic principalement basé sur l'exclusion d'autres encéphalopathies. Comme la DAV offre un tableau neuropsychologique typé, l'évaluation neuropsychologique joue un rôle prépondérant dans l'identification de cette condition. Le but de cet article est donc de clarifier le concept de DAV, d'abord sur le plan neuropathologique, puis sur le plan clinique, en la distinguant des démences de type cortical, et ensuite de mettre en évidence les enjeux neuropsychologiques qui s'y rattachent.

L'incidence de la DAV est difficile à déterminer, pour plusieurs raisons. D'abord, la définition même de la démence varie normalement d'une étude à l'autre. Les critères changeants de sélection des sujets, ainsi que les différentes méthodes d'évaluation et d'interprétation des résultats rendent les études peu comparables entre elles. De plus, l'introduction de l'AZT, qui retarde l'apparition des symptômes de la démence, influence les données. De 15% à 60% des patients en phase SIDA pourraient en être atteints. L'évolution de la démence s'échelonne de quelques semaines à quelques mois, avec une survie moyenne de 6 mois.

Neuropathologie

Le VIH évolue dans le système nerveux central, le liquide céphalo-rachidien et le cerveau, bien avant que les symptômes cliniques ne soient mis en évidence. Le virus ne semble pas s'attaquer directement aux neurones, ce qui permet de renverser les dommages, si les processus sont détectés assez rapidement.

La pathogenèse n'est pas encore claire, et le substrat qui la soutient est toujours matière à débat. Il est important d'exclure avant tout les infections opportunistes qui affectent le système nerveux central. Parmi ces infections, notons entre autre la toxoplasmose, le cytomegalovirus (CMV), la leucoencéphalopathie multifocale progressive, les néoplasmes et les tumeurs. Chacune de ces infections a sa propre marque clinique distinctive.

La démence associée au VIH est caractérisée par une destruction diffuse des cellules dans les noyaux diencephaliques, une destruction multifocale de la matière blanche ainsi que des structures sous-corticales. Les changements pathologiques se situent principalement dans les structures de la base, comme les noyaux gris centraux, le thalamus, le tronc cérébral (Navia et al 1986a). Une grande portion des fibres qui traversent et font synapse dans le diencephale sont des connexions afférentes et efférentes qui composent le système d'activation fronto-réticulaire, et sont responsables de la régulation et du maintien du tonus cortical. L'activation corticale, l'éveil, et l'attention sont intimement liées à l'intégrité de ces connexions. Un court-circuit de ces connexions aura un impact sur les aspects diffus de la cognition (efficacité du traitement de l'information, flexibilité mentale, etc.) (Cummings 1990).

Démences corticales et sous-corticales

Cummings (1990) distinguent les démences corticales des démences sous-corticales en impliquant les premières dans les fonctions instrumentales de l'activité humaine (langage, praxie, gnose) et les secondes dans les fonctions fondamentales (éveil, tonus cortical, attention, vitesse de traitement de l'information). Tant au niveau des indices neuropathophysiologiques qu'à l'examen des déficits cognitifs qui la définissent, il semble que la DAV s'inscrive dans la famille des démences sous-corticales. Cependant, il ne faut pas oublier que la formation réticulée ascendante et descendante a des projections diffuses ainsi que des projections spécifiques à des régions corticales définies. Il est trop simpliste de conclure qu'une atteinte sous-corticale n'influe

pas sur les fonctions mentales supérieures. Le cortex cérébral reste toutefois relativement préservé dans ce type de démence. Les symptômes d'implication corticale sont d'ailleurs peu fréquents. La DAV s'apparente donc plus aux démences de type Parkinson et Huntington, qu'aux démences associées à la maladie d'Alzheimer, démence franchement corticale.

Implications cliniques

La DAV est associée à une triade de déficits moteurs, cognitifs et comportementaux. Au niveau moteur, on note des tremblements, des difficultés à effectuer des mouvements répétitifs de façon rapide, des pertes d'équilibre, de l'ataxie, une hypertonie, une hyperreflexie, des déficits de poursuite oculaire et de saccades. Les anomalies comportementales se traduisent par de l'apathie et du retrait social.

Les cognitions des personnes atteintes de démence sont aussi affectées. Le DSM-IV définit la démence comme étant caractérisée par le développement de multiples déficits cognitifs incluant des déficits de mémoire, accompagnés soit d'aphasie, d'apraxie, d'agnosie, ou de déficits des fonctions exécutives (pensées abstraites, planification, initiation, séquence, modulation et arrêt de comportements complexes, etc.), causés directement par des effets physiologiques d'une condition médicale générale, des effets persistants d'une substance, ou par de multiples étiologies. Dans le cas spécifique de la DAV, on remarque une absence d'aphasie, d'apraxie et d'agnosie. D'ailleurs, des problèmes de cet ordre suggèrent plutôt une infection opportuniste autre que la DAV, chez les individus atteints du SIDA.

Les phases initiales de la DAV sont caractérisées par de légers ralentissements psychomoteurs, de la lenteur de pensée (bradyphrénie), ainsi que des troubles de mémoire et d'attention. À ce stade, la DAV peut facilement être confondue avec de la dépression. On remarque cependant l'absence de dysphorie, et l'inefficacité des antidépresseurs. Alors que la sévérité de la démence s'accroît, les signes deviennent de plus en plus marqués.

Les déficits de mémoire peuvent prendre différentes formes pour différentes pathologies. Chez les patients atteints de DAV, la mémoire récente semble déficitaire. Les souvenirs lointains restent bien préservés. Ces patients démontrent aussi des déficits de récupération d'information plutôt que d'apprentissage ou d'encodage tel qu'indiqué par leur performance aux tâches de rappel indicé. En considérant les circuits neuronaux affectés, il est peu surprenant de constater des déficits de la mémoire procédurale plus marqués que les déficits de mémoire déclarative. Ces patients conservent le savoir, les souvenirs nominaux (dates, lieux, etc.) mais ont une performance plus faible aux épreuves de savoir-faire.

Les patients démontrent des difficultés aux tâches qui exigent de la vitesse mentale, de la flexibilité, de la spontanéité, un contrôle des mouvements fins, et de l'intégration visuo-motrice. Comme la réduction de vitesse de traitement de l'information est une composante majeure du tableau neuropsychologique, les tâches chronométrées seront les plus sensibles (Navia, 1990, Lezak, 1995).

Enjeux neuropsychologiques

Il est de première importance d'être en mesure d'identifier les signes précoces de la DAV, et ce, pour plusieurs raisons. Ce type de démence s'est avérée sensible au traitement à l'AZT. Son diagnostic influencera donc le plan de traitement médical. Une approche plus agressive sera privilégiée, espérant ainsi ralentir l'évolution de la sémiologie. L'évolution documentée de la DAV représente alors un excellent indice de l'efficacité du traitement de la zidovudine (Portegies et al, 1990). Il reste à déterminer à quel point l'intervention précoce aura un effet bénéfique à long terme sur la qualité de vie de l'individu. L'évaluation de la DAV fournit en plus un outil précieux de l'évolution de l'infection. Les indices cliniques de la DAV engendrent une détresse psychologique chez les patients, ainsi que dans leur entourage. La DAV influence les activités de la vie quotidienne et doit être présentée et expliquée au patient, le cas échéant. Il peut même parfois s'avérer nécessaire de modifier l'environnement de certains patients, pour l'adapter à ces capacités limitées.

À l'heure actuelle, les batteries neuropsychologiques sont souvent trop longues à administrer pour être utilisées de façon systématique dès qu'une démence est soupçonnée. Quant aux outils de dépistage de la démence traditionnellement employés, ils se sont avérés inefficaces pour détecter les signes légers de la démence (Mc Arthur, 1987). Ceci peut être dû au fait que le plus populaire de ces examens, le Mini-Mental State Exam (Folstein, Folstein, & McHugh, 1975) a été développé spécifiquement pour une autre encéphalopathie, nommément la démence d'Alzheimer, qui présente un tableau neuropathologique totalement différent en raison des régions corticales touchées, et de l'âge typique des patients.

Pour suivre l'évolution de la DAV chez une personne atteinte, il faut prévoir qu'éventuellement, cette personne, au stade SIDA, sera peut-être confinée au lit. C'est pourquoi l'évaluation neuropsychologique devrait être composée de tâches faciles à administrer au chevet d'un patient alité. De plus, une telle évaluation devrait offrir la possibilité d'être répétée plusieurs fois, sans grand effet d'apprentissage. De cette façon, l'évolution de la démence sera bien documentée. Nous travaillons en ce moment à un tel outil de dépistage précoce de la démence.

Populations particulières

La population séropositive est hétérogène, et porte en elle des défis au niveau de l'évaluation neuropsychologique. Différentes

clientèles méritent des considérations particulières. En ce sens, les cliniciens doivent porter une attention spéciale aux patients toxicomanes, ainsi qu'aux enfants atteints. Il semble d'ailleurs que l'incidence de la DAV augmentera chez ces deux populations très distinctes dans les prochaines années.

