Psychotherapists have treated HIV-positive gay men over the past two decades and, based on this work, have developed effective treatment goals and compassionate interventions to help these clients. As a result of these efforts, providers have contributed to the creation of mental health programs that assist those infected and people in their support networks to better manage the emotional impact of HIV infection. These programs continue to provide effective and meaningful services, suggesting that mental health providers have developed a reasonably accurate sense of the psychosocial issues facing HIV-positive gay men.

In recent years, however, there has been a resurgence of unsafe sexual behaviors, increasing difficulties with sustaining adherence to antiviral medication regimens, complex emotional reactions to issues of disability and returning to work, a growing generation gap among HIV-positive gay men, and a decrease in community support. What is perhaps most striking about these issues is that many mental health providers had not anticipated how significant these concerns would become in the lives of gay men. It is, therefore, worth reexamining our understanding of the psychosocial needs of HIV-positive gay men today and how these changing needs appear in psychotherapy.

The Evolution of Presenting Issues

In a 1984 article discussing the psychological impact of AIDS on gay men, receiving an AIDS diagnosis was described as “catastrophic,” leaving many people to cope with an “overriding sense of gloom and helplessness.” During this time, many HIV-infected gay men presented for mental health services with acute anxiety and depression, hypochondriasis, brief reactive psychoses, and suicidal crises. Since HIV disease was poorly understood and no antiviral treatments were available, many of these men were left feeling that their illness was to be endured and that death was imminent. Mental health practitioners responded to these presenting issues by providing information, counseling during periods of acute distress, and offering support groups and pharmacotherapy as needed.

By the late 1980s, the first antiviral medications became available and healthcare providers became better able to understand and manage opportunistic diseases. These advances transformed the experience of having HIV for many gay men from one of emotional terror and rapid physical decline to one of learning to live with a life-threatening illness over a period of years. It also became clear that the gay community was confronting a crisis of unknown duration. Common presenting concerns expanded to include anxiety-ridden thoughts about illness and disability, isolation and loneliness, and a shrinking social life resulting from disability. As gay men struggled to integrate the HIV experience into their lives, it also became apparent that those with mental health and substance use histories often had a more difficult time coping with HIV-related psychosocial stressors.

Through the early and mid-1990s, many gay men who had been living with HIV for 10 years or more continued in good health with few or no symptoms, while others had varying degrees of disability and illness. HIV began to be compared to other chronic illnesses such as diabetes, and as with other chronic illnesses, adherence to...
New technologies for HIV treatment and methods of testing have brought important changes to the way HIV is managed. Treatment advances, in particular, have raised new issues such as medication adherence, treatment failure, and tough decisions about returning to work.

But, according to this month’s issue of FOCUS, these concerns often aren’t the predominant ones of clients seeking psychotherapy. In many respects, clients enter psychotherapy with similar presenting issues that have been raised throughout the epidemic: concerns about depression, relationship conflicts, and substance use. While relying on an admittedly small sample of psychotherapists working with HIV-infected gay men, Domenic Ali writes about experiences that are useful for providers and program planners.

Beyond reporting on similarities across time, Mr. Ali also looks at the ways in which the epidemic has experienced a psychosocial evolution and maturation. In part, this has meant that in some cases, HIV-related issues play a less noticeable role in therapy now compared to several years ago. Many clients today are concerned with broader life issues that are not unique to HIV infection or other life-threatening illnesses, for instance, a general lack of meaningful relationships in life, mid-life transition issues, and sexual dysfunction.

In another article, Susan Morin and Charles Malyon consider the ways in which advances in testing technology, specifically the development of the detuned ELISA, a test that can tell if a person’s HIV infection occurred in the past six months, have brought changes. While some providers have hoped that detuned assay technology would enhance the notification of partners, given that the shortened time period makes it more possible for clients to identify those with whom they’ve been sexual, this fact alone may not be sufficient and, as with the case of changing risk behaviors, psychological readiness is important to bring about an action.

For providers, these articles suggest that changes in the HIV epidemic may not necessarily change an individual’s response to being infected in the way providers might expect, and we cannot rely on assumptions about current “hot issues” to determine what an individual’s concerns may be.

