HIV COUNSELOR PERSPECTIVES

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MENTAL ILLNESS

People with mental illness may be at increased risk for HIV infection due to behaviors influenced by their condition. Mental illness might also inhibit people from incorporating HIV risk-reduction into their lives. This issue of PERSPECTIVES discusses the factors that may contribute to increased risk for HIV infection among people with mental illnesses such as depression, anxiety, bipolar disorder, and schizophrenia. The Implications for Counseling section provides strategies for working with clients with mental illness in an HIV test counseling session.

Research Update

Approximately three million people in the United States suffer from severe and persistent mental illness (SPMI), a term typically referring to schizophrenia, bipolar disorder, major depression, or anxiety. The wide range of SPMIs have in common psychological symptoms that persist over time and adversely affect daily living skills, social interactions, relationships, and jobs or education. (See chart on page 4 for descriptions of symptoms of the basic types of mental illness.)

Consequently, people suffering from mental illnesses often lack the ability to judge HIV risk behavior or to successfully implement HIV knowledge in real-life situations. The debilitating nature of mental illness affects both emotional and physical health and can cause people’s behavior to be governed by poor cognitive skills and symptoms of their illness.

Rates of HIV Infection

Most studies of HIV infection among mentally ill people have come from New York City, where nearly 9 percent of psychiatric patients in hospital settings are HIV-infected. Studies in Baltimore, Maryland and Columbia, South Carolina have found HIV infection rates to be nearly 6 percent. A comprehensive review of all HIV seroprevalence studies among the mentally ill estimates that approximately 8 percent of psychiatric patients in the United States are HIV-infected, which is more than 25 times greater than the estimated infection rate among the general population.

Research from several U.S. cities indicates that between 20 percent and 50 percent of psychiatric patients with chronic mental illness report high rates of HIV risk behavior. One study of psychiatric patients found 27 percent to be at “medium” HIV risk and 26 percent at “high” risk. However, only 33 percent of “high-risk” participants had been tested for HIV—compared to 40 percent of people at high risk in the general population. This is consistent with other research indicating that most psychiatric patients do not know their infection status and do not receive HIV counseling and testing.

Risks for HIV Infection

A common misconception about people with mental illness is that psychiatric hospitalization, psychotropic medications, and functional disabilities decrease sexual activity, injection drug use, and other HIV risk behaviors. Research
indicates, however, that HIV risk is common among mentally ill people. A 1997 study found that 68 percent of participants with an SPMI had been sexually active within the previous year. In addition, 13 percent of men and 30 percent of women reported having two or more male partners, and 24 percent of men reported having two or more female partners. Study participants reported frequently choosing sex partners at psychiatric clinics or bars and using condoms inconsistently. 

Other research has corroborated high rates of HIV risk behavior among people with mental illness. In a 1998 study, nearly 50 percent of participants reported having multiple sexual partners in the three months prior to being interviewed. The same study found that mentally ill people experience high rates of sex associated with substance use (23 percent), coerced sex (20 percent), sex with injection drug-using partners (14 percent), and sex in exchange for money, food, clothing, or housing (16 percent of women and 6 percent of men). In addition, participants reported using condoms only 32 percent of the time during vaginal sex and 27 percent of the time during anal sex, even when their partners were considered to be at high risk for HIV infection. The researchers speculated that unprotected sex was often the result of having poor negotiating skills in sexual relationships.

Many mentally ill people experience symptoms that require repeated hospitalizations and ongoing mental health care. Although medical treatment often eases psychiatric symptoms, prolonged treatment may interfere with the ability to work and interact socially. As a result, people with a mental illness are likely to be unemployed, economically and socially disadvantaged, and living in temporary housing—conditions associated with increased vulnerability to HIV infection. Furthermore, people with an SPMI may view HIV infection as only one of many life-threatening problems and one that is of less immediate concern than others such as avoiding violence or accessing health care.