Il est bien documenté que les toxicomanes, qui sont la population à risques à plus haut taux de croissance, offrent un portrait neuropsychologique particulier. Mises à part les séquelles permanentes de l'utilisation de drogue sur le système nerveux central, ces patients se distinguent pour plusieurs raisons. Ils proviennent souvent de milieux socioculturels défavorisés, et ont souvent des antécédents médicaux psychiatriques, et neurologiques. De plus, il peut s'avérer difficile d'obtenir leur collaboration pour la passation des épreuves.

Chez les enfants, les infections opportunistes du système nerveux central sont plutôt rares. La DAV est une conséquence plus fréquente de l'infection que chez les adultes. Tout comme la population des toxicomanes, la population pédiatrique impose des contraintes particulières à l'évaluation neuropsychologique. Ces enfants proviennent aussi de milieux socioculturels défavorisés, et à cela s'ajoute le grand isolement dans lequel sont tenus ces patients. Les hospitalisations fréquentes non seulement les sous-scolarisent comparativement à leur pairs, mais les isolent socialement. Il est donc important de tenir compte de ces variables.

Beaucoup de zones grises doivent encore être clarifiées. La DAV reste un concept en évolution. Il est important d'aborder cette problématique de tous ces angles, neurophysiologique, neuropsychologique et neuropsychiatrique, en utilisant tous les outils à notre disposition. De plus amples recherches doivent être faites, notamment au niveau de l'identification précoce des signes de DAV. Les recherches en cours, dans les différentes spécialités nous feront converger vers un portrait définit de la DAV, pour éventuellement augmenter le mieux-être des patients.

Bien que l'incidence de la DAV soit matière à controverse, les conséquences sont suffisamment perturbantes pour nécessiter une compréhension claire de tous les professionnels et intervenants qui entourent les patients.

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Women Living With HIV/AIDS: Re-Examining Lives

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The major findings of a two-year project on women living with HIV/AIDS are summarized. The purpose of this work was to explore the nature of identity renegotiation in HIV-positive women. In other words, the focus of this research centers primarily on the following question: How has the experience of becoming infected affected women's understanding of who they are? This adoption of an identity perspective departs substantially from current psychological practices in this area. Thus, a brief review of current research methodologies and theoretical perspectives that guide and constrain psychological research on HIV-positive women is first presented.

The culturally dominant image of the person living with HIV/AIDS continues to be that of a male, notably a gay male, despite the following facts: AIDS cases among women have been reported since 1981 (e.g., Ellerbrock et al., 1991; Corea, 1992); over 24,323 women are currently diagnosed with AIDS in the United States (Centers for Disease Control, August 1992) and 100,000 are HIV-infected (CDC, 1995); and women proportionately comprise the fastest growing group of HIV-infected individuals (e.g., Ickovics & Rodin, 1992).

Psychology's involvement in HIV/AIDS research, education and prevention efforts began very early, "more quickly than for any other major health issue" (Backer, Batchelor, Jones, & Mays, 1988, p. 5). These initiatives, however, largely excluded women. In a recent extensive review of empirical research on the psychological impact of HIV/AIDS (Kalichman & Sikkema, 1994), the majority of the studies cited focused either exclusively or predominantly on men. Only one study examined the experiences of HIV-positive women and here the emphasis was on psychiatric morbidity (Brown & Rundell, 1990). Four additional recent studies have specifically examined the psychosocial experiences of seropositive women (Brown & Rundell, 1993; Commerford et al., 1994; Pergami et al., 1993; Semple et al., 1993). The predominant methodological practices in all four studies emphasize psychiatric diagnoses to the exclusion of descriptions of how women render their seropositive experiences meaningful. The women's experiences are explicitly labelled as stressors and the only available options within such a circumscribed structure include the adoption of "adaptive" and "maladaptive" strategies, both of which are rigidly defined by the psychological corps.

The relevance of such work notwithstanding, it is limited on both theoretical and methodological grounds. First, work in this area is largely a theoretical -- little attempt is made to generate conceptual frameworks explaining women's experiences of living with HIV/AIDS. If there is one conceptual perspective that characterizes most of this work, it is the psychopathology orientation towards behaviour and experiences. This focus on intrapsychic (and frequently axiomatically pathological) processes obscures the fact that illness is not merely an individual reality to be reckoned with: Each medical diagnosis also confers a particular "sick role" on the patient (Quam, 1990) which, in turn, signals the onset of a complex interplay of social and personal relations (Sherwin, 1992).

Second, the reliance on standardized scales does not permit an exploration of how the experience of becoming HIV-positive might result in a change in women's understanding of who they are. Standard questionnaires also tend to obfuscate the very real contradictions, conflicts and mutable realities that constitute the essence of individuals' accounts of their experiences (Billig, 1987 cited in Murray, 1994). These complex "interpretations of the world are washed out or concealed in the typical averaging of responses" (Murray, 1994, p. 34). Nor does this approach address such issues as how women actually live with HIV/AIDS and how they interpret and integrate the ubiquitous culturally-constituted meanings about HIV/AIDS (Squire, 1993). And finally, the importance of both the historical and more temporally immediate conditions within which the women live their lives is ignored.

The subjective complexity of HIV-infected women is particularly vulnerable to distortions, omissions, and erasures within AIDS discourses, given their simultaneously "under- and overgendered nature" (Squire, 1993, p.5). Women are alternately ignored and implicated: in some instances, when gender is viewed as irrelevant, they are conspicuously invisible and in others, they are subsumed under, at best, simplified and imprecise categories (e.g., "partners of" HIV infected individuals) and, at worst, under misleading and stigmatizing categories (e.g., "vectors of transmission"). The scripts available to women in existing discourses on HIV/AIDS also tend to dictate narrowly-defined prescriptive categories which preclude identification with other women living with HIV/AIDS (Squire, 1993).

Representations that reflect accurately women's multiple and variable experiences of seropositivity can only be derived from discourses grounded in research efforts that are directed at exploring the contradictory, mutable, shifting subjectivities of life with a chronic illness.

This begs the question of how an HIV diagnosis can be meaningfully situated in the context of an ongoing life story, since this one event is mapped onto an existing continually unfolding script of one's life. What is needed are methodologies and theoretical frameworks that capture this reinscription of the self in process. In other words, the adoption of an identity perspective is suggested. An appropriate methodology for capturing such transformative possibilities can be found in qualitative research (for reviews see Denzin & Lincoln, 1994; Tesch, 1990); in particular, the focused interview method. Conceptualizations thus derived, taken together with existing personal testimonies (e.g., O'Sullivan & Thomson, 1992; Rudd & Taylor, 1992), represent more than just portraits, textual still-lives or even accurate recountings of real experiences -- collectively they have the potential to contribute significantly to an existing and a continually revised cultural text of HIV/AIDS, a text that is currently lacking much of women's reality.

In the present study, living with an HIV diagnosis was reframed as a dynamic process of renegotiating one's identity within one's social and medical spheres. This process inevitably entails a re-assessment of "one's life story" (Gergen & Gergen, 1983), an active renegotiation of one's identity. Semi-structured interviews with 13 HIV-positive women formed the basis for extracting the relevant psychosocial and identity issues from the women's narrative accounts of their illness. The women's health status ranged from asymptomatic seropositivity to full-blown AIDS (in two cases). They ranged in age from 25 to 57 ($M=38.9$; $SD=9.8$). The grounded-theory approach proposed by Glaser and Strauss (1967) was used to identify the relevant identity - transformation issues. The grounded-theory method is an inductive data-analytic technique which permits theory construction in areas that are not easily accessible via traditional research methods (Rennie, Phillips, & Quartaro, 1988).

Although each woman's experience is decidedly unique in many respects, identifiable common themes connected all the stories. Because the primary aim of this work is to develop a conceptual representation which is closely linked to the unique contribution of each participant (and for brevity's sake), only the commonalities will be addressed here. A recurrent theme that appeared across all of these narratives is contradiction and duality of existence. This pattern was subsumed under the core category: Existence in Multiplicitous and Polychronic Realities. The women exist in multiple, mutable realities that transcend temporal boundaries: their accounts are suffused simultaneously with ambiguity and certainty, acceptance and disavowal, hope and hopelessness, living only in the present and reconciling the

future, appeals to science/medicine and theistic/spiritual invocations.

Life in these seemingly oppositional realities exhorts the women to engage in an accelerated and continually shifting traversal through past, present and future. In most cases, this itinerant trajectory begins long before the medical diagnosis is rendered. For instance, although nearly all the women reported initial feelings of shock upon discovering their seropositive status, all but one also indicated that the diagnosis was simultaneously a confirmation of previous suspicions, hunches. In most cases, these expectations were based on signals from the body connected to previous behaviours or events. This is clearly illustrated in the following excerpt from a 26-old woman whose seropositivity was diagnosed five years prior to the interview, but who contracted HIV at least three years earlier:

"I had 6 or seven tests and I wanted to have one more. I just wanted to confirm that I have AIDS. I had every test in the book. Ok, I had about five tests between 1987 and 1989. All of them came back negative, but I'm SURE I was positive when I was 17 or 18 years old.... I knew, I knew exactly. I used someone's needle who had AIDS and I knew he had AIDS. I didn't even bother to clear it. His blood was still in it."