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reveals the most common presenting concerns (in order of frequency): recent diagnosis (29 percent), depression (29 percent), relationship conflicts (14 percent), alcohol and other drug use (16 percent), declining health (14 percent), improving health and returning to work (10 percent), medication compliance (10 percent), grief and loss (10 percent), lack of social support (5 percent), and safer sex (5 percent).

With the exception of medication compliance, improving health, and returning to work—all of which are largely a consequence of combination treatment—these concerns seem to be the same as those seropositive gay men have presented since almost the beginning of the epidemic. The immutability of these presenting issues across time, however, is less stable than first appears. In a focus group with 10 AIDS Health Project psychotherapists—some of whom have been working with HIV-infected gay men for more than a decade—nearly all noted that HIV-related issues play a less noticeable role in therapy now than they did several years ago. According to these psychotherapists, more clients today are concerned with a general lack of meaningful relationships in their lives, mid-life transition issues, sexual dysfunction, and adjusting to living on disability income than the immediate and direct consequences of being HIV-positive. AHP psychotherapists as well as some other San Francisco-based practitioners have also observed the emergence of a generation gap related to psychosocial concerns within the HIV-infected gay community. Younger HIV-infected gay men seeking therapy tend to feel more comfortable than older gay men with their gay identities. Older gay men with HIV also tend to have more hopeful attitudes regarding the manageability of HIV disease. At times, this hopeful attitude can become distorted into a denial about the severity of HIV disease. By comparison, older gay men tend to have greater feelings of alienation, and a long history of HIV-related grief and loss that has not marked the experiences of men only a few years younger. In addition, many older HIV-infected gay men who had not anticipated living so long are also confronting issues of “generativity”—the need to establish and guide the next generation within one’s community.6

Silent Issues

Issues of treatment adherence and returning to unsafe sex, two issues that receive substantial attention in the media and in research literature, are notable for their absence from the list of common presenting concerns. Literature suggests that many HIV-positive gay men are having difficulty sustaining adherence to antiviral regimens.7 People miss doses for a variety of reasons—forgetting, sleeping through a dose, being away from home, or being busy. One client poignantly admitted to being tired of “the burden of perfection” required by antiviral treatment and noted this is a more common feeling among his friends than they often like to admit. Many clients, particularly those who are informed about the importance of adherence, may feel ashamed about raising this issue in psychotherapy because they “know it is wrong” to not take medications on schedule.

Similarly, concern about unsafe sex is a surprisingly uncommon current presenting issue for gay men seeking psychotherapy. A study conducted by the Centers for Disease Control and Prevention found that unprotected anal intercourse among gay men in San Francisco increased nearly 30 percent from 1994 to 1997. One journalist identified silence as a frequent component of unsafe sexual behaviors. In a news article, the journalist stated, “Call it burn out, denial, or false hopes, but many gay men are tired of AIDS taking center stage in their lives. They don’t want to hear any more about HIV prevention.”8 This silence may have carried over to psychotherapy,


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where the infrequent appearance of safer sex concerns by clients appears inconsistent with behavioral trends.

**Implications for Psychotherapy**

The current presenting concerns of HIV-positive gay men bring attention to three broad issues. First, the psychosocial impact of having HIV is, for many gay men, less well-defined than it once was. While it is possible that HIV is less relevant in the lives of gay men now than it was in the past, it is more likely that HIV has grown more subtle and pervasive in its effects and, hence, more difficult to fully articulate. Psychotherapists need to listen with extra care to these clients, particularly those who have been diagnosed for many years, to understand how the impact of HIV is affecting their lives. With this in mind, it is often helpful to encourage gay clients to explore what HIV status means to them in the context of the history of the epidemic and in terms of their participation (or lack thereof) in the gay community.

Second, adult development is becoming increasingly relevant in the context of HIV-related therapeutic issues. In retrospect, this seems obvious; as both the epidemic and the gay community undergo an inevitable maturation from their early years, gay men with HIV disease will most certainly face a different set of issues. Psychotherapists should consider how a gay client’s HIV status has influenced his adult development and, conversely, how the client’s maturational stage is affecting how he perceives the meaning of HIV in his life.