A study of 122 homeless and mentally ill men found that 16 percent had been diagnosed with a non-psychotic disorder, such as major depression and bipolar disorder, and 84 percent had been diagnosed with a psychotic disorder such as schizophrenia. Twenty-four percent of the total sample reported engaging in unprotected sex with non-monogamous partners; this included 52 percent of sexually active men reporting sex with women and 60 percent of men reporting sex with men. Seventy-six percent of homeless men had sex occasionally—once per month or less—but because many of them had unprotected sex with non-monogamous partners, these isolated sexual encounters put them at high risk for HIV infection.

**Impaired Behavioral Skills**

Symptoms of mental illness may influence a person’s behavioral skills. A “lack of insight,” for example, may lessen the ability to avoid HIV risk. A common symptom of bipolar disorder—a condition characterized by both manic and depressive episodes—is hypersexuality, which may cause a person to act impulsively and engage in risky behaviors. Some people who are depressed have little interest in sex, while others find that sex or substance use makes them “feel better.” The low self-esteem characteristic of depression may also decrease the feelings of security, acceptance, and control that may be necessary to reduce HIV risk behavior.

In one study, teenagers with three or more symptoms of depression were nearly six times as likely to engage in sex work than those with asymptomatic depression. The study also found that teenagers with symptoms of anxiety were 11 times as likely than those with asymptomatic anxiety to engage in sex work and nearly five times as likely to use injection drugs.

Research indicates that having sex with multiple partners is nearly three times as common among mentally ill people with psychiatric symptoms—delusions, hallucinations, disorganized speech, or disorganized behavior—than among asymptomatic psychiatric patients, possibly because these symptoms impede cognitive functioning. Research also indicates that mentally ill people with many “excited” symptoms, such as mania, are more than five times as likely as mentally ill people with few excited symptoms to trade sex for money, drugs, or housing, and twice as likely to be sexually active. Psychotic behaviors—common among people with schizophrenia—are more likely to result in homelessness, substance abuse, and incarceration, all of which are associated with increased risk for HIV infection.

People with mental illness may be especially susceptible to HIV infection due to deficient social and problem-solving skills, which may, for example, impede their ability to negotiate for safer sex. Many studies have found that people with schizophrenia, bipolar disorder, and depression have difficulties with complex social interac-
Related Issue: Dual Diagnosis

The presence of either mental illness or substance abuse can increase a person’s risk for HIV infection, but clients with a dual diagnosis of both mental illness and substance abuse are at especially high risk. One study of homeless, substance using, mentally ill men in various residential treatment settings found that the highest rate of HIV infection—more than 18 percent—occurred among dually diagnosed clients. A mentally ill person’s cognitive functioning may also affect his or her capacity to consent to HIV antibody testing. A client who is unable to comprehend the benefits and perceived risks of confidential or anonymous testing and who cannot make a rational decision about whether or not to test may not be considered to be legally “competent” to provide the required consent to receive an HIV test.

Treatment options for mental illness include psychotherapy, psychotropic medications, and a combination of both. Because many mentally ill people lack adequate support systems, the presence of a psychotherapist as an objective listener can often provide the comfort and compassion needed to begin the treatment process. When psychotherapy alone is not enough to treat mental illness, psychiatric medications are often effective. For severe cases of mental illness, particularly schizophrenia and other psychotic disorders, hospitalization is often necessary.

Misinformation about HIV

Misinformation about HIV infection has been associated with frequency of high-risk behavior among people with mental illness. In comparison to the general population, people with mental illness tend to have lower levels of knowledge about HIV transmission and prevention. Research indicates that between 20 percent and 40 percent of mentally ill people report inaccurate information and knowledge about HIV disease and prevention strategies. A Canadian study found that more than 50 percent of psychiatric patients had been sexually active within the previous year, and 33 percent indicated that they would “give in” to their partners’ request not to use a condom during sex, a tendency researchers believed to be partly influenced by a lack of practical knowledge about modes of HIV transmission and prevention.