Although the medical diagnosis was not received until a few years ago, the initial movement towards a new way of thinking about the self began in the preceding several years. These movements are in most cases tentative, reluctant and frequently unarticulated until much later, but they, nonetheless, represent an incipient progression towards a shifting identity. This progression becomes considerably more pronounced, and to varying degrees, accelerated once the test results are obtained.

The women's subsequent work focuses on the maintenance of an intact former identity and the assimilation of the continually transforming self. A pervasive theme articulated by all the women is this sense of being fundamentally the same but yet significantly changed. This duplicitous self-regarding is accomplished, in part, by maintaining the precarious balance between accepting the diagnosis and integrating it into an understanding of oneself, while simultaneously recognizing the utility of denial in the day-to-day pragmatics of living. For instance, this woman who is very public about having AIDS and is very active in AIDS education and policy efforts all over North America says:

"I locked myself up, unplugged my phone, pulled the blinds down, didn't answer the door and went through hell for six weeks. I'm really glad I did that -- it was hell, I thought I was going to die from the pain, the emotional pain, but I didn't have the years of conflict with it. I accepted it a lot faster than a lot of people do, um, and then I started telling people."

And later she adds:

"It's [AIDS] a part of my life,... it's not all of my life, although as you get sicker, it becomes more a part of your life, it constantly changes, like the ebb and the flow, it constantly changes,... sometimes my answering machine will say, 'hi, if you're calling about AIDS, I don't want to hear about it today, call back tomorrow, and they say 'oh, she's having a necessary day' [days she doesn't think about AIDS]."

In this way, then, the significance (and presence) of this event in the women's lives is alternately amplified and diminished, as they continually modulate its magnitude.

Within this context of identity renegotiation, disclosure of one's positivity is a key component of preserving the integrity of the self. This new status needs to be asserted not only privately and medically, but also in the women's social sphere. In other words, the act of disclosing and subsequent responses to that information must be incorporated into the emerging revised self-schema. The sanctions against disclosure, and hence, the precise conditions under which such public acknowledgment occurs, vary from woman to woman, and are dependent upon the particulars of her individual sensibilities, her social, familial and economic realities. It is, clear, however, that the continuity of self is sustained dialogically, as the self "is at once decentered and reauthorised" (Kohlberg, cited in Day & Tappan, 1995, p. 47).

The women's identity work is the inevitable result of an ongoing ontological reassessment, accentuated by urgency of reconciling living and dying. There is strong evidence that women's various experiences and transformations all serve to maintain an intact identity. There are multiple threats and disjunctures along that path, but they manage to create spaces which not only maintain the integrity of their identities, but which also gesture towards an enhancement of self. The avoidance of such work would, essentially, eventuate in ontological erasure.

In summary, the exigency of recasting the issue of women living with HIV/AIDS in terms of identity work is dictated by the absence of adequate representations of these women and by the need to question the ethicality "of reducing the fear, pain, joy, and urgency of people's lives to analytic categories" (Lather & Smithies, 1995, p. 100), which is the *modus operandi* of current psychological approaches in this area. Additionally, because language is more than a representational system, because it is also agency and possesses social and political potency (e.g., Foucault, 1972; Shotter, 1993), a lexicon grounded in women's own accounts of their experiences of life with HIV/AIDS has far-reaching implications not only for accurate biographical and historical accounting, but also for medical interventions, as well as policy, advocacy, and educational initiatives. In other words, such "an epidemiology of signification" (Treichler, 1988, p. 68), consisting of a multiplicity of meanings based on women's voices

can powerfully influence subsequent research, policy and social practices. As Treichler (1988) suggests, accurate readings of stories of HIV/AIDS and the development of relevant interventions can only begin once AIDS is understood as "both a material and linguistic reality" (p. 40). For women, the production of this linguistic or textual reality of living with HIV/AIDS is still in its nascence.

It is suggested that the most appropriate methodology for capturing the self as a dialectical builder is the focused interview and subsequent narrative analysis of the content (guided by grounded theory, as one possible alternative). In other words, methodologies and conceptual frameworks are needed that neither valorize nor pathologize HIV-positive women, that capture the "ordinariness" (O'Sullivan & Thomson, 1992), of these women as much as movements beyond the prosaic. And finally, reframing HIV experiences of women as identity altering will contribute to research on HIV positive women by developing a theoretical framework of life with HIV/AIDS and a discourse about identity renegotiation. The goal of such research is to provide an alternate way of talking about the illness experience and engaging the experience of illness in a way that does not provoke new kinds of suffering.

Note: The conceptualization of chronic illness as "identity altering" is explored extensively by Mathieson and Stam (1995) in their examination of the experiences of cancer patients. The theoretical and methodological approach used in my own research is greatly inspired by their work (see also, Mathieson, 1993).

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HIV/AIDS Psychotherapy - What Psychologists Need to Understand

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with contributions from Frederick Haineault and "J.E."

Dealing With Diagnosis

Most people discovering they are HIV-positive quickly learn that they are not experiencing just a physical problem - complex mental, emotional, and spiritual aspects influence the quality and direction of daily life lived through the filter of HIV. Usually it turns out that it is not AIDS itself that is the problem (i.e., its medical definition), but rather what AIDS means inside one's mind, feelings, and spirit, as well as in the reactions of others. Such psychosocial factors accompanying an HIV diagnosis have much deeper influence than medical symptoms on the path each person's journey will take during the time they are living with the virus and trying to make sense out of it all.

"My very first response to being diagnosed with HIV was immediate and emotional: I burst out crying... That's certainly not the kind of response that I was used to having. I wasn't used to showing a lot of emotion in my life. I come from a background of abuse and I learned to shut my emotions off, [so] this immediate response was very surprising to me, but also I guess very necessary" [F.H., p. 1].

"Ten years ago I tested positive and was told to make my will because I was going to die.... The news I got that day has changed my life forever, and I wake up each day knowing it." [J.E., p. 1].

I didn't set out to become a therapist counseling people with terminal illnesses but found myself becoming an early "expert" as HIV increasingly emerged as an urgent issue among clients I was already specializing in treating (primarily from cultural minorities or societally marginalized populations such as Deaf, First Nations, gay and/or two-spirited men and street youth). Clients began to share with me their own HIV-positive status, that of loved ones, fears relating to it all, and so forth.

Revealing such things, even now years into the second decade of HIV is risky in itself because there is still no way to know how friends and family will react. There is serious import to the advice commonly given at diagnosis: "Once you tell, you can never un-tell". Once a person has divulged being HIV-positive, the perceptions or responses from others will never be the same; there's a new filter.

Because knowledge about AIDS and its various treatments is continually emerging, both medical and psycho-social truth is only situationally relative and prone to sudden changes or reversals without much advance notice. My clients find themselves frequently encouraged by their doctors to do things one way one day and then the next told to switch to something different. It's not that doctors are incompetent - they are doing the best they can when dealing with the unknown - its just that new information is being discovered literally daily.

"When first diagnosed, when people are experiencing that immediate reaction, there are also a lot of accompanying emotions that go along with it... I think the biggest one for me, and the most prolonged response, was the shock - it is really something to all of a sudden hear that you have in your body this virus. You don't really know what it is going to do to you eventually... There is this big unknown that is probably the most shocking thing about being HIV-positive". [F.H., p. 1].

This lack of firm foundation and frequent readjustment of reality frameworks makes it difficult to keep updated while counseling people infected or affected by HIV - and it's even more slippery for people living with the virus themselves to somehow make sense of it all while trying to activate coping strategies or realize life goals - especially as AIDS seems to be turning into a long-term manageable chronic disease. It is not uncommon for clients to be living a dozen or more years as HIV-positive and still healthy.

In HIV psychotherapy clients are dealing not only with those issues commonly expected in those facing death but also often those encountered in abuse. My clients often express feeling abused and disabled by virtue of having lost the majority of their own personal power or their right to exercise control over what is happening to their bodies and lives.

"There is still a stigma attached to being diagnosed with HIV [and] AIDS. And I did feel dirty. I did feel ashamed that I had this virus. And I wasn't really sure at that moment when I heard that I was HIV-positive exactly how I was going to deal with it" [F.H., p. 2].

This pervading uncertainty and lack of clear direction affects not just clients, but also us therapists, who are used to working within fairly predictable outcomes, whereby if we do things a

certain way, predictable results will likely happen. With AIDS., there has not been a lot of time to develop a sense of consistent direction, of learning what will most help clients (and ourselves) survive the limbo and find meaning in the chaos. Hopefully this article will begin to shed some light on what HIV infected/affected clients are experiencing psychosocially, as well as suggest some possibilities that might be of better help to them.