Third, there appears to be a long-term emotional exhaustion for many HIV-infected gay men as well as for the community as a whole. This exhaustion may make it difficult for many to fully acknowledge the continuing presence of HIV in their lives. This may, in part, help HIV mental health providers better understand the daily struggle of many people to sustain health-promoting behaviors such as safer sex and medication adherence. Psychotherapists should explicitly discuss medication adherence and safer sex issues with gay clients and work towards normalizing the difficulties clients may have sustaining these behaviors. While therapists should not use these situations as opportunities to infuse the therapy with their own personal or political agenda, it is critical that they assist clients in openly and honestly discussing some of the most emotionally charged issues HIV-positive gay men face today.

**Conclusion**

Recent years have seen the emergence of what some describe as the “AIDS is over” dilemma—the perception some people have that HIV is on the decline. While the HIV-related death rate in the United States has decreased, the incidence rate remains constant at about 40,000 new infections per year. The psychosocial impact of the epidemic will likely continue to evolve in subtle and pervasive ways. If the survey of presenting issues discussed here is an indication of where to focus psychotherapeutic efforts, it suggests that mental health clinicians should work to better understand how HIV is affecting adult gay development, learn to more effectively help HIV-infected gay men explore the issues of sustained safer sex practices and medication adherence, and listen more attentively to the hard-to-express emotions of what it means to be HIV-positive 20 years into the epidemic.
New HIV antibody testing technology—the “detuned assay”—has enabled HIV counselors to identify clients who were probably infected within six months of testing, distinguishing “recent seroconverters” from people who have been infected for longer than six months. The UCSF AIDS Health Project’s HIV Counseling and Testing Program is one of a small number of sites that is piloting the detuned assay. The project's brief experience with the assay offers some insight into the limitations of the test and the range of concerns for people who have recently seroconverted. This article reviews this experience and suggests that recent seroconverters in San Francisco share similar concerns with people who have been infected longer than six months.

Between September 1998 and May 1999, 107 clients tested HIV-positive at the project’s HIV Counseling and Testing program (HCAT).1 Of the 89 seropositive clients who received results of the detuned assay, 88 were male, and 24 had probable infection within the last six months. Twenty of the 24 recent seroconverters were gay men, two were bisexual men, one was a heterosexual man, and one was a man of unknown sexual orientation. In reviewing the detuned pilot experience, it is important to keep three factors in mind. First, many HCAT clients test regularly, so they may already know if an infection is recent: of the 24 recent seroconverters, more than half had tested within the last year. Second, AIDS education about the “window period” of infection has discouraged people from testing within six months of a possible exposure. Third, the detuned assay sets up an arbitrary distinction: six months is “recent,” seven months becomes “long-standing.”

All clients who test seropositive through HCAT are referred immediately to linkage counselors who facilitate a process whereby clients can begin to move from the visceral experience of testing HIV-positive—an experience of emotional crisis—to a more active and practical state of decision making. This is a critical period for clients as they make choices, consciously or not, about disclosing their serostatus, potentially infecting others, and pursuing medical or mental health treatment.

Partner Notification

When the detuned assay detects a recent infection in a client who was otherwise unaware of this possibility, it is the emotional functioning of the client that determines whether that client notifies past partners. Emotionally high-functioning clients can often move from a position of concern for themselves to concern for others, even when they are overwhelmed by the devastating confirmation of HIV infection. So, as in many other areas, knowledge of recent infection is not enough; there must also be a psychological readiness.

Two examples demonstrate the range of outcomes. One client with a recent infection informed his new partner whose own detuned assay indicated a long-standing infection. In this case, the detuned assay helped locate the source of infection—rather than people to whom it might have spread.1 Another client, emotionally lower-functioning and in early recovery, had a long-standing infection. He was angry and bereft because “no one had ever taken care” of him. Rather than notify partners, he expressed a desire to “go out and infect

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See also references cited in articles in this issue.
people.” His linkage counselor validated his sadness and anger, and contracted with the client not to “infect” anyone until their next appointment several days later. At the second appointment, the client was no longer so emotionally reactive, and the linkage counselor was able to both normalize and contain the client’s angry feelings.