In a 1999 study of schizophrenic psychiatric patients, 55 percent of participants reported believing that “HIV-infected people always look sick,” and 42 percent reported believing that “a person must have...
many different sexual partners to be at risk from AIDS.” In comparison, 10 percent and 11 percent, respectively, of a non-schizophrenic control group believed these statements to be true.5

A qualitative study found that many mentally ill participants had inaccurate information about the HIV risks of various sexual behaviors, as evidenced by comments such as “A man can’t get it from a woman.” Likewise, some clients who believed that vaginal sex is a way of “catching a disease” also believed, incorrectly, that unprotected anal sex is safe.1

Other research indicates that many people with a mental illness believe that HIV testing is a routine procedure during psychiatric or medical examinations. In one study, more than half of mentally ill women thought they had been tested for HIV, but they could not be certain.1 Consequently, many mentally ill clients may provide inaccurate information about their HIV infection status.

People with an SPMI may demonstrate superficial knowledge about HIV—for example, they may know that HIV can be transmitted sexually—but many have limited comprehension of the actual process of HIV transmission and how to apply such information to reducing risk. Research on HIV-related risk behavior among mentally ill people found many participants to be confused about the different body fluids that carry sufficient HIV for transmission. Saliva, semen, blood, tears, vaginal secretions, and sweat were all thought by some study participants to transmit HIV, while semen, breast milk, or blood were thought by other participants to be unable to transmit HIV.1 It is also common for mentally ill clients to err on the side of caution, with many believing that a person can “get AIDS from sharing a glass or from casual kissing.”19
Implications for Counseling

Although HIV test counselors are not trained to diagnose or treat psychiatric conditions, they are likely to work with clients who have some form of mental illness. It is, therefore, useful for counselors to have a basic knowledge of how mood states and disturbed thought processes affect risks for HIV and other sexually transmitted diseases (STDs), to understand how mental disorders can affect the dynamics of the counseling session, to learn strategies for counseling clients with mental illness, and to be familiar with psychiatric referrals in the communities they serve.

The role of referrals is particularly important when working with clients who have a mental illness. In addition, many people have what appear to be symptoms of various mental illnesses, yet many people without mental illness commonly experience these feelings. Likewise, many people have experiences of being “depressed” without having a mental illness.

If a client discloses his or her mental illness to the counselor, the counselor should inquire if the client is prescribed any medications for the mental illness and if he or she is taking the medication as prescribed. Explore whether the client’s HIV risks increase at times when he or she does not take the prescribed medication. If the client is not taking medication, the counselor should make a referral for psychopharmacologic evaluation and explain that effective treatments for depression and anxiety are available.

If a client does not disclose information about having a mental illness, be attantive to any hints in the client’s behavior that might indicate the presence of a mental illness. For instance, when working with a client who expresses little interest in work, relationships, or his or her overall well-being, the counselor might ask if this is a problem for the client and if it affects him or her own wellness.

It is important for counselors to avoid making diagnoses about mental illness. Such a diagnosis is not within the training or scope of the HIV test counselor’s work. In addition, many people have what may appear to be symptoms of mental illness without being mentally ill. For instance, low self-esteem and disinterest in daily activities are symptoms of various mental illnesses, yet many people without mental illness commonly experience these feelings. Likewise, many people have experiences of being “depressed” without having a mental illness.

A Counselor’s Perspective

“The first time a client told me he was mentally ill, I was intimidated by the situation. But I remained client-centered, kept the session focused on HIV risks, and provided a referral to a local mental health center.”

A counselor’s perspective

“When clients tell me that they suffer from severe depression or anxiety, I’m sometimes tempted to try to help them feel better, but I know my limitations and that my mission is to discuss HIV risks.”

Intervention

Different counselors have different levels of counseling skill. Some have professional training outside of their role as an HIV counselor and some do not. When it comes to working with a client who has mental health issues, counselors must exercise caution about pursuing complex therapeutic issues.

