Report from the XI International Conference
Psychological Distress and Support
Robert H. Remien, PhD

The XI International Conference on AIDS, which took place in Vancouver in July, included more than 5,000 oral and poster presentations covering topics ranging from the prevalence and impact of depression and psychological distress to the role and effects of coping and community support. While these reports rarely broke new ground, they did confirm much of our understanding of the psychosocial issues involved in living in the shadow of the pandemic. The inclusion of participants from many disciplines and cultures also highlighted the importance of human rights, culture and family, and community mobilization as factors fundamental to health and mental health.

As is evident from this report, conference presentations did a good job of documenting both aspects of psychological distress among people with HIV disease. However, they did not often take the next step to test interventions aimed at reducing distress and improving functioning. And while conference presentations covered in depth the clinical implications of major medical advances—triple combination therapy, the protease inhibitors, and viral load testing—there was practically no discussion of the psychological impact of what appears to be a dramatic change in HIV treatment.

Psychological Distress
There were many presentations about psychological distress as an outcome of HIV infection, its relationship to coping with HIV infection, and as a predictor of HIV-related risk behavior. For example, as has been reported at previous international conferences, presentations reflected a wide range of prevalence rates for depression and psychological distress among people with HIV disease: findings ranged from 5 percent to 70 percent of people exhibiting significant distress among various samples worldwide. Higher rates of distress are reported primarily in studies in developing countries where people with HIV disease are isolated, suffer discrimination, and lack resources and supportive services. Also, in developed countries, women, ethnic minority men (heterosexual and homosexual), and men and women in HIV serodiscordant relationships were more likely than members of other subgroups to exhibit high rates of distress. It is notable that since these studies did not find strong differences in distress between seropositive and seronegative people, researchers concluded that distress often reflects socio-cultural stressors such as poverty, violence, substance abuse, and discrimination, rather than HIV-related factors (for example, see Tu.C.2479).

A large number of reports explored the relationship between a history of sexual abuse, HIV-related risk behavior, and substance abuse. For example, a Canadian study of men who have sex with men found independent associations between risky sexual behavior and both childhood sexual abuse and drug use (Mo.C.900). A New York study found a high prevalence of trauma, drug use, and distress among seropositive women (Th.D.5164); another found an association between high rates of psychological distress and sexual risk behavior among women taking methadone (Tu.C.2481). Finally, another Canadian study found independent relationships between needle sharing and both underlying psychological distress and a history of sexual abuse (Mo.D.363).

Interpretations of causality in most of these studies is risky, and no single study was able to sort out the precise nature of...
The XI International Conference on AIDS in Vancouver was really well-organized. This may sound like faint praise, but when 15,000 people convene in one place, it is the organization that determines whether or not participants get anything done. Incredibly—to anyone who has attended other AIDS conferences—sessions began and finished on time, signs were clear, and hundreds of volunteers offered directions about getting from point A to point B.

Likewise, for a variety of reasons, the major scientific findings presented at the conference were comprehensible because of their organization. There were many presentations on viral load, the protease inhibitors, and combination therapy. This focus—and the uniformity of findings—accented the message of hope and the call for a new way to think about HIV-related treatment.

But, as both Robert Remien and Matthew Chappell point out in this issue of FOCUS, conference presentations failed to follow these treatment prescriptions to the next level, leaving questions about the psychological implications of treatment advances unanswered. Counselors on the front lines might consider the questions posed by these authors as signs of future issues that may arise in therapy.

As exciting as the treatment news was, presenters like Jonathan Mann reminded participants about the huge divergence in resources between the industrialized and developing worlds, leaving many of us with the queasy feeling: once the world was united in its pursuit of a cure; now that drugs appear more than ever effective, we are more than ever divided into haves and have-nots. This challenge may be reflected in communities throughout the world. If our hopes are realized—if HIV disease becomes more manageable for more people—will this, as Chappell implies, estrange those who survive from those who do not?

If future conferences (see page 6 for details) follow Vancouver’s lead in terms of focus, the stage will be set for addressing these issues. But, it is up to providers on the front lines, as well as conference organizers, to ensure that conference presentations respond to the most pressing questions.

