Psychotherapy with HIV/AIDS Patients: Assessment and Treatment Plan Development

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Successful psychotherapy with patients who test positive for HIV/AIDS involves a sensitive, careful, and thorough biopsychosocial assessment with specific, detailed attention to the impact that a diagnosis of HIV/AIDS has on overall level of patient functioning. Careful evaluation and review of a patient's level of functioning in the areas of mental health and/or substance abuse, intimate relationships, family relationships, social support and peer relationships, work, and overall health are critical to an accurate assessment. Once the clinician fully evaluates these areas, a treatment plan that identifies specific problem areas can be developed. Clear goals, objectives, and treatment modalities, which address areas of concern, can then be established.

DEVELOPMENT

EPIDEMIOLOGY

By the end of 2006, an estimated 1.1 million people were living with HIV. The Centers for Disease Control and Prevention (CDC) estimated that in 2006, 65.4% of individuals living with HIV were found among minority racial/ethnic groups. The CDC estimated that among individuals living with HIV, 46.1% were African-Americans, 34.6% were Caucasians, 17.5% were Hispanic, 1.4% in Asian/Pacific Islanders, and .4% were Native American/Alaskan Natives (CDC, 2008). The CDC estimates that the most common modes of infection in 2006 were male-to-male sexual contact, followed by high-risk heterosexual contact, followed by injection drug use (CDC, 2008).

Significantly improved treatments, the use of multiple medications or combination therapies, and prevention of opportunistic infections have increased the longevity of patients with HIV/AIDS (SAMSHA, 2000).

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This is evidenced by the declining death rate from HIV–related conditions, which dropped 47% between 1996 and 1999, though the incidence of new HIV infections remained approximately the same during this time (SAMSHA, 2000).

**DESCRIPTION OF HIV AND ITS TRANSMISSION**

Human Immunodeficiency Virus is transmitted through infected human body fluids, such as blood, semen, vaginal secretions, or breast milk (SAMSHA, 2000). Therefore, activities involving the exchange of bodily fluids, including intravenous drug use, unprotected sexual activity, blood transfusions and organ transplants (prior to 1985), and childbirth are modes by which HIV can be transmitted.

A human retrovirus, HIV infects by attaching itself to blood mononuclear cells, particularly CD4+ T cells, which are responsible for proper functioning of the immune system. Once introduced in an individual, the virus releases its ribonucleic acid (RNA) chain into the host cell. The RNA then converts into deoxyribonucleic acid (DNA), penetrates the cell nucleus, and the virus’s DNA is copied onto the host cell’s chromosomes. This allows the cell to replicate, reproducing more HIV particles (SAMSHA, 2000). Increasing HIV viral loads and decreasing CD4 counts cause profound changes and deficiencies in the individual’s immune system. If CD4 count falls below 200 or if the individual experiences an AIDS-defining illness (the CDC identified more than 20 specific illnesses as AIDS defining—e.g. *pneumocystis carinii* pneumonia, cerebral toxoplasmosis, a diagnosis of AIDS is made (American Psychiatric Association, 2000). At this stage, the individual is susceptible to infections (often called opportunistic infections).

**ASSESSMENT AND TREATMENT PLAN DEVELOPMENT**

A multitude of factors may affect an individual’s response to a diagnosis of HIV and the subsequent requirements for psychotherapy treatment. The patient’s response can take many forms, ranging from denial, to acute depression, to debilitating anxiety. The context in which the diagnosis occurs is important and influences the accurate processing of critical information about HIV/AIDS. Vulnerability to the emergence or recurrence of mental health issues and similarly, the emergence of (or relapse to) substances of abuse is an important area to assess. The progression of the virus, the presence of opportunistic infections, and other medical conditions (e.g. hepatitis C) also may interfere with the patient’s ability to cope effectively with multiple emerging stressors. In addition, the extent to
which at-risk behaviors are present also affects engagement and adherence to treatment. The ability of a patient to access a partner’s or spouse’s emotional support, familial contact, or a peer social support network may affect prognosis in terms of coping with the emotional sequelae of living with HIV/AIDS.