**Early Treatment**

One of the projected benefits of the detuned assay was that it might increase the likelihood of clients pursuing early treatment for HIV. One linkage counselor confirmed that some HIV-positive clients—whether recent or long-standing seroconverters—test both because they assume they are seropositive and because they are at the “ready for action” stage of behavior change: being ready for action in this context may include the pursuit of medical treatment.

However, the counselor added that many clients are not making treatment decisions based on their detuned assay results. He pointed out that psychologically integrating an HIV-positive result is a process, and initially clients deal with emotional rather than practical concerns. Another linkage counselor described a client with a recent infection, who felt he had plenty of time to educate himself about treatments. In this case, the confirmation of a recent infection led to reduced pressure or urgency for immediate medical treatment.

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Clients who have not already decided to pursue medical treatment face a complicated decision-making process and a range of medical opinion on the importance of early treatment. It is important to note that the detuned assay was not available until the brightest hopes for combination therapies had begun to fade. As with partner notification, a client’s pursuit of early treatment appears to be less about the knowledge of recent infection, and more about the degree to which he or she emotionally integrates the reality of being HIV-positive, the belief that medical treatment is valuable and available, and a readiness for action.

**Seroconversion and Emotional Crisis**

Throughout the epidemic, HIV diagnosis has remained a complex psychological, social, and medical challenge for clients. In a culture that values individualism, strength, and control, and distrusts sensuality and sexuality, it can be profoundly upsetting to test seropositive for a sexually transmitted and life-threatening disease. It is a vertiginous moment when the ground falls away for the client. One counselor described clients moving into an unconscious space where the deep fears they express are part catastrophic expectation, part existential truth. This complexity is reflected in statements such as: “My life is over.” “I will never be in a relationship.” “This is going to kill my mother.” “I just want to know how much time I have.”

The expressions of fear, loss, shame, and identity confusion are the same expressions antibody test counselors have heard throughout the epidemic, as gay men wrestle with mortality, vulnerability, meaning, and worth. In 1999, when a linkage counselor asks a client about his or her primary concern, there is a good chance the client might respond: “Telling my family.” The emotional and existential crisis of HIV diagnosis pulls such clients toward primitive concerns of connection and separateness.

**Conclusion**

Anecdotally, it appears that the detuned assay and early treatment have less bearing than might be expected on the immediate experience of gay men who test HIV-positive; this experience is still characterized by emotional crisis. However, when clients begin to integrate the fact of HIV infection, confirmation of early infection—if not otherwise known—and the availability of treatment are significant developments in the current HIV testing landscape.

**Expressions of fear, loss, shame, and identity confusion in response to receiving a positive HIV test result are the same expressions antibody test counselors have heard throughout the epidemic.**

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**Comments and Submissions**

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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Psychiatric Treatment and HIV


In a study assessing the effectiveness of psychiatric treatment for HIV-infected clients, 49 percent of participants showed an improvement in mental health as a result of individualized treatment. The study also found that poorer treatment outcomes were associated with injection drug use and other substance use disorders, history of psychiatric inpatient admissions, and poor compliance with treatment. Sociodemographic variables, however, had no impact on treatment results.

The study consisted of 126 participants who were referred for psychiatric evaluation to the outpatient HIV clinic at the Johns Hopkins Hospital. Seventy percent of subjects were male, 65 percent were African American or Hispanic, 60 percent were heterosexual, and 14 percent were employed. In addition, 53 percent had current substance use disorders, and 49 percent reported prior psychiatric treatment.

Each participant completed an individualized treatment plan that targeted his or her specific mental disorders and lasted an average of 15 months. Subjects also attended follow-up meetings roughly every other week for an average of 14 months after treatment. Clinicians assessed substance use and risk behavior as well as missed visits and failure to comply with prescribed medication regimens.

Based on a scale assessing symptom relief, functioning, and change in HIV-risk behaviors, study researchers rated 30 percent of participants as being “better” after treatment, 19 percent were rated “almost well,” and 51 percent were rated as showing “no change” or being “worse.”

The study also assessed compliance with treatment by looking at the number of meetings a subject missed and the subject’s estimated adherence to prescribed medication. In the assessment of compliance, 28 percent of participants were rated “good,” 24 percent “fair,” and 48 percent “poor.” Of those whose compliance was good, 95 percent showed at least small improvement, while 85 percent of poorly compliant subjects were rated as showing “no change” or becoming “worse.” In addition, patients who were considered to have poor compliance achieved complete abstinence from substance use only 32 percent of the time, while “good” compliers achieved complete abstinence 68 percent of the time.