The studies were consistent in suggesting that prevention include the early identification of sexual abuse and depression and involve counseling and support. For example, an inner-city Boston health care clinic applied a flexible, community-based, and culture-specific model to deliver a range of mental health services to people for whom these services would otherwise be inaccessible (Th.D.5160). By encouraging medical staff to act as colleagues in the provision of mental health services, as well as by offering specialized mental health interventions, this program was able to achieve increases in: screening for addiction behavior for adults; mental health screening and referral for children; self-perceived competence among primary care and allied providers regarding substance abuse problems and HIV-related mental health resources; attention to family issues among HIV primary care providers; and the ability of nurses and social workers to respond to some mental health problems. It also achieved decreases in mood disturbance among patients served directly by project staff.

A related issue—suicide—also received attention at the conference. A large European study found that rates of suicide and suicidal ideation peaked at the time of HIV diagnosis and at the end stage of illness, and suicide was associated with relationship stress and bereavement (We.D.242). The study documented the following rates: 5 percent successful suicides; 21 percent suicide attempts; and 50 percent suicidal ideation. Several other studies, looking at assisted suicide, found indications that both physicians and nurses were willing to assist patients in suicide (We.D.243; We.D.244). A British Columbia study found that assisted suicide is often implemented by non-medical professionals, and often employ inadequate euthanizing drugs and poor planning (We.D.241).

The relationship among these variables. One presenter suggested (Tu.D.134): “Physical and sexual abuse of women contribute to risky heterosexual behavior indirectly by virtue of their association with substance abuse and depression...and along with substance abuse, they contribute to women having riskier sex partners by increasing passive coping, stress, sexual coercion, and partner abusiveness.”

Coping, Depression, and HIV Progression

There were numerous reports on HIV-related coping that confirmed earlier findings regarding the importance of social support, proactive coping strategies, and community mobilization to optimize mental health and psychological resilience (for example, Th.D.5110; We.D.370; We.D.370). In many contexts and in many countries,
Hidden beneath the science, the big news of the Vancouver conference was the psychological implications of the medical advances—issues that remained unexplored.

researchers found the following proactive coping strategies to be associated with reduced psychological distress: problem-solving, positive reappraisal, seeking information, seeking social support, engaging in goal-directed behaviors and personal growth activities, spirituality, and affective expression. Conversely, they found the use of “negative” coping strategies—that is, wishful thinking, isolation, avoidance, and fatalism—to be associated with increased distress and diminished well-being.

A few reports showed that psychosocial interventions can both increase the use of proactive coping and improve mood. Most notably, a San Francisco model, Coping Effectiveness Training (CET), demonstrated how stress and coping theory can be translated into skills-building interventions that increase coping efficacy, reduce perceived stress and burnout, and decrease psychological distress in gay men with HIV disease (We.D.373). The model helps clients: increase their awareness of “distress cues,” distinguish between changeable and unchangeable aspects of specific stressors, and apply problem-focused and emotion-focused strategies depending on their appraisal of the situation. Similarly, researchers reported that individuals who were successful in substance abuse recovery used high levels of approach-oriented coping, particularly “planful problem-solving” and “positive reappraisal” (Th.D.5112).

The above findings provide a framework within which to better understand the consistently mixed findings regarding the relationship between depression and HIV disease progression. Since the beginning of the epidemic, researchers have sought to confirm two (perhaps conflicting) hypotheses: that depression is a direct (and normative) outcome of HIV illness progression, and that depression directly causes HIV illness progression. Indeed, there has been some data supporting both of these hypotheses. In Vancouver, however, as has been true at all past AIDS conferences, many reports demonstrated the lack of a relationship between symptoms of depression and both symptomatic illness and HIV disease progression. Several researchers suggested that coping is perhaps the key mediating variable in this equation (for example, We.D.372). Thus, whether one believes that HIV has a direct central nervous system effect that can cause depression or that depression is a psychological reaction to disease progression, there is substantial evidence that proactive coping plays a key role in preventing and ameliorating the resulting depressive symptoms, even in people with symptomatic HIV disease.

Studies of comparing “long-term non-progressors” and rapid progressors found no statistically significant differences between the two groups in terms of personality dimensions, psychological distress, coping strategies, or stressful life events (for example, Th.D.5158). This is not surprising given the emerging evidence that biological factors—such as genetics, host immune response, virulence of the HIV virus—play a big role in non-progression. In interpreting this data, however, it is important to distinguish non-progression from long-term survival. Past research on long-term survival has shown that coping strategies—such as being vigilant about physical symptoms, having a good doctor-patient relationship, and being aggressive with medical treatment—clearly play a role in improving quality of life and increasing survival among people with symptomatic disease. If emotions affect disease progression, it is likely that they do so because they facilitate such health-seeking behaviors.