The likelihood of patients with HIV/AIDS entering mental health treatment is growing. In 2006 the number of people with new HIV infections was 56,300, with an average of about 55,000 new infections each year since 2000 (CDC, 2008). As the number of AIDS cases and death rate have continued to decline, with more and more people living with HIV/AIDS, research shows HIV/AIDS patients have a higher incidence of psychiatric disorders than the general population (APA, 2000).

A careful and thorough assessment and evaluation is critical to successful patient care when working with HIV/AIDS patients. There are several areas in particular that need to be evaluated with some depth when developing an appropriate treatment plan. These areas include

- pre-existing mental health/substance abuse,
- the nature of current intimate relationships,
- family and peer relationships and social support
- work status and satisfaction, and
- current health status.

**Mental Health and Substance Abuse**

For persons who have a pre-existing psychiatric illness, a positive HIV diagnosis often brings with it an exacerbation of acute psychiatric symptoms or substance abuse. In addition, depending on the individual’s viral load, CD4 count, and the presence of opportunistic infections, a person’s mental health becomes vulnerable to changes in his or her medical condition.

Common psychiatric disorders experienced by people with HIV disease include mood disorders, psychotic disorders, anxiety disorders, adjustment disorders, personality disorders, and sleep disorders, any of which may have been present prior to and/or following the HIV diagnosis (HRSA, 2001). Suicidal ideation frequently is reported within six months of an initial diagnosis of HIV (Glass, 1988). The strongest predictors of suicidal ideation, however, are previous suicide attempts and depression preceding the HIV+ diagnosis (Rabkin et al., 1993). In working with an individual diagnosed with HIV and developing a treatment plan for him or her, it is critical to gain a clear understanding of the patient’s overall level
of psychological functioning and his or her ability to manage and cope with significant psychosocial stressors.

Common psychological problems and symptoms emerge from underlying feelings of shame, stigmatization, humiliation, guilt, embarrassment, fear, and anger about being diagnosed and living with HIV/AIDS. These underlying feelings are strong and can manifest in many different areas of the patients' life, including intimate, family, and peer relationships and work and play. A diagnosis of, and living with, HIV/AIDS may represent a significant loss of a specific quality of premorbid level of functioning. Depending on the progression of the illness, a person living with HIV/AIDS may have to cope prematurely with a general loss of overall health and potentially, begin to prepare for hospice care and death. An HIV/AIDS diagnosis may also recapitulate earlier psychological traumas (e.g. childhood abuse) as well as trigger new losses and traumas (the ending or changing of relationships). Existential issues related to suffering, aloneness, and isolation are not uncommon for individuals living with HIV/AIDS. These are reasons why a thorough assessment of these underlying experiences on different areas of the patients' life and their impact on level of functioning is necessary. It is essential to convey a strong sense of sensitivity, empathy, and respect to the patient to facilitate the development of the therapeutic alliance. This enhances the patient’s willingness to share and disclose not only very important information, but also very sensitive and traumatic experiences and history that affect treatment.

Clinicians need to assess for varying degrees of denial, as this is a common defense employed by individuals diagnosed with HIV. Denial can manifest in a variety of ways among different people and at any stage of the disease. For example, denial can be problematic if individuals continue to engage in high-risk behaviors (e.g., sharing needles or having unprotected sex), thereby increasing the risk of re-infection with potentially another strain of the virus or infecting others. Denial is equally problematic, with individuals who refusing to believe they are infected despite positive test results. Similarly, denial is problematic in the HIV+ patients who refuse to see physicians or take medications as prescribed or believe that having “undetectable” HIV means that they are free of the virus and unable to transmit it. Equally troublesome are those patients who believe that missing doses of medication periodically is inconsequential. Patients may continue to hold these kinds of beliefs despite education on the impact of
nonadherence to regimens on viral mutation, treatment resistance, viral load, CD4 count, and subsequent health.