"I was twenty. I made a list of all the things I needed to do in order to be able to consider my life a success before I die, and set out determinedly to pursue them. I got my education and excelled in my career. I found a partner and had someone to love and love me. I made healthy changes in my lifestyle. I had success until one day I got sick and had to quit work. I dealt with HIV fine until I quit work, and then the problems started. I lost the validation of it, the financial reward of it, the status of it. My health had deteriorated, and the dream seemed to be coming to an end." [J.E., p. 1].

Psychosocial consequences of living with HIV

Frequently, only the medical aspects of treatment or prevention are given attention, as if maintaining the body's physical health is the patient's sole responsibility, while far too often there is much less preparation for encountering, understanding, or coping with the numerous psychosocial issues that also arise. But the consequences of living daily with HIV, and its resulting limitations not directly connected to medical problems (such as poverty or relationship difficulties), are sometimes harder to deal with due to their more subtle and socially-isolating nature, particularly for individuals without a strong emotional support system through friends or family.

In truth, for most HIV-positive people, the problems encountered during the first several years are not medical ones; they are psychosocial. It is common for clients to explain that knowing they had tested positive was not the same as really believing it inside themselves - and thus the onset of their first illness often caused a second psychological crisis located somewhere midway between "positive visualization of ongoing health" and "denial". With HIV these two attitudes are often hard to distinguish between. With long-term survival becoming increasingly possible, most clients believe they will truly be the lucky one not going on to develop AIDS. And thus trying to get them to deal realistically with possible end-of-life issues may not be the goals most important to their health or stress reduction.

"To me, over the years, I had a lot of losses that I've had to deal with. Some of them were familiar... The hardest loss that I've had to deal with was the loss of ability... [like] when I was on my back because I was sick and I couldn't do anything. I couldn't pick up the phone. I just didn't have any energy. I couldn't think, because my energy was just gone. That to me was the hardest thing to deal with, because that was not my character, my usual 'modus operandi' - not me. Ever since I can remember I've been an active person. I was always doing

something, like my grandfather used to do... [So] when I got to that point that doing anything was impossible, it was unbearable" [F.H., p. 5].

Many clients express that it isn't being dead that worries them as much as the dying, and accompanying fears of being abandoned or consumed with pain in the process. Through therapy, they journey through life-review and life-closure issues, along with grief, anger, guilt (sometimes including survivor guilt), relationship difficulties, and resolution of "unfinished business" with family.

But these are also therapy topics with people who are not facing death; they are general health-enhancing explorations that can provide anyone with release from stress and self-empowerment in their activation of self-advocacy and proactive self-care. But with HIV-positive clients, each goal successfully accomplished still leaves the client dangling in an unfinished "limbo" where it's unclear whether to pause or keep living. If they only knew how long they were likely to live, they could make informed and sensible decisions; however, unlike cancer there's not such clear time-line expectations for prognoses. In HIV psychotherapy, psychological distresses such as depression or watchful anxiety can be seen not just as symptoms needing alleviating, but might instead be good indicators of needed and healthy grieving or necessary health vigilance in partnership with overworked doctors who must count on their patients to keep track of all the details.

"People deal with HIV in different ways. Suicide..., denial.... [and] I experienced anger. HIV is not easy to deal with. There is quite a feeling of depression that lingered in my life for a while. Not a deep depression, not a disabling depression, but this low level depression that didn't quite come out to the surface. But I was aware of it; I knew it was there. I didn't immediately jump into acceptance - I had to go through quite a struggle to get to a point - to get to THAT point. To get to the point of acceptance, to the point where I could publicly say, 'I have AIDS'. I was ashamed about that. [And] to get to that point that I realized that, I don't know when, but I'm going to die" [F.H., p. 4].

The grieving for self and others never quite completes itself, as anticipatory grief and compassion fatigue overwhelms any attempt at dealing with death and emotional loss on a one-by-one basis like pre-AIDS life, where there was time to get over one loss before another arrives. Loss of others is difficult enough; however, with HIV gnawing away at one's abilities and lifestyle, "loss" has deeper meaning and cuts a wider swath.

'Now that I was HIV-positive, believe me, this is a whole new journey in losses. That is probably the one concept that all of the emotional and psychosocial issues that I had to deal with - is that dealing with all the losses.. First off, right at the point of diagnosis, is the loss of status. We may have a very high position... in society, but if you are HIV-positive, this is gone

right now. You do not increase your status if you are HIV-positive [F.H., p. 3].

Many clients tell me that it's hard to have AIDS-free time, that, as one client explained, *"It's always there on my shoulder, riding along with me wherever I go"*. AIDS "tenderizes" people, making them vulnerable in sudden unexpected ways, and yet often much less willing to again risk being open to feelings of intensity of any kind. Clients tell me that they feel more free being "out" with HIV, but that once having done so, they find it difficult to get others to treat them like ordinary people. A client told me that he feels his friends are watching him from behind glass.

"There are a lot more different aspects of who I really am. I am not HIV, I am not AIDS. I am a person who has many many life experiences, and all of those life experiences and all of those talents and desires - is who I am. But most people don't know that [because] most people haven't experienced that with me, not the people who are in my life now. Most of them know me as an AIDS activist and AIDS educator, yet that has only been a small part of my life. AIDS is a very important part of my life right now, and something that directs all of my activities, and I am very proud of doing the work that I have been fortunate to be able to do - but that's not who I am" [F.H., p 6].

And for clients who are not doing as well medically and have started into yet another health decline, all this talk about positive thinking and health activism can be tiring and produce feelings of failure. It is exhausting to have to keep up the image of a survivor when one no longer feels that way. Friends seem fine when a positive attitude is apparent, but sometimes get uncomfortable when the person is truly sick and weak. One client, who is a busy activist, told me that he felt so bad realizing death was near, because it would disappoint so many of his friends that he hadn't been able to beat it.

I find I frequently have to remind clients like him that dying is not failing, that not everyone gets to stay healthy, and that it really is normal to be sick once in a while without having to feel guilty about it. With HIV it is easy to appear attractive and healthy even while the body is being consumed by various infections, and so clients sometimes are accused of exaggerating complaints or using tiredness as an excuse.

One client described the not-well-but-not-sick feeling as being like forever treading water- *"You know how when you get sick? Well, with me "being sick" is never "over"; the best I can hope for is that it's just not getting any worse - I don't think I'll ever feel fine again, No, I'm not sick, but neither am I ever well... I'm just always very very tired"* [B.R.; private communication).

For both those infected and affected by HIV, grief and anger and desolate feelings must often be put somewhat "on hold", because the politically correct image currently in vogue is that of

"survivor", rather than "victim", so one must be strong, keep a positive image foregrounded (which, as mentioned earlier, is often ironically seen by others as 'denial'), and not allow thoughts of dying into the picture of self that is communicated.

This 'survivor' image that keeps death further at bay makes it even more difficult for loved ones to breach that barrier into the more raw layers of painful emotions and fears, as the person often feels inappropriate (or not socially correct) when dwelling upon these thoughts. So loved ones are at a loss - and their own trauma and feelings frequently kept secret, a conspiracy of silence that is sometimes so deeply hidden in the unconscious as to be practically inaccessible. Political correctness sometimes overrides unmentionable thoughts. And so therapy with loved ones of the HIV-positive client also becomes complex.

Many people who go home to tell their families that they have tested HIVpositive must also at the same time explain how they got that way - and for people who have not explained their sexuality, drug use, or other risky behaviors, this is a big topic to cover in one visit. Sometimes families do reject the person and make it clear they are no longer welcome, and other times there is a surprisingly supportive reaction (often with clients most fearful that love would be terminated or left conditional).

"I think the hardest aspect for me to deal with in the beginning was dealing with my family. I had this vision in my own mind about what my relationship was with my family. I knew the hardest thing for me to do was to go home and tell my mother that I was HIV-positive. It's the same thing as going to your parents and telling them that you are going to be dying of AIDS - it's one and the same thing in everybody's mind... I knew how she was going to react, and there was a part of me that said, 'I don't want to be the cause of my mother's grief. I love my mother and I know my mother loves me. Why do I need to go home and tell her that her favorite son is going to die of AIDS?' She broke down and cried like I've never seen her cry before. Then she gave me a hug, and said, 'I love you and I've always loved you, and I always will...' I had never ever seen my family react like that before - I was not prepared for that. That was a very powerful emotional experience for me" [F.H., p. 8].

But families and friends are also human, and sometimes their fear or exhaustion hits a limit in the caring they are able to provide. Clients who are ill expect to be taken care of, and issues can arise when caregivers can give no more. One woman who went home to die found her parents lovingly supportive - until she surprisingly improved, and found her welcome quickly chilled. There is often need to grieve the breaking of trusted assumptions that those who promise to always be there sometimes, in the end, simply cannot be.

"Recently I realized that... I have reached out to my family [but] they did not return that. They did not pick up the telephone to give me a phone call, to see how I was doing. I had been living

with this image in my mind that I had a close relationship with my family, and that they supported me. And when I came to the realization that they did not support me - not because they didn't say they loved me, but because they didn't follow through with their actions - this was a very big shock, and I have only recently discovered it. I'm still going through the grieving of this. In my culture, family is almost everything" [F.H., p. 8-9].