A counselor can help provide structure for clients by staying focused on the topic. If necessary, the counselor can say to the client, “I’m not skilled in those areas. Do you have a provider who can help you with that?” or “I’d be happy to provide you with a referral.”

If the focus of the session gets lost or muddled or if the client is prone to going off in tangents, the counselor can shift the focus of the session to completing the data collection form, or during a disclosure session, to the test results and a concrete explanation of the meaning of the results. By doing this, the counselor will create a sense of structure that may help the client feel safer so that he or she can answer the questions concisely. A counselor who is unable to work with a client should refer the client to his or her supervisor.

If a client says that he or she is so depressed that it does not matter if he or she becomes infected, respond empathetically and invite the client to discuss his or her risk. A client who is passively suicidal may be placing him or herself in potentially high-risk situations.
Inquire if the client is receiving treatment for depression, and if the client is not, encourage him or her to seek treatment by acknowledging the severity of the depression and its effect on the client’s risk.

Some clients may say that they engage in unprotected sex during periods when they do not take their prescribed antipsychotic medications. In such situations, explore if clients might be able to use protection during these periods. Encourage clients who have not spoken with their physicians about this to do so. It may help to point out that, according to what the client has said during the session, the client’s HIV risk is directly related to medication lapses. When clients say they dislike the side effects of their medication, empathize and encourage them to discuss this with their providers because it may be possible to make alterations in treatment regimens.

Clients with a history of depressive or anxiety disorders may also have a history of substance use, sometimes as a way to self-medicate in an attempt to feel better. During these situations, clients may act out their feelings by placing themselves at risk for HIV infection through unprotected sex or needle sharing.

When working with clients who self-medicate, proceed with the session as with any client whose risks for HIV are influenced by substance use, and encourage these clients to speak openly with their physicians about their need to use alcohol or other drugs to feel better and how this affects their risk for HIV infection.

In some cases, a client who does not say that he or she is depressed and who reports engaging in high risk behaviors may appear to have symptoms of depression. Ask the client what he or she thinks is the cause of his or her risk taking. If this approach yields nothing, it may be helpful to say, “You seem upset about something, and I’m wondering if it may have something to do with your placing yourself at risk?”

Sometimes this will generate a response from the client about his or her feelings, about the situation connected with the feelings, or about how the risk is connected to the feelings. Reflect back to the client the risk and its co-factors—the feelings of depression—and ask if the client is in treatment. If the client is not in treatment, discuss the ways in which these feelings seem directly related to the client’s risk. After acknowledging the seriousness of the client’s risk, offer an appropriate referral. If the client does not recognize a connection between his or her feelings and risks, remain client-centered and discuss other risk concerns the client may have.

Some clients with anxiety disorders may be overly concerned

References
### Case Study

Casey is a 28-year-old, heterosexual, single woman who has bipolar disorder. Although well-informed about HIV, she often has unprotected sex with multiple partners. Although Casey has met many men at bars while drinking alcohol, she says that she has also had unprotected sex when she has not been drinking. She says that she enjoys the thrill of “picking up men and taking them home to have wild sex.”

**Intervention**

Find out what factors are at play for Casey when she places herself at risk. Ask her if she thinks anything other than alcohol affects her risk, perhaps by saying, “Alcohol seems to play a role, but there are times when you have not been drinking and have put yourself at risk. I’m wondering if anything else is going on for you that contributes to your risk.” If Casey cannot think of any other risk factors, ask if her medications may be playing a role in her risk. Casey might say that she occasionally manipulates the dosage levels of her psychiatric medications to bring about her manic episodes because these are the only times she feels good enough about herself to have sex.