Many HIV–infected patients have coexisting substance abuse or dependence disorders, and psychologists should screen patients for these problems. Injection drug users represent the largest HIV–infected, substance–abusing population in the United States. Injection drug users risk infection if they have multiple sex partners, exchange sex for drugs, share drug paraphernalia and/or engage in other “at-risk” behaviors that involve the use of alcohol and other noninjection substances that impair judgment (SAMSHA, 2000).

It is not unusual for individuals infected with HIV to manage news of their diagnosis through escalating substance abuse. Not only does ongoing substance use put their immune systems at further risk, but it also makes the decision to begin antiretroviral treatment complicated and patient adherence to medication extremely difficult. There is a strong correlation between substance abuse and medication nonadherence (Cheever, 2001). Because of the effect of medication nonadherence on viral mutation and viral resistance, decisions to delay treatment are often made in the presence of ongoing substance abuse. Patients also may choose not to initiate HIV medication regimens because it requires stopping the use of their drug of choice.

A full assessment into the nature and extent of mental health symptoms and/or substance abuse helps the psychologist to develop and match appropriate treatment interventions. For example, with patients who have irrational thoughts and beliefs about the nature of being infected and living with HIV/AIDS, cognitive therapeutic interventions would be appropriate. Another example, would be for a patient who is abusing benzodiazepines. Referral to a psychiatrist who can assess the need for anti–anxiolytic medication with tapering concomitant to psychotherapy will be helpful in treating underlying symptoms and causes of patient anxiety. Most important to treatment is the ability of the therapist to develop a warm, empathic, genuine, caring, positive, and hopeful attitude toward the patient, and have that attitude reflect respect for the patient and his or her experiences. Many patients living with HIV/AIDS have had significant traumatic experiences, whether it is the diagnosis of HIV/AIDS, a history of childhood neglect, physical or sexual abuse, or the fallout and negative consequences of years of substance abuse. As noted earlier, living with HIV/AIDS, for many patients, can exacerbate and recapitulate the suffering associated with these previous experiences, and for many, the ability to develop a trusting relationship with others to share these experiences has
been difficult. The more that a therapist is able to express accurate empathy with a patient, and develop the ability to reflectively clarify and amplify a patient’s experiences, the more the patient feels heard, listened to, and understood. This increases the likelihood that the patient will share even more sensitive life experiences with the therapist. It also increases the power of interventions that are well matched with well-understood experiences, problems, and symptoms. While it is important to treat specific symptoms with empirically validated and supported treatment approaches, in working with patients with HIV/AIDS, one of the most important treatment strategies is to convey what we hope to develop during treatment—openness, warmth, honesty, genuineness, respect and hope.

**Peer Relationships and Social Support**

Given the significant impact that HIV, co-existing psychiatric and substance abuse disorders, and opportunistic infections can have on patients’ lives, the presence of peer relationships and the ability to access social support is critical. The effect of social isolation on overall health can be significant. Persson, Gullberg, Hanson, Moestrup, and Östergren (1994) found that a low CD4 cell count was present more often in HIV+ men with low social participation, reflecting the potential relationship between social support and overall health. Unfortunately, accessing social support can be challenging for individuals diagnosed with HIV. Often, patients find that family, friends, and significant others have difficulty understanding the patients’ experiences. Patients may be afraid of the reactions individuals might have to the disclosure of the HIV diagnosis. As a result, patients fear and avoid disclosure and familial or social contact, thereby reducing the social support that is potentially available for them. This leads to a significant under utilization of social support and increasing feelings of isolation and shame, which are fueled by stigma and fear of humiliation.

It is critical for psychologists to assess fully the presence of meaningful peer relationships, wishes, and desires for social relationships in a patient’s life and to identify perceived obstacles that compromise the patient’s ability to develop peer relationships and access social support. Once the assessment is completed, specific behavioral treatment approaches can be designed to help patients develop strategies to overcome those obstacles. Of individuals diagnosed with HIV, the greatest stress has been experienced by those who have been disengaged behaviorally and emotionally from others and who felt less secure (or more anxious) in their interpersonal relationships (Koopman et al., 2000). To help individuals access or
develop healthy support systems, it is often necessary to assist them as they sort through the various thoughts and feelings about disclosure and to identify irrational beliefs that prevent them from accessing potential support. Having a strong support system helps patients feel connected and motivated to work to improve areas of their lives that they are concerned about and wanting to improve. Increasing patients’ ability to become more aware of their own supports and strengths increases the likelihood that they can experience a sense of self-efficacy in coping with being HIV+.