The bottom line is that severe distress, including clinical depression, is not the norm for people with HIV disease. When present, it is usually the result of of factors other than HIV infection and should be treated as they would in the general population: by appropriately responding to psychiatric disorders, facilitating the use of positive coping strategies, and increasing available supports.

Social and Community Support

Conference reports from many countries—including India, Brazil, Kampala, Denmark, and Germany—confirmed the ability of social support, like coping, to reduce psychological distress and improve quality of life for people with HIV disease. Of particular note was the positive value of perceived emotional support, contact with friends and family, and the negative value of interpersonal conflict. Presentations also explored the benefits of community-based and integrated supportive services, disclosure, self-help groups, and group therapy in reducing anxiety and depression, improving self-esteem, improving quality of life, and reducing HIV risk behavior (for example, We.D.3910, and Th.D.5139).
These consistent findings have led to calls for governments to ensure the accessibility of supportive environments where seropositive people can gather and share their experiences and feelings without fear of discrimination (for example, Pub.D.1499). Struggles to achieve this goal serve, for those of us who can take for granted the availability of supportive services, as a reminder of their importance and fragility.

At a plenary session, Brazilian sociologist Richard Parker said that responding to AIDS must go beyond individual behavior change; it must address the underlying issues of inequality and injustice that have created the conditions for the spread of HIV infection. He also reminded his audience of the relative limitations of individual psychology as the sole foundation for intervention and prevention programs. Instead, Parker said, new models focusing on collective empowerment and community mobilization as central to interventions must join psychological approaches. These interventions, by their nature, would be: “Driven as much from the bottom up as from the top down, and guided not only by models of psychological process but by theories of cultural dissemination and social transformation...These [models] can be found in conceptual frameworks of the international human rights movement, of liberation pedagogy, of feminism, and of sex worker and gay rights movements—in short, in the work of social movements that have emerged in countries and communities around the globe in order to fight for social justice and inequity.”

It is crucial to note that Parker’s conceptual framework is applicable not only to prevention interventions but also to support strategies for people with HIV disease. As mental health providers, it is our role to consider this approach when working with our clients whether this means helping to empower them to obtain—or even organize—community support, or actively mobilizing grassroots initiatives ourselves when such resources are absent.

**Conclusion**

While many people with HIV disease are psychologically well-adjusted, others face behavioral and social issues that lead to impaired functioning. While it is important that conference presentations documented factors associated with psychological distress, it is notable that, for the most part, they failed to move beyond describing these factors to test interventions aimed at improving psychological functioning in those subsets of people who do exhibit significant HIV-related distress.

In addition, in the midst of a conference dominated by what are, by every measure, positive scientific developments, presentations failed to explore the psychological complications that are bound to arise as a result of medical advances: the emergence of hope after years of resignation, the impact of hope on HIV-related risk behaviors, the emotional impact of the treatment advances on those for whom they are not working, the effects on quality of life of new treatment approaches and complicated combination treatment protocols, the risk—resulting from non-compliance—of developing drug-resistant strains of HIV, the still-complex process of making treatment decisions and accessing care, and the psychological adjustment for people who are suddenly able to consider the future after having resigned themselves to disability—quitting their jobs and letting go of family and community obligations. These issues comprise, hidden beneath the medical data, the big news of the Vancouver conference for mental health providers.

**References**


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Two Worlds: One Conference
Matthew Chappell

I attended the International Conferences on AIDS in Amsterdam in 1992 and in Berlin in 1993 and left both in complete despair. As an activist and an AIDS counselor, I was able to appreciate the accuracy of the results presented at these conferences; as a person with HIV disease, I was unsettled by their failure to demonstrate an effective response to the AIDS epidemic.

In my heart I wanted hope—an end to the misery and devastation caused by AIDS. I learned from these experiences that it is unrealistic to expect a conference to reveal some incredible advance or cure. I wondered upon hearing the word "hope," who was it really for? Was it really for those of us with AIDS or those affected by the epidemic? I left Amsterdam and Berlin cynical and hopeless: we all know that hope helps to sell drugs just as sex sells dish soap.