Counseling needs, issues, and techniques

Very little of what is happening [in the early years] is what the virus is doing to the body at that time. You have to deal with emotional and mental issues as well as social issues... [Although] my culture and traditions gave me courage to deal with issues in my life... there are times when I am just going along doing my business, walking down the street... and all of a sudden, out of me comes all of these emotions" [F.H., p. 3].

Offering psychotherapy to people living with HIV is a complex task, and it is extremely important to not perceive a problem until the client defines it as such. Good therapy involves co-constructing the mental reality that both client and therapist are participating in, and since it's the client whose needs are being addressed, it is very important to take cues from that person's understanding and explanation of what is happening to them, how they make sense of it all, how they are coping with various big and small losses, and hearing each story without judgement or external expectations.

"I knew that I couldn't change being HIV-positive, no matter how much as I wanted to. But what I could change about my situation, was the way that I was to deal with it" [F.H., p. 3].

Listening intently, reflecting back to be sure there is understanding, acknowledging feelings and trying to explore them to know them better, keeping hope without being condescending, respecting the right to choose one's own path and have it change as needed, and other such attitudes are goals that I think important not just for the client, but also for the therapist. My HIV-positive clients have taught me a lot and deeply affected the way that I try to help them.

"1995 was a time of grieving for me, trying to put the pieces together after losing two of the most important people in my life [my lover and my best friend]. In September, my Mom was diagnosed with cancer...She died at the beginning of February [1996], and I was there with her at the end...It was an agonizing and painful death...The shock of what I had seen lasted two weeks, and when I finally started to feel again, all there was an empty black hole. I was very frightened. I hadn't been able to grieve my Mother's death and I felt a large part of me had died with her.

"I knew I was in trouble and called on my therapist again, as I had after my lover's and ex's deaths. She allowed me the safety to express all I was feeling. There was just a huge hole in my

heart. I no longer felt [anything], and I was terrified to look into it for fear it would swallow me and I would lose sanity. She listened very well, repeating what I had said back to me to be sure she understood what I was saying, and then the probing would start.

"She has a way of questioning me that makes me look at the situation in a different light, or from a different angle. By urging me gently in certain directions, she brings up aspects of the pain I am in, allowing me to come to an understanding of the multitude of issues that are at work here.

The uselessness, emptiness, confusion, the lack of strength I felt to continue, and how overwhelmed I am at grief and dying for family and friends, and for myself. The validation of the normalcy of my emotional state is one of the best things I get out of it [counseling]; the other is that as we explore all the issues I realize that taken one by one, I can deal with them. Like separating the trees from the forest, I am able to see far clearer.

"She does not do the work for me - she brings issues to light and from there the ball is in my hands. Another wonderful aspect is that as I am making progress, I can report back to her on my growth, and we can talk of the insights I've gained, of the stronger, wiser person I've become, and the implications these have on the rest of my life.

"I know I am a strong and courageous person, a 'survivor' if you will, but there are times I need help handling my life and its obstacles, and there are times when I act from the heart and end up overwhelmed and a bit lost. I really don't know where I would be today were it not for the help and safety that she has offered me in my times of crisis" [J.E., p. 2].

Issues for Psychologists

As AIDS is devastating particular groups of people and cultures in something resembling a plague or genocide, it can also easily become a personal issue for those therapists trying their best to help their clients deal with the same thing. No psychologist specializing in HIV psychotherapy remains untouched by multiple deaths in clients or friends.

Despite a lot of new promises regarding treatments, AIDS is a client concern where there is presently very little hope, when even the dreaded word cancer is losing its throathold due to increased survival rates. Clients can survive AIDS, but in reality very few do, and for those who do live a lot longer than expected, survivor guilt is another major issue that arises - as is poverty!

Trying to help clients deal with their own imminent death, and/or the guilt/pleasure of not dying (yet) and still managing to beat very heavy odds, can be a heavy load for any therapist. If that therapist also has not yet dealt with the inevitability of their own death (and how confronting it can actually be very empowering), they are likely not going to be able to help other people clear the

numerous issues around their own. This is a place where transference and countertransference can easily intrude.

If the psychologist has lost friends, family, or lovers to AIDS, they will be wearing their own layers of anger, grief, frustration, and so forth while they try to help others experiencing the related diseases. In this there is not only the danger of personal burnout as the diagnoses increase, but also that in the numbers' multitude, therapists might innocently resort to functional generalizations, categorical labelings, and other consequences of AIDS' increasingly large numbers and thus reduce the client to less than a full complex human in their attempts to treat so many of them.

There are clients dealing with AIDS to try to help, as well as their families, friends, lovers (or those who reject them) to help them communicate with. There are also simple medical consequences such as dementia or incontinence which can threaten the therapist's own limits of tolerance.

Sometimes our own mental stability becomes increasingly overwhelmed by something too complex to encompass therapeutically and/or with medical odds too predictable to keep continually extending our hopes, and our clients', toward the goal of surviving day after day, client after client.

Also there are numerous therapeutic issues clients are trying to deal with, the likes of which I never dealt with in graduate school training; for example, what can I tell a client who finds that people are unwilling to become sexually intimate or even emotionally committed with him because he might die soon (but then again, he may not), or because one tiny error or sloppy sexual practice might result in a possible death sentence?

And then there is one more issue which is not so frequently mentioned in professional discussion about HIV treatment: Psychologists who are themselves HIV-positive or who have arrived at the full diagnosis of AIDS. These are professionals who are quite competent and doing just fine, but for whom the clients' issues are suddenly their own. Transference/countertransference issues are even more complicated when those psychologists in some of the same situations as their clients are actually some of the very best people to be able to help them.

Therapists who are themselves HIV-positive have personal dilemmas that were likely not even conceived of when they were receiving training from instructors who could never have prepared them for some of the choices they must now make about self-disclosure or not (what about duty to inform the client? if the client seems to be AIDS-phobic, should the therapist reveal HIV-positive status?), taking on new clients or not (what if the therapist gets sick and can't work before this client is finished with therapy?), telling colleagues (they say they're comfortable with clients having AIDS, but what about a colleague - does that become more threatening or too close for comfort?), and other more complicated issues which just didn't exist in the days I received my training.

If clients are hospitalized for solely-medical, but not mental, reasons (like drug infusions) is it ethical to continue to see them inside their own hospital room instead of the therapist's office? If they are home-bound, is a home visit acceptable? Can I gently touch a client to offer comfort or communicate caring, without this signaling mothering/smothering/transference issues (or even worse, breaching ethics?). These sorts of boundary dilemmas arise from yet another kind of "closet", one which is inside the emotional house of all of us doing this work, and there are no simple clear answers.

Conclusion

Sometimes the best thing I can do for my client is to honestly say I do not have answers and cannot give them any advice that will cure them. But healing is my business, and a safe comfortable private space in which to regularly explore what is happening to them is what my therapy tries to provide.

Recommended Readings

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Frederick Haineault was a close friend and colleague of Weiser who died of AIDS on December 6, 1995. Co-founder of "Healing Our Spirit B.C. First Nations AIDS Society", he was an AIDS educator who blended traditional Cree teachings with counseling First Nations people about AIDS. His comments included in this paper are from a transcription of a presentation they gave together at an AIDS conference in Prince Rupert, BC in September, 1995 - that they had taped with the intention of jointly authoring this article.

"J.E." is the pseudonym requested by a client of Weiser who, when hearing she was writing this article, brought her two pages he decided to write about their counseling journey (that he titled "Why therapy?"), giving her permission to quote from it. He has been living with HIV for more than a decade and wrote this "so that people would understand that looking healthy doesn't mean you don't have problems".

HIV and mental health in Canada: Issues for psychologists

Bruce Mills

Health Canada/ CPA HIV/AIDS Partnership Project
Ottawa, Ontario

Abstract: Since the appearance of HIV in Canada, Health Canada has worked to promote awareness, education and support pertaining to the mental health aspects of HIV disease by supporting research and health promotion/prevention strategies and programs. The mental health dimension of HIV was targeted by the National Working Group on HIV and Mental Health and subsequent projects of the Group have aimed to increase awareness and expertise in the field. This article suggests ways the Canadian Psychological Association can share in promoting mental health and psychological support for individuals living with HIV and describes a partnership project between the Canadian Psychological Association and Health Canada that is working towards this goal.

Résumé: Depuis l'apparition de VIH à Canada, Santé Canada a travaillé promouvoir la sensibilisation, l'instruction et le soutien concernant à la santé et les programmes. La santé mentale était étudiée par un comité national, et les projets de ce comité ont accru la sensibilisation et l'expertise. Cet article suggère plusieurs de méthodes que la Société canadienne de psychologie peut employer pour promouvoir la santé mentale et le soutien psychologique pour l'individu, et il décrit un nouveau projet de partenaires entre Santé Canada et la Société canadienne de psychologie qui doit attendre l'objectif.