**Work**

Consideration must be given to the effect of HIV on an individual’s ability to work. A thorough assessment is needed to gauge a patient’s premorbid level of work functioning and satisfaction along with current occupational/vocational goals. Employed persons can find their work schedules affected by the progression of the virus, the presence and severity of other disease processes, and the impact of the medication regimen. The effect this may have on an individual’s career can be profound, having multiple consequences on earning potential, job security, relationships with supervisors and peers, perceptions of vocational/professional successes and accomplishments in life, and the ability to set future work goals. It is common for dilemmas to emerge around decisions of whether or not to apply for financial disability. Those continuing to work may experience significant distress over whether to tell supervisors and coworkers because of a fear of stigmatization. Once the area of work functioning has been evaluated, treatment plans can then be designed to support and empower patients to identify specific occupational/vocational goals that feel meaningful and bring satisfaction and develop and strategies can be implemented that work toward this end.

**Family Relationships**

The decision of whether and how to disclose one’s HIV status to family members is complex. Often this may involve other disclosures as well, such as substance abuse or sexual orientation. If the family is receptive to the disclosure, it can provide important social support to the patient, and many times the disclosure may result in deeper levels of emotional support.

The challenge of divulging this information to others, particularly one’s family, can be a source of much distress. Patients often feel faced with the possibility of rejection and withdrawal from their family and social support network. Ruminations over specifically whom, when, where and how to tell are common. Many patients fear the worst; they believe their families will judge them, react with harsh criticism, and eventually ostracize them.
Patients will have many thoughts about which family members might react harshly. They will worry about how they could or would be abandoned. Sometimes these thoughts are irrational and reveal more about the patients' own feelings of shame and guilt. Unfortunately, sometimes the fears about outcomes following disclosure become reality.

Psychotherapy can help patients explore their thoughts and concerns, test their thinking against reality, and develop and establish more rational thoughts and expectations about the outcome of divulging their HIV status. Patients can evaluate their perceptions and beliefs by examining the evidence that exists for these thoughts and considering alternative outcomes. At times, the patients' perceptions may be correct. Their families may lack an understanding of HIV/AIDS, its transmission, medications and their efficacy, and knowledge about survival outcomes. Family members often respond to myths that exist about HIV, such the virus being a "death sentence" or having the ability to transmit through casual contact. The family can benefit from education about HIV through couples and family meetings with health care providers or educational literature about HIV/AIDS.

Similar to the patient's adjustment to HIV+ status, the family will need time to adapt to a family member with a chronic illness. The family must be considered. In addition to evaluating how the family is adjusting to change at this time, past coping style and transactional patterns in response to stressful events and illnesses should be evaluated. It is important to assess the family's communication patterns and behaviors, how flexible or rigid they are, and how they be affected will upon disclosure of their loved one's HIV status. What are family members' fears and concerns about their ability to provide support to the patient or themselves? What feelings of anger, guilt, anxiety, depression, or issues of substance abuse exist in the family? How will these be affected? Family therapy sessions can increase the family's coping skills, help realign the patient's support system, and assist in renegotiating or reestablishing family relationships.

**Intimate Relationships**

In couples, not surprisingly, relationships often deteriorate if the partner who hid his or her HIV+ status infected the patient. Often, the patient is left with mounting anger and significant distrust in the partner. This distrust might be generalized to other relationships and situations, seriously impeding a patient's ability to commit and find satisfaction and enjoyment in relationships in general.