A Three-Ring Circus

The Vancouver conference appeared as most conferences appear to me—a three-ring circus without a ringmaster. As I went from presentation to presentation, joined by thousands of other people amidst the frenzy of pharmaceutical company advertising, I anxiously sought further confirmation of the conference’s buzz words: "hope" and "manageable disease." While I did not leave Vancouver full of hope, I did not leave in despair. My challenge now is to figure out how to cope with the confusion that follows the slew of treatment reports that have been presented over the past 18 months.

The theme of the conference was "One World, One Hope." The reality of the conference is a tale of two worlds, one hope. It is painfully evident that the options we have in industrialized nations are privileges, unavailable, and unthinkable, in developing countries. Delegates from impoverished countries were underrepresented at the conference, but then, many of these nations cannot even afford to offer their citizens aspirin much less the triple combination treatments that were the focus of the conference. The whole conference was reminded of this disparity by the words of plenary speaker Catherine Nyirenda from Zambia: "Thank you for my air ticket, the cost of which would feed my [two young] children from now until they reach adulthood."

The hope trumpeted by the conference is most directly the result of data regarding the protease inhibitors, drugs that block the action of an enzyme—protease—that is necessary for HIV replication. There are 22 protease inhibitors, three available in the U.S. market and the rest in development. Particularly in combination with any two other antiviral drugs—for instance, zidovudine (ZDV; AZT) and didanosine (ddI)—the protease inhibitors significantly reduce the amount of HIV circulating in the blood.

The data regarding protease inhibitors were so compelling because of another finding: the correlation of viral load to HIV disease progression. By confirming their validity as "surrogate markers," conference presentations proved that viral load could be used to judge the efficacy of treatments like the protease inhibitors. Viral load tests—either polymerase chain reaction (PCR) or branch DNA (bDNA) testing—quantify the amount of HIV RNA in blood. Increases in viral load correlate with disease progression; decreases in viral load correlate with a reduced risk of progression and death. These relationships seem to be more direct than the relationship between disease progression and T-helper cell count, which up to now has been the standard marker.
Hope and False Hope

While these findings embody enough truth to be exciting, they do not deserve the media hype that treatment advances will lead to “the eradication of HIV.” It is vital that information not be used to mislead people with HIV disease. In fact, for individuals, hope is complicated—even dashed—by questions about these medical advances.

For instance, protease inhibitors do not fully arrest HIV replication, and they may have interactions with antidepressant and antianxiety drugs, drugs that treat opportunistic infections, and with both older antiviral drugs and a relatively new class called the non-nucleoside reverse transcriptase inhibitors (NNRTIs; including nevirapine). In addition, since HIV has the ability to mutate, it can become resistant to drugs such as the protease inhibitors, and a viral strain resistant to one protease inhibitor may be cross-resistant to others. Finally, there is no long-term data on the protease inhibitors: conference presentations reported on studies lasting only 48 weeks.

Similarly, while refinements are making viral load assays more sensitive, so far, the lower limit of detection is 500 copies per milliliter of blood—a level labeled “undetectable.” Such a result suggests that treatment is working, but does not mean that HIV has been eradicated. In addition, the test has not been used in clinical trials to measure HIV RNA in tissues other than blood, for example, the lymph nodes or the central nervous system (where HIV infection can cause cognitive impairment). In addition, while in most cases, decreases in viral load correlate to increased health, in some individuals, decreases coincide with the development of opportunistic infections, and in others, increases coincide with improved health.

The conference was dominated by presentations related to antiviral treatment; absent were many reports on opportunistic infections treatment advances. One study did suggest that azithromycin for Mycobacterium Avium Complex [MAC] lowers the risk of Pneumocystis carinii pneumonia [PCP]). There was also no new information on the neurological complications of HIV infection.

The focus on antiviral treatment also eclipsed presentations on HIV prevention, devaluing the importance of helping people to remain HIV-negative. For example, one Australian study reported on outreach strategies that have effectively eliminated seroconversion among gay men. Such prevention intervention reports may embody the most positive findings of all.

Conclusion

There are too many questions for me to let down my guard and let in hope. For whom do the new treatments and combinations work? When should a person initiate or change treatments? For how long will these drugs improve life, and do they prolong life? Will resistance lead to more virulent strains of HIV? Does a person need to make a life-long commitment to three-drug combinations? Does the ability of treatment to slow replication mean that the immune system will rebuild itself? Will drugs used to treat opportunistic infections restrict the efficacy of the protease inhibitors and other antiviral drugs?