Health Canada and AIDS

The guiding mission of Health Canada is *to help the people of Canada maintain and improve their health* through a number of federally supported universal strategies and programs.

Related directly to this guiding mission, Health Canada established the Federal Centre for AIDS in 1987 to respond quickly and appropriately to the AIDS pandemic in Canada. Through the guidance of the Federal Centre for AIDS, now called AIDS Care, Treatment and Support Unit, national AIDS strategies, prevention and health promotion programs accompanied funding and support for important HIV research. Federal funding facilitated the foundation of community-based support agencies for people living with the virus, their significant others and families. National programs, such as the Canadian AIDS Society and the Canadian Hemophilia Society assured linkages between community groups in all parts of Canada, including programs for ethnic and aboriginal populations.

The National Working Group on HIV and Mental Health

In response to the growing awareness of mental health issues associated with HIV disease, including the growing concern about the negative impact on the mental health and the shortage

of skills of a relatively small group of caregivers nation-wide, the Federal Centre for AIDS convened the National Working Group on HIV and Mental Health in 1988. This group comprised experts from a number of professional disciplines including psychology, psychiatry, social work, nursing and medicine. People living with HIV were also members of the panel who provided accurate and expert input on all phases of the work.

The Working Group was responsible for sponsoring two national conferences for caregivers. More than 800 professional and non-professional caregivers attended the two day conferences called Caring Together/Entraide held in Ottawa and Calgary in 1990. The self-titled report functioned not only as a written report of the conferences, but as a reference for caregivers working in HIV care across Canada to learn about self-care and to cope with a large, young and *terminal* caseload.

In collaboration with Montreal General Hospital and McGill University the Working Group conducted a thorough review of world literature on HIV and mental health, including psychological, neuropsychological and psychiatric aspects of the disease and the mental health impact of HIV on caregivers and families. Several models of care were presented in the documentation. In 1994, an update of the Literature Review was conducted by Bruce Mills for AIDS Care, Treatment and Support Unit. In addition, the Group conducted national needs assessment and national hearings to carefully evaluate the mental

health impact of HIV. Finally, the Working Group produced the report, *Ending the Isolation: HIV and Mental Health in the Second Decade*, published by Health Canada in 1992. This document provided an examination of mental health issues involved in HIV disease, provided clear and concise information and included a number of recommendations for HIV care in Canada in order to cope with a second decade of pandemic.

Followup: National Workshop on HIV and Mental Health

Subsequently and in accordance with the recommendations contained in *Ending the Isolation*, Health Canada convened the National Workshop on HIV infection and Mental Health held over three days in Toronto in 1993. This conference provided opportunities for professionals and non-professional caregivers to dialogue about the mental health issues of HIV, to prioritize issues and actions according to importance for individuals infected and affected by HIV and for those working in the field.

The National Workshop aimed to improve collaboration, coordination and communication among Canadian caregivers working HIV care, and in particular, those directly involved in the mental health aspects of the disease. Finally, the Workshop aimed to strengthened linkages between Workshop participants and thereby promote productive outcomes. Fifteen round-table discussions examined financial security issues (as a most significant impact on mental health), knowledge and skills building tools (for caregivers) and mental health support systems (for HIV generally). The National Workshop was endorsed in 1993 by the Canadian Psychological Association.

The document entitled, *Framework for Action* was published and contained all of the recommendations and statements which arose from work done during the National Workshop by participants. Recommendations pertaining to the promotion of mental health in the context of HIV disease included bolstering financial support to individuals infected with the virus, working harder on building knowledge and skills for coping with the mental health impact of HIV and improving mental health support systems for both individuals diagnosed with HIV as well as families, significant others and for caregivers.

The Role of the Canadian Psychological Association

A lack of psychological support services for people living with HIV in Canada has long been identified in Canada in national research and more directly and urgently by mental health consumers. Similarly, a deficit of HIV-related training for psychologists in Canada and a lack of resources for psychologist currently working with HIV caseloads have both been identified as problems affecting psychological services to persons living with HIV and in particular, seriously restricting psychological services to this consumer because of a clear lack of expertise, training and human resources.

Can the Canadian Psychological Association take an active role

in mobilizing the recommendations arising from the National Workshop on HIV and Mental Health? Are there targets Canadian Psychological Association could use to promote both mental health and psychological support for people living with HIV disease?

The answer is yes. In the context of documentation for the National Workshop and following closely on the heels of *Ending the Isolation*, the following key recommendations were identified as specific areas that Canadian Psychological Association could share with other professional groups in order to improve mental health and psychological support for people living with HIV:

- dialogue with professional education programs re: curricula that is inclusive of the enormous mental health dimension of HIV.
- develop training and support services for caregivers, counsellors.
- establish better communication networking and linkages with other mental health services.
- provide mentorship programs for new psychologists to practice in HIV work.
- develop mechanisms and protocols for reaching and working with hard-to-reach and marginalized populations, including substance users, sex trade workers and homeless populations (those who do not traditionally seek out mental health services but who nevertheless will be referred at some point during disease progression).
- develop sensitization programs for professionals to improve or alter attitudes, phobias, prejudices, etc.
- solicit the direct input of people living HIV to enhance practical knowledge and education base.
- conduct more research in HIV encephalopathy (HIV-E), neuropsychological factors involved in disease progression and related, develop:
 - info kits, mental health checklists
 - training in HIV dementia
 - work to reduce reliance on medical model for treatment of dementia
 - expertise around alternative therapies, holistic approaches (meditation, visualization, biofeedback, etc).
- develop specific protocols for psychotherapy for people living with HIV and improve availability of short-term psychotherapy to this caseload.
- when possible, rotate psychotherapists to reduce potential for caregiver burnout.
- adapt clinical protocols, i.e. abnormal, grief, addictions, gay sexuality, harm reduction, etc to pertain to HIV cases.

New Populations, New Needs and Issues

The changing epidemiology of HIV in Canada suggests that a new caseload is emerging from the population which presents new and challenging needs and issues. Aboriginal peoples, children and youth, ethnocultural communities, gay men, individuals with disabilities, individuals in prisons, the homeless,

people who use injection drugs and women are among major population affected by HIV. However, HIV is increasing most among homeless populations, street youth and others who are traditionally marginalized from formal health and mental health services. Psychologists may need to learn to adapt approaches for the HIV client instead of depending on tried and tested approaches that are successful with other caseloads. For example, while behavioural change may be the most beneficial outcome for a patient in general, a homeless patient with HIV may benefit more from learning to "come to terms with" a bad situation since learning to change it completely may be impossible, given the circumstances.

Psychologists may also need to take special efforts to consider the mental health consequences of HIV disease as they pertain to persons *affected* by HIV, including partners, friends, families and caregivers who are confronting burnout, anxiety, depression and the impact of multiple and repeated losses.

Psychologists may undertake important research in Canada by examining some of the existing research gaps, including shifting demographics, the impact of health services reconfiguration in Canada, psychological issues of AIDS-related suicide, assisted suicide and euthanasia and other psychological topics in HIV and mental health. There is also a major shortage of research on the neuropsychological factors of HIV, including HIV encephalopathy.

Health Canada/Canadian Psychological Association HIV/AIDS Partnership

In June 1995, at the annual meeting of the CPA in Charlottetown, a small group of individuals convened to explore topics around the psychological aspects of HIV. A Working Group was formed to sustain interest in the topic and a proposal to Health Canada was submitted to obtain support for the work of the group. In April 1996 and now funded by Health Canada, a Working Group consisting of 10 members of the Health Section of the Canadian Psychological Association started working on a 12 month project which aims to promote psychological education, resources and services around HIV disease for psychologists in Canada. Similar to other projects undertaken by the Canadian Psychiatric Association, the Society for Obstetricians and Gynaecologists of Canada, the Canadian College of Physicians and other professional organizations, the Health Canada/CPA partnership will provide a core body of expertise and a practical resource tool for members and associates.

Specifically, the project will first produce a resource document outlining the psychological aspects of HIV disease according to the stages of disease presenting, from diagnosis through late phase illness and the process of death and grief. Approximately fifty-five topics will be examined, including personality, cognitive, general, affective and neuropsychological issues, and topics such as previous history of mental illness, transference and counter transference, stigma, homophobia and AIDS phobia, in addition to other clinical issues. Effective interventions,

approaches and self care techniques are discussed alongside complex ethical and legal issues related to HIV.

Second, the resource, when completed, will be launched on the Canadian Psychological Association homepage of Worldwide Web (WWW) where the interactive information base will be easily accessible to psychologists, educators and others working in mental health services.

Third, the Working Group will develop graduate school curricula which aims to sensitize and train a new generation of counsellors and health care providers to work effectively with people living with HIV. Besides forming linkages with other HIV-related projects in Canada and USA (such as the HIV projects of the Association of Canadian Medical Colleges and the APA's HOPE training program), the Working Group will participate in a number of conferences and meetings during 1996 including the International AIDS Conference, the APA Conference and the Canadian Psychological Association International meeting in Montreal.