HIV-Related Stress


According to a review of literature, the use of two complementary psychotherapy models that focus on stress response is effective for treating people living with HIV. The Horowitz model outlines five phases of stress responses common among clients who face events that threaten their core personal beliefs. The Janoff-Bulman “assumptive world” model organizes these core beliefs into three categories. Together with an assessment of the severity of stress response that acknowledges the continuum of emotional reactions to HIV-related events, these models can help in developing intervention strategies for HIV-infected clients who have difficulty coping with stress.

According to the Horowitz model, HIV-related stress often leads to a progression of psychological responses ranging in severity from normative to those that warrant clinical diagnosis.
ing the stressful event and feeling overwhelmed by it. To help clients achieve psychological equilibrium during these alternating phases, therapists can selectively combine techniques that facilitate direct confrontation with the stressful event with techniques that buffer its psychological impact. For example, an intervention for a client who denies the necessity of HIV-related medical care may include encouraging the client to assume more active involvement with his or her health care while considering the degree to which denial may serve as an adaptive psychological buffer.

In the Janoff-Bulman model, much of the psychological distress arises from discrepancies between the facts of HIV-related events and three categories of preexisting, core personal beliefs. Severely stressful events can challenge a category of core beliefs associated with the benevolence of the world, including perceptions of safety, goodness, and security. Manifestations of such concerns include heightened feelings of anxiety, vulnerability, anger, and sadness. Another category of core beliefs includes assumptions about the justice and meaning of negative life events. For example, HIV-infected clients may ask “Why me?” or may feel unable to control their own destiny. The third category relates to self-esteem, such as when people perceive themselves to be tarnished, damaged, or defective as a result of HIV-related physical deterioration.

Depression Treatment for People with HIV
(Cornell University.)

A comparative study of four psychiatric treatments found interpersonal psychotherapy to be an effective alternative to pharmacotherapy in alleviating depression among HIV-infected participants. The study sample consisted of 101 subjects recruited through advertising and referrals. Eighty-five percent of subjects were male, 80 percent were gay or bisexual, and 58 percent were White. The mean age of the sample was 37 years old. All participants needed to have known their serostatus for at least six months, exhibit clinically significant signs of depression, and appear sufficiently healthy to attend outpatient treatment.

Subjects were randomly assigned to receive one of four treatment interventions within a 17-week period. Interpersonal psychotherapy sessions focused on the ways mood changes relate to events and changes in a subject’s life while pragmatically encouraging subjects to develop strategies to address problem areas, find new life goals, and make adjustments to help achieve these goals. Cognitive behavioral therapy helped participants to identify irrational, negative thoughts associated with depression and to challenge the validity of these thoughts.

The supportive psychotherapy intervention, which served as a control group, included client-centered therapy and education about depression and HIV. The fourth group combined the antidepressant medication imipramine with supportive psychotherapy. There were no significant differences in demographics or severity of depression among treatment groups.

Analyzed by a variety of methods to determine outcomes, researchers found that subjects receiving interpersonal psychotherapy had greater improvement with depression than those receiving imipramine, those receiving cognitive behavioral therapy, or those receiving supportive psychotherapy.

Next Month
In the age of triple combination drug therapies, researchers, service providers, and activists must often remind people that the AIDS epidemic is not over. In October’s annual conference issue of FOCUS, Pamela DeCarlo and Olga Grinstead, PhD, MPH, of the UCSF Center for AIDS Prevention Studies (CAPS), discuss the impact of HIV treatment advances as presented at the 4th International Conference on the Biopsychosocial Aspects of HIV Infection (also known as the AIDS Impact Conference), in Ottawa, Canada.

One of the emphases of the AIDS Impact Conference is the connection between medical research and its psychosocial implications. In the second article of the October issue, Pamela DeCarlo and Ellen Goldstein, MA, also of CAPS, write about an AIDS Impact Conference satellite meeting in Ottawa that sought to strengthen and promote HIV-related community based research.
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