A thorough assessment into the nature of intimate relationships is
critical. Patients who choose to establish intimate relationships with new a 
partner after being infected with the HIV are confronted with a unique set 
of dynamics and concerns about the varying potential reactions of the 
partner. Emerging issues often center around areas of trust, fears of 
abandonment, feelings of guilt, thoughts of victimization, anger, uncer-
tainty around health status, concerns over transmission, helplessness, fears 
of death, and feeling as though one’s life will be shortened. These concerns 
include a decision to continue the relationship and work through the 
disclosure with a partner or a decision to continue the relationship and 
withhold the information. Following disclosure, the patient may fear the 
partner’s ending the relationship or sharing the information with others. 
These issues can affect the patient’s motivation, ability and commitment to 
be able to establish and work towards shared relationship goals.

Even when patients and their partners know of HIV+ status, they may 
deny the impact that the virus can have on either of them and continue to 
engage in high-risk behaviors. This places their health and their relation-
ship at significant risk. Some HIV+ patients comment about the joy they 
receive from having partners who “love me so much that [s]he is willing to 
die for me.” These reactions reflect a level of denial and minimization in 
the relationship, and lead to further high-risk behaviors that can further 
complicate their relationships and health status. In some relationships, 
though both partners know the HIV status, education regarding the effects 
of the virus and its transmission are lacking, placing the couple at increased 
risk of infection or re-infection. Psychologists should assess the unique set 
of characteristics that comprise the relationships and areas of stress and 
difficulty, separate from (but including) issues related to HIV. Levels of 
sexual communication between partners and their knowledge of HIV 
transmission are important areas to assess.

There are several additional stressors needing to be assessed in rela-
tionships where one member is HIV+. These stressors include fear of 
stigmatization and alienation from friends, family, other couples and the 
community. In addition, other common stressors confronting couples in 
which one or both partners are HIV+ are a perception of broken dreams 
of creating a family and a loss of a second income. Couples must adapt to 
a new lifestyle, which may include frequent medical visits, fatigue, side 
effects of medication, and changed sexual practices. Another stressor is 
adjusting to the anxiety associated with medical appointments that mon-
itor the progression of the CD4 count and measure viral load. As an 
individual and as a couple, flexibility in the relationship is called upon to 
balance a fear of the unknown with maintaining an awareness and knowl-
edge of the infection and its progression as well as maintaining some aspects of control (e.g., taking medication and going to medical appointments). Ongoing and open communication is vital in any relationship, and this is particularly true with couples in which one or both partners are living with HIV/AIDS. This is especially true in reference to how living with HIV/AIDS affects each of them and their relationship, how sexual functioning and intimacy are negotiated, and how they gauge hopes and set goals for the relationship.

**Health**

Addressing health issues is a very important part of treatment when beginning psychotherapy with individuals living with HIV/AIDS. Assessment in this area is significant as the progression of the virus has a profound effect on vulnerability to opportunistic infections, the need for multiple medications, and the level of functioning and disability, all of which have a intense impact on quality of life. In addition, many patients living with HIV/AIDS discuss being in a constant state of readiness for the impending worsening of their health. These ongoing fears influence overall quality of life. Sometimes, health can be relatively stable with HIV well controlled; nevertheless, fears continue about worsening health remain. Frequently, though HIV is well controlled, other co–occurring medical conditions are prominent and negatively influence overall functioning (e.g. hepatitis C). Careful evaluation in this area helps the clinician develop strategies that address health issues with the patient, for example, referring specialists, encouraging detailed, truthful discussions with primary care provider, reinforcing follow through with attendance at medical appointments, and supporting adherence to medication regimens.

**Conclusion**

Today, practicing psychologists are more likely to encounter patients who are HIV+ because of the improved treatment outcomes for this patient population. In working with patients with HIV/AIDS, careful assessment in the areas of mental health/substance abuse, peer relationships and social support, family relationships, intimate relationships, work, and health are important in developing an appropriate and effective treatment plan. The importance of developing a solid therapeutic alliance, with high levels of empathy, facilitates this dimensional evaluation and adds to accurate assessment of a patient’s level of functioning across various domains of their life. This enhances the ability to develop a treatment plan that effectively addresses patient treatment needs.
REFERENCES


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