Finally, the project will develop and conduct regional training workshops designed to improve the skills of counsellors who work with different groups known to be vulnerable to and living with HIV. The training workshops are slated for early in 1997.

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Emotional Reactions and Safe Sex Practices of Individuals Who Are Newly Diagnosed HIV+

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Abstract

The purpose of this study was (1) to identify the process of adaptation and adjustment that individuals experience when learning of the HIV diagnosis, and (2) to examine safe sex behaviour of individuals in the context of the newly discovered HIV+ diagnosis. We examined the experiences of 92 HIV+ persons at three intervals: immediately following diagnosis, six months after diagnosis, and (on average) 3.5 years after diagnosis. We believed that the need for support and help was likely to change over time. It was also important to understand whether safe(r) sex practices of HIV+ persons changed over time.

Résumé

L'objectif de cette recherche devait (1) identifier le procédé d'adaptation et ajustement de individus quand ils doivent connaître du diagnostic de VIH, et (2) à examiner le comportement de pratiques sexuelles sûres des individus dans le contexte du nouveau diagnostic de VIH. Nous examinons les expériences de 92 personnes aux trois scènes différentes: suivant aussitôt l'information du diagnostic, six mois après le diagnostic, et (sur le moyen) 3.5 années après le diagnostic. Nous croyions que les besoins pour le soutien et l'assistance devrait changer comme le temps passer. Il était aussi important à comprendre les changements des pratiques sexuelles des personnes pour la même période de temps.

A profound trauma is experienced by individuals when they learn they have been tested positive for HIV. The problems and concerns that arise from the new diagnosis follow a similar pattern for many people. Many clients of the Sexually Transmitted Diseases (STD) clinic have reported that learning of the HIV+ diagnosis causes a subsequent feeling of numbness. Most reported that after hearing the HIV+ diagnosis from a doctor or nurse, they were unable to remember anything other than the HIV status. While they could sustain conversation and answer questions with the nurse or doctor, they were later unable to recall any content of either questions or conversation. Despite this fact, many professionals attempt to provide education and reassurance to the newly diagnosed person immediately after giving positive test results.

Method

We asked 92 persons who had been diagnosed HIV+ for longer than six months to complete a questionnaire about their memory of the experience of the HIV+ diagnosis and the needs and problems that arose from the HIV+ diagnosis. Table 1 below shows the demographics of the sample.

Table 1 Demographic of Sample

<u>Age</u>		<u>Gender</u>	
average	34 years	Male	93%
range	21-62 years	Female	6%
		Transsexual	1%
<u>Sexual orientation</u>			
Gay	71%	Heterosexual	10%
Bisexual	13%	Unknown	6%

Results

Many persons (45% in this sample) thought it was likely they were HIV+ when they were tested. In spite of this expectation, they still experienced shock upon hearing the news. Denial is a major problem associated with receiving traumatic news, and we found this consistent in the context of the HIV+ diagnosis.

One way to help people to face their positive diagnosis is to provide the option of retesting. Just over half (55%) of our sample was retested. Almost 2/3 of those who were retested reported that retesting did help them to accept the HIV+ result and to begin to face the diagnosis with more honesty.

Over 61% of the group sought counselling within three months of receiving the HIV+ result. The places sought for counselling varied. Many HIV+ persons found it difficult to find counselling. 25% went to a psychologist, 17% sought counselling from their general practitioner, 12% joined a support group and 10% saw a psychiatrist. It may be significant that 20% did not know the qualifications (designation) of the person they saw for counselling.

Generally, counselling helped (70%) the person to adjust to the HIV+ diagnosis and provided assistance around decision making and future planning. A sizable group (10%) reported counselling was a negative experience. An additional 14% reported counselling was not helpful. This means that almost 1/4 of those seeking counselling did not find the counselling to be a helpful experience in addressing the effects experienced in learning of the HIV+ diagnosis. It is suspected that this group of counsellors have less formal training and merely made themselves available to those in need of counselling. The helpfulness for the unidentified counsellors was rated less than half that of the

helpfulness rated for other identified professionals. Nurses, social workers, and psychologists were seen as most helpful. Other professional groups were rated about equally for helpfulness.

We asked all respondents to identify emotions that they experienced when they were first diagnosed, after six months and at the present time (on average 3.5 years following diagnosis). Table 2 shows that when first discovering they are HIV+, people often experience a profound sense of being alone. This feeling is accompanied by anxiety and worry. These emotions change over time. Anxiety, loneliness, confusion, and suicidal feelings become prominent six months after diagnosis. It is interesting that grief was initially experienced, but six months later, feelings of grief had greatly diminished. Worry also decreased over the first six months, while anger remained a prevalent emotion.

Table 2 Emotions Following Diagnosis

When Hearing of Diagnosis

High		Low	
Loneliness	66%	Revenge	10%
Anxiety	59%	Relief	16%
Worry	58%	Anger	20%
Fear	54%	Guilt	20%
Confusion	46%	Suicidal	26%

Six Months After Diagnosis

High		Low	
Anxiety	56%	Relief	6%
Loneliness	53%	Revenge	7%
Confusion	41%	Denial	9%
Suicidal	38%	Disbelief	9%
Fear	34%	Anger	9%

Some of the sample sought counselling for their problems. Table 3 shows that people sought counselling for feelings of fear, anxiety, confusion, worry and loneliness. The confusion often occurred around making plans for the future, learning about HIV and who to tell about the diagnosis.

Table 3 Emotions Experienced for Which Counselling was Sought

Fear	64%	Revenge	24%
Anxiety	63%	Relief	34%
Confusion	61%	Suicidal	34%
Worry	54%	Denial	36%
Loneliness	52%	Shame	38%

The problems that the sample identified after diagnosis are detailed in Table 4.

Table 4 Problems Experienced After Diagnosis

Immediately after Diagnosis

Telling Family	20%
Telling Friends	18%
Telling Partner	9%
Not Sharing HIV Status	1%
Sleep Difficulties	18%
No Interest in Sex	10%
Being Gay	10%

3-6 months after Diagnosis

Telling Family	40%
Telling Friends	34%
Telling Partner	12%
Not Sharing HIV Status	28%
Sleep Difficulties	30%
No Interest in Sex	26%
Being Gay	4%

Telling family and telling friends of the HIV+ diagnosis became more of a problem over time. Loss of interest in sex and difficulties with sleep also increased as problems overall, "who to tell" and "how to tell" significant others became problematic over time. Sleep and sex were the daily living problems most affected by the HIV+ diagnosis. It is important to note that in six of seven problem areas, more HIV+ people experienced these problems after the first six months. In other words, people diagnosed HIV+ initially experienced emotions that subsided over time, but other problems became more common over time. The problem "being gay" decreased over time.

The kind of problems for which HIV+ persons sought counselling were similar to the problems reported. Counselling was sought for telling friends, telling family, and sleep difficulties. Sharing the HIV+ status and "no interest in sex" were also frequent problems.

Safe(r) Sex Behaviour of HIV+ Persons

All respondents were asked how often they engaged in safe(r) sex. They were to define what they believed was safe(r) sexual behaviour. In other words, these are self reports of the frequency that the respondents felt they put themselves and/or others at risk. Each respondent was given six options:

- no sex
- always safe
- safe 60-80% of the time
- safe 40-60% of the time
- safe 20% of the time
- never safe

They were asked to recall safe sexual behaviour at four time periods:

before diagnosis
 immediately after diagnosis
 three years after diagnosis
 now (when the questionnaire was completed)

The category "never safe" is an important one to examine. We found that the frequency of never having sex decreased for HIV+ persons over time. Table 5 shows a dramatic change in behaviour was seen before diagnosis versus after diagnosis.

Table 5 Sexual Behaviour "Never Safe"

Before Diagnosis	22%
Immediately After Diagnosis	4%
3 Years after Diagnosis	4%
Now	2%

The number of HIV+ people who reported not having sex decreased over time (Table 6). This indicates that as the HIV+ person became more comfortable with the diagnosis, s/he became more comfortable with sexual activity.

Table 6 No SEX

Before Diagnosis	----
Immediately After Diagnosis	26%
3 Years after Diagnosis	17%
Now	10%

It is important to note an increase, over time, in the number of HIV+ positive persons who reported "always safe" sexual behaviour (Table 7). This figure almost doubled from immediately after diagnosis to the "now" category. This indicates that time was required to integrate safe sexual behaviour into sexual activities. It is important to note that only 60% of those surveyed did not put themselves or others at risk at any time by their own definition of safe sex.

Table 7 Sexual Behaviour "Always Safe"

Before Diagnosis	----
Immediately After Diagnosis	23%
3 Years after Diagnosis	45%
Now	51%

To make the results easier to understand, the next group we reported examines the percentage of sexual encounters that were safe 20% to 90% of the time safe. All three groups, (20% of the time safe, 40% - 60% of the time safe, and 80%-90% of the time safe) decreased over time, with the exception of the 20% of the time category which increased slightly from 3 years after diagnosis to the "now" category. Generally, there was an increased frequency of engaging in safe(r) behaviour, but there was still a significant proportion engaging in unsafe sexual activities (Table 8).