In this case, empathize with Casey and encourage her to speak with her physician about her medication and about her risks during manic episodes. If Casey is reluctant to discuss this with her physician, tell her that she can do it in a way that is comfortable for her, such as by leaving out the part about picking up multiple sex partners and focusing instead on her manic episodes and her inability at those times to negotiate safer sex. Explain that the physician may need this information to better adjust her medication regimen.

Acknowledge the seriousness of Casey’s situation, and explore if she is able to use condoms at other times apart from manic episodes. It may be that Casey lacks the skills necessary to successfully negotiate condom use with a sex partner. If this is the case, make a referral to a support group or an assertiveness training that would help her develop these skills. A referral to local Alcoholics Anonymous (AA) meetings would also be appropriate.

Emphasize the seriousness of Casey’s risk while expressing concern about the times that she combines alcohol with her medications. While remaining empathetic, the counselor should acknowledge his or her lack of information and expertise regarding Casey’s disorder and related medications while keeping the session focused on HIV risk reduction.

**Referrals**

Depending on the client’s degree of mental illness and the success of the client’s treatment, a referral to a support group or to an assertiveness training group or class may be appropriate.

Determining how well the client can stay on track and express him or herself will help the counselor make an appropriate referral. A client who is somewhat chaotic would disrupt a group setting; individualized or group psychotherapy designed for people with severe mental illness would be a more appropriate referral for such a client. For those clients with a mental illness that is not gravely disabling and for whom a cognitive learning environment is not overwhelming, assertiveness training may be a good way to learn negotiation skills. Explore with the client how he or she may feel about being in a group. For clients who believe that being in a group would be too overwhelming, provide a referral to individualized assertiveness training focusing on sexual negotiation.

Some other referrals for clients with mental illness may include the community mental health program through the local department of public health, therapists (including those who accept MediCal), and STD clinics, if the client has a history of unprotected sex. Clients who abuse substances may benefit from referrals to local Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings.
Test Yourself

**Review Questions**

1. True or False: The hospitalizations, medications, and behavioral limitations that are common to people with mental illness make them unlikely to engage in HIV risk behavior.

2. True or False: Symptoms of a mental illness do not affect a person’s risk behavior.

3. Options for treating mental illness include: a) psychiatric medication; b) group support therapy; c) individual psychotherapy; d) all of the above.

4. Risky sex for people with mental illness often occurs as a result of: a) coerced sex; b) trading sex for money or food; c) having sex with injection drug-using partners; d) all of the above.

5. True or False: Most clients with mental illness are likely to know their HIV infection status because of repeated hospitalizations.

6. What is the estimated rate of HIV infection among people with mental illness in the United States? a) 2 percent; b) 8 percent; c) 35 percent; d) 50 percent.

7. People with mental illness are often at increased risk for HIV infection as a result of which of the following factors? a) homelessness; b) poor social skills; c) incomplete or inaccurate HIV knowledge; d) all of the above.

8. The term “dual diagnosis” often refers to people with mental illness who also: a) have a learning disability; b) abuse substances; c) are homeless; d) are unemployed.

**Discussion Questions**

1. How can counselors respond to clients whose mental illness impedes them from comprehending their HIV risks?

2. How can counselors be aware of referrals that are appropriate for clients with mental illness?

3. If a counselor feels unable to communicate effectively with a client with mental illness, what should the counselor do?

4. What should counselors do when they have reason to believe a client has a mental illness even though the client does not disclose such a condition during the counseling session?

5. What can counselors do when faced with a client who seems to be overwhelming due to a possible mental health disorder?

**Answers**

1. False. Research has shown that HIV risk behaviors such as unprotected sex with multiple partners and injection drug use are common among people with mental illness.

2. False. Symptoms such as mania may cause people to act impulsively and increase the likelihood that they may engage in behaviors that place them at high risk for HIV infection.

3. a).

4. d.

5. False. Many mentally ill clients do not know their HIV status, and many incorrectly believe that HIV antibody testing is a part of their routine medical examinations.

6. b.

7. d.

8. b.
DID YOU KNOW?

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