What happens to people who lack insurance or the means to obtain these high-priced treatments? Will active substance users be denied protease inhibitors because of presumptions that they cannot handle these treatment regimens? What about the rest of the world? As hope manifests itself in industrialized nations, will the developing world be relegated to the sidelines?

I am left hanging, waiting for answers. I wonder about those of us who have AIDS who may live to see a time when it is truly a “manageable disease.” I am haunted by the image of surviving the concentration camps of World War II; why would one person live through the experience and not another? It is this trepidation that shades the feeling that, somehow, for the first time in the midst of the devastation of AIDS, I begin to feel some optimism, while I anxiously wait for answers that can emerge only with the passage of time.

Future Conferences

The 12th World AIDS Conference will take place in two years—July 28 to July 3, 1998—in Geneva, Switzerland. To contact the organizers, write: Congrex(Sweden)AB, Box 5619, S-114 86 Stockholm, Sweden; 46 8 612 69 00; (Fax: 46 8 612 62 96; Email: aids98@congrex.se; Internet: http://www.ias.se).

Next year—July 22 to 25, 1997—the Third International Conference on the Biopsychosocial Aspects of HIV Infection will take place in Melbourne, Australia. To contact the organizers, write: AIDS Impact, 108 Church Street, Hawthorn, Victoria 3122, Australia; 61 3 9819 3700; (Fax: 61 3 9819-5978; Email: meeting@iaccess.com.au).
How many traffic accidents need to occur at one intersection before a traffic light gets installed? How many studies must demonstrate the efficacy of needle exchange before public policy makers implement these programs?

In a carefully crafted statistical analysis presented at the Vancouver AIDS conference, Peter Lurie estimated that the failure to implement needle exchange programs (NEPs) throughout the United States has led to at least 8,361 and as many as 19,673 additional seroconversions between 1987 and 1995—with a health care cost of between $470 million and $1.09 billion (Tu.C.324). By the year 2000, the number of preventable seroconversions could jump by as many as 22,800.

Lurie also cited six national reviews of needle exchange programs, all of which agreed that needle exchange is effective in reducing HIV transmission and does not lead to increased drug use. But despite this evidence, the United States continues to ban the use of federal funds to run NEPs and most state and local jurisdictions severely restrict needle exchange (Mo.D.364): only nine states have authorized exchanges, and only six exempt NEPs from drug paraphernalia laws.

Conference presentations confirmed the conclusions of the studies Lurie cited: NEPs do not lead to higher drug use (Tu.C.320), they reduce HIV-related risk through decreased frequency of injection and needle sharing (Mo.D.361; Tu.C.2529; We.C.3537), and they reduce seroconversion (Tu.C.322; We.C.3544). The occasional finding of high seroconversion rates was attributed to other HIV-related risk factors, principally a history of sexual abuse, depression, prostitution, male-to-male sexual behavior, frequent cocaine injection, and multiple social disadvantages (Mo.D.363; Tu.C.320; Tu.C.321; Tu.C.322; Tu.C.2533). High seroconversion rates were also related to restrictions on needle distribution, for example: limited hours, inconvenient locations, lack of knowledge about needle exchange, lack of pharmacy availability, cost, and requiring one-to-one exchange (Mo.D.365; Mo.D.1858).

In addition, NEPs may encourage or enhance social networks and create opportunities for HIV education in what would otherwise be hard-to-reach populations (Tu.C.320; Mo.D.1938). NEPs are effective at referring clients to drug treatment programs (We.C.3561), thus potentially reducing the social costs of drug-related criminal behavior and of repeated incarceration (We.D.235). In fact, according to one presentation, if a needle exchange program stops only one seroconversion per year among seronegative, injection-drug-using inmates, it will be cost effective (We.D.235).

Changing Public Policy

If needle exchange is such a powerful tool, what can be done to implement it on a wider scale? One study of the legal situation in the United States proposed four approaches (Mo.D.364): 1) Legalize syringe exchange programs [SEPs]; 2) Allow the use of federal funds for SEPs; 3) Repeal syringe prescription laws and regulations to allow the sale of syringes in pharmacies; 4) Reform drug paraphernalia laws to exclude syringes from the definition of paraphernalia. Other studies proposed pharmacy purchase programs or over-the-counter sales, approaches that have been effective in other countries (Mo.D.365; Tu.C.322).