Table 8 Unsafe Sexual Behaviour "Some of the Time"

Before Diagnosis	78%
Immediately After Diagnosis	47%
3 Years after Diagnosis	34%
Now	37%

Discussion

Gay men comprised most of the sample. This group felt it was better to know the HIV positive status. Retesting to verify the HIV+ result helped the individual to accept the HIV+ diagnosis. Over half sought counselling after receiving the diagnosis and found counselling to be helpful. Helping professionals providing counselling were seen as the most helpful.

Initially our sample experienced loneliness, anxiety, worry, fear and shame. Over time, individuals continued to feel anxiety and worry, but confusion and suicidal feelings became more prominent. Counselling was sought for fears, anxiety, confusion, worry and loneliness.

Generally, problems in living became more prominent from time of diagnosis to six months after diagnosis. Telling family, friends and others were the major problems encountered. Counselling was sought for these problems in addition to sleep difficulties and no interest in sex. Safe(r) sexual behaviour generally increased over time after diagnosis, but over 1/3 of the sample reported unsafe encounters more than three years after diagnosis.

Training counsellors to address the types of problems experienced by persons diagnosed HIV+ is important. Counsellors must be aware of concerns and problems confronted by the person who is diagnosed HIV+ and must be able to help the individual to resolve these issues effectively. Counsellors cannot assume that simply because a client appears to be responsible that s/he will automatically engage in safe sexual behaviour. The counsellor must be able to address the issue of unsafe sexual behaviour and be in a position to help the HIV+ person to explore sexual behaviour and feelings about being unsafe if they are putting themselves and others at risk.

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Brief Book Reviews

The Social Psychology of HIV Infection

JB Pryor & GD Reeder (Eds.)
Erlbaum, Hillsdale, NJ
1993
Hardcover
ISBN 0-8058-0991-0

This book consists of an excellent variety of chapters. It is organised into two sections, each with two sub-sections containing 2, 3 or 4 chapters. The first section entitled the Theoretical Roots of Prevention begins with four chapters outlining the social cognitive view of risk perception followed by three chapters on intervention strategies. The second section deals with people living with AIDS and contains chapters on stigma and coping.

The individual authors generally provide a very thorough review of the various topic areas. The major attraction of this book is the grounding of research in theory. So often, health psychology research drifts into a plethora of disconnected statistical associations. The theoretical basis of this book could serve as a model for other aspects of health psychology and as such the book as a whole is a very worthwhile addition to the library.

Admittedly, one weakness is that it is placed clearly within mainstream social psychology and as such does not consider the rich and growing stream of research within the more discursive interpretive perspective. However, that would probably be another book.

Children, Families, and HIV/AIDS: Psychosocial and Therapeutic Issues

N Boyd-Franklin, GL Steiner, & MG Boland (Eds.)
Guilford, New York
1995
Softcover
ISBN 0-89862-147-X

This is a useful collection of 19 papers on different psychosocial aspects of HIV/AIDS. It is divided into six sections: Introduction, Epidemiological and Medical Aspects, Issues for Different Groups, Therapy for children and families, Service deliverers and systems, Research and policy. As is apparent this book is more oriented towards the practitioner rather than the researcher. It does a good job in detailing the context within which AIDS and AIDS care occur and suggesting appropriate intervention for different populations. As such, it is an excellent book for the practitioner.

Forgotten Children of the AIDS Epidemic

S Geballe, J Gruendel, & W Andiman (Eds.)
Yale, New Haven, CT
Softcover
ISBN 0-300-06271-0

As is evident from the title this book concentrates on the needs of children with AIDS. It follows a similar structure to the previous book in describing the background and then discussing particular needs of children. I particularly liked the final section which is given over to the voices of the children themselves. The book concludes with an extensive resource guide.

HIV Care: A Comprehensive Handbook for Providers

LJ Andrews & LB Novick
Sage, Thousand Oaks, CA
1995
Softcover
ISBN 0-8039-7150-8

This book is designed as a handbook for those providing various forms of care for AIDS patients. In brief outline format it provides details of the medical and psychological aspects of AIDS, the various treatment options, financial and legal issues, etc.

It concludes with a very extensive list of contact addresses and resources. Unfortunately, almost all of these are in the U.S. However, for the Canadian practitioner it still a useful handbook which I am sure would be immensely valuable to the busy practitioner.

Michael Murray

Health Psychology Section Annual Report 1995-1996

1. Officers: At the Section AGM held in Charlottetown, PEI the following members were elected officers for the period 1995-1997: Dr. Michael Murray (Chair), Dr. Gordon Butler (Secretary/Treasurer), and Dr. Patricia Dobkin (Chair-elect).

2. Membership: Recent figures from the CPA head office would suggest that there has been a decline in section membership since last year, along with an overall decline in CPA membership. According to CPA figures there are currently 157 members. The Secretary/Treasurer is reviewing the membership list to clarify any inconsistencies with head office.

3. I.U.P.S. Congress: The Section intends to host a reception for members and international delegates at this Congress. This reception will provide members with an opportunity to showcase their work and meet international visitors. Members are encouraged to submit material for a display at this reception. The Section is also sponsoring a symposium on "Social and critical issues in health psychology". This will be chaired by Michael Murray and will feature speakers from Switzerland, Britain and Brazil, as well as from Vancouver and Kingston. Section member Dr Robert Martin will be participating in a symposium entitled "Health psychology around the world" in which he will report the findings of his survey on health psychology in Canada. In addition, many other section members will be presenting individual papers at the congress.

4. Student Prize: At last year's CPA congress the student prize was awarded to Mesfin Mulatu (Queens) for a paper entitled "Lay beliefs about the causes of psychological and physical illnesses in Ethiopia". This paper was subsequently published in the Canadian Health Psychologist. It is intended to award a similar prize at the I.U.P.S. congress.

5. Website: We were pleased to launch our own Website this year. The site will feature access to some of the section's papers and documents and will include the table of contents and abstracts from the section newsletter. Suggestions and submissions to the Website are encouraged. The e-mail address for the site is hlthpsy@is.dal.ca or point your browser to <http://is.dal.ca/~hlthpsyc/hlthhome.htm>

6. Membership Directory: All members were contacted for details of their research/ practice interests. These details were included in our new directory which has been distributed to members.

7. Training survey: A survey of health psychology teaching was completed and a compendium of potential training sites is being compiled. This will be made available to anyone who expresses an interest.

8. Canadian Health Psychologist: Our newsletter continues to be published on a regular basis. Two issues were produced in 1995 - a total of 60 pages. The first issue of 1995 contained a special 24 page section on Child health psychology. The first issue of 1996 contains a special section on HIV/AIDS research and practice.

9. International: The section became an affiliate member of the International Society of Behavioral Medicine. This will entitle members to reduced rates for subscription to the International Journal of Behavioral Medicine and for registration at their conference.

NOTICES/ANNONCES

CONFERENCES

I.U.P.S. CONGRESS MONTREAL, 16-21 AUGUST 1996

RECEPTION

The Health Psychology Section intends to organise a reception at the I.U.P.S. Congress. This will take place from 2.00 - 4.00 pm on Saturday 17 August in the Argenteuil Room at the Hotel Meridien.

The aim of this reception is to provide an opportunity for members to meet international visitors and to display the work of section members.

As part of this reception we intend to mount a display. All members are strongly encouraged to attend the reception and to submit material (e.g. copies of articles) to be included in the display.

All material should be sent to: Dr. Patricia Dobkin, Department of Medicine, Division of Clinical Epidemiology, Montreal General Hospital, 1650 av. Cedar, Suite L10417, Montreal (PQ) H3G 1A4.

STUDENT AWARD

It is hoped to award a prize for the best paper on health psychology presented by a student at the congress. If any students, or supervisors of students, would like a paper to be considered for the prize they should submit a copy of the abstract to: Dr. Gordon Butler, Department of Psychology, Victoria General Hospital, Halifax, NS, B3H 2Y9.

11th International Conference on AIDS Vancouver

July 7-12, 1996

Contact: P.O. Box 48740
895 Burrard Street
Vancouver, BC, V7X 1T8

PSICOSALUD '96

2nd International Conference on Health Psychology

October 14-18, 1996

Contact: Dr. N.P. Valdes
Sociedad Nacional de Psicologia de la Salud
Conseja Nacional de Sociedades Cientificas
Ministerio de Salud Publica
Calle L No. 406e/
23y25, Vedade
La Habara 4,
Cuba, C.P. 10400

8th World Congress on Pain

Vancouver

August 17-22, 1996

Contact: ASP Secretariat
909 NE 43rd Street, Suite 306
Seattle, WA 98175

10th Conference of European Health Psychology Society

Dublin, Ireland

September 4-6, 1996

Contact: EHPS '96, Dept. Of Psychology
Royal College of Surgeons in Ireland
Mercer Building, Mercer St. Lower, Dublin 2