Some cities have superseded local laws forbidding needle exchange programs by invoking states of medical emergency. This tactic could be applied more widely, resulting, for instance, in mandates regarding HIV education, condom distribution, and STD education in schools. In addition, in Washington state, sex and HIV-related education programs must, by law, be medically accurate. This has enabled state officials to veto sex education programs that promote only abstinence and to require school programs to discuss condom use (Tu.D.2818). Legislation like this can go a long way to ensure that the verifiable research that supports controversial prevention efforts gets the attention that it deserves.

Needle exchange programs, as is clear from a preponderance of supportive evidence, are effective. They work because they focus not only on the individual but also, as Jonathan Mann has labeled it, on the “societal context” in which individuals live and because they clearly represent a nonjudgmental societal commitment to help individuals reduce harm and maintain health. They work because they reflect an understanding that risky behavior is a social event, not an individual one, and that individual change requires societal change.
Recent Antiviral Treatment Guidelines


In response to considerable scientific advances over the past 18 months—including a better understanding of HIV replication, the correlation of viral load to disease progression, and the availability of new drugs and new drug combinations—guidelines for HIV-related care must address changes in the timing, composition, course, and tracking of treatment, according to the recommendations of a 13-member panel of the International AIDS Society–USA.

**Predicting HIV Disease Progression**

Most viral replication that leads to the progressive immune deficiency characteristic of HIV disease actually occurs in the fixed lymphoid tissues, but the amount of virus in the lymph glands is not easily quantified. Plasma RNA—or viral load—assays indirectly address this issue by measuring the amount of HIV in the blood, a result that is proportional to the number of infected cells in the body as a whole.

Viral load levels have been correlated with disease progression and appear to be better predictors of progression than T-helper cell counts (although T-helper cell counts are still useful to determine timing of treatment). Studies have demonstrated that individuals with the lowest viral load (less than 5,000 HIV RNA copies per milliliter of blood) have the lowest risk of progression to AIDS, while subjects with plasma virus levels of greater than 30,000 to 50,000 copies per milliliter have the greatest risk of disease progression.

Ideally, treatment should begin before irreversible immunologic damage occurs. The panel recommends treatment for asymptomatic patients under the following conditions: T-helper cell counts of less than 500; T-helper cell percentages below 25; T-helper cell counts greater than 400 if viral load is higher than 30,000 to 50,000; or rapidly declining T-helper cell counts. Data do not support treatment when T-helper cell counts are above 500, and such early treatment has potential drawbacks ranging from long-term drug toxicity, to expense, to the possible induction of drug-resistant virus. Finally, all patients with symptomatic HIV disease should begin antiviral treatment.

**Treatment Regimens**

There are two equally defensible treatment strategies: using the most potent antiviral therapy in all patients; or reserving such therapy for patients with a higher pre-treatment progression risk: those who are symptomatic, those with rapidly falling T-helper cell counts, those with high viral loads, and those who worsen after less potent treatment regimens.

The most potent treatment regimen at this time consists of two nucleoside analog medications and a protease inhibitor. The recommended nucleoside analog combinations are zidovudine (ZDV; AZT) and didanosine (ddi); ZDV and zalcitabine (ddC); and possibly ZDV and lamivudine (3TC). Especially for those who do not tolerate ZDV, ddi monotherapy is a reasonable option. The choice of treatment approach should be based on drug efficacy and potency, safety and tolerability, durability of effect, resistance patterns, and cost.

The panel recommends changing treatment when failure occurs: that is, in response to a rebound to one-half to two-thirds of pre-treatment viral load; a T-helper cell count decline to pre-treatment levels; or the appearance of an opportunistic infection. Other reasons for change include patient noncompliance with a more complex regimen. In conclusion, the panel notes that new data are emerging quickly and treatment guidelines will have to be updated frequently.

**Next Month**

Anxiety, like depression, is a mood disorder that seems to be a natural response to HIV disease. Also, like depression, it is a label that encompasses a range of disorders. The November issue of *FOCUS* looks at anxiety and its HIV-related origins. Donald I. Templer, PhD and Raymond C. D. Greer, both of the California School of Professional Psychology–Fresno, define “death anxiety,” and its relation to HIV disease and to generalized anxiety. They enumerate the correlates of death anxiety and suggest treatment approaches.

Daniel Karasic, MD, an Assistant Clinical Professor of Psychiatry at the University of California San Francisco and a psychiatrist at the UCSF AIDS Health Project, discusses the epidemiology and manifestations of anxiety in the context of HIV disease.
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