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## MENTAL HEALTH CHALLENGES IN HIV POSITIVE WOMEN, ADOLESCENTS AND CHILDREN

This article provides a brief introduction to mental health challenges among women, adolescents, and children with HIV infection. It broadly outlines the scope of the epidemic while providing a general overview of psychological and psychosocial issues, and it concludes by proposing mental health treatment approaches.



### Women

In the United States, women now comprise 23% of all AIDS cases (CDC, 2001). Women of color remain over-represented accounting for 77% of all women diagnosed (CDC, 1999). As HIV rates among young women have increased, HIV infection and AIDS have increasingly affected entire family constellations (Haven, Mellins & Pilowski, 1996). Within affected families, multiple members representing multiple generations may be living with HIV infection (Pequegnat & Bray, 1997). For instance, some two-parent families consist of couples where both individuals are HIV positive, and children born to HIV positive mothers may be

infected unless aggressive prenatal and perinatal antiretroviral treatment is undertaken.

HIV positive women may be challenged by an array of mental health complications including HIV-related neuropsychiatric disorders, substance abuse, and numerous psychological and psychosocial stressors. Although HIV does not inevitably result in psychological problems, many women living with HIV experience a high level of emotional distress at some point in their illness. Not surprisingly, women with more stressors (e.g., substance abuse, pregnancy, sexual problems) report more significant psychological distress (Swartz, Markowitz & Sewell, 1998). Similarly, women with more AIDS related losses report more anxiety (Ickovics, Druley, Morrill, Grigorenko & Rodin, 1998).

Depression is one of the psychiatric disorders most commonly found among women with HIV. Often this is manifested in sleep disturbances and "a loss of ability to derive pleasure or satisfaction from the activities that usually provide it" (Treisman, Angelino, & Hutton, 2001). In one study, non-HIV related stress (e.g., poverty, physical

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attack, grief) independently accounted for high rates of depression among HIV infected women (Moore, Schuman, Schoenbaum, Boland, Solomon & Smith, 1999). HIV positive women are also more likely to be depressed if they have a history of childhood abuse (Simoni & Ng, 2000). Indeed, many HIV infected women are poor, have pre-existing mental health problems and/or a history of sexual or other abuse. Among those with few economic resources, the issues are multiple: limited transportation, substandard or unstable housing and childcare, limited social support, unemployment, and poor access to health care (Bachanas & Golde, 1996).

Substance abuse is also common among women with HIV. In one recent study, 41% of HIV positive women were infected through injection drug use and a much higher percentage used drugs and alcohol (Hader, Smith, Moore & Holberg, 2001). Factors such as substance abuse and poor social relationships that put women at risk of contracting HIV, also put them at risk for developing mental health complications (Lyon & Munro, 2001).

After HIV diagnosis, preexisting problems are compounded by concerns about health, possible inability to work, intermittent periods of sickness, stigma related to HIV, and concern over disclosure. In a study of mothers with HIV, the strongest predictors of depression were perceptions of health, feelings of stigma, and physical health (Miles, Buchinal, Holditch-Davis, 1997). These HIV related factors and increases in viral load are associated with depressive symptoms (Lyon & Munro, 2001). Additionally, mothers frequently face the issues of permanency planning, disclosure of their status to their children, and guilt over past behavior. Mothers of HIV infected

children also carry the burden of caring for their ill child or children while experiencing their own physical deterioration (Bachanas & Golde, 1996).

In addition to pre-existing mental health issues or those resulting from HIV diagnosis and life circumstances, HIV can directly infect the central nervous system. Minor motor-cognitive disorder (MMCD), for instance, is a common mild syndrome of cognitive or motor dysfunction that causes minimal functional impairment (McDaniel, Chung, Brown, Cournos, Forstein, & Lyketsos 2000). Intervention for MMCD often consists of teaching strategies to increase functioning. These include encouraging patients to make medication logs, to limit distractions, and to continue to talk about difficulties (Buckingham & Van Gorp, 1999).

Immune compromise also enables medical opportunistic infections (e.g., toxoplasmosis, cryptococcal meningitis) to infect brain or other central nervous system tissue. Although these must ultimately be treated medically, mental health professionals must be aware of possible neurological complications and note changes in mental status or in psychological symptoms. These changes can alert the mental health worker to the patient's need for medical care (McDaniel et. al., 2000).



## Adolescents

Adolescents are the fastest growing group of individuals newly diagnosed with HIV in the United States. As of 2000, the Centers for Disease Control estimated that there were approximately 4,061 adolescents (ages 13 to 19), and over 294,000 adults between the ages of 20 and 34, who were living with AIDS in the United States (CDC,

2000). Given the long incubation period of HIV, it is highly likely that a large number of these adults contracted HIV during adolescence. African American females are at particular risk for HIV, representing 73% of 13-19 year olds diagnosed with HIV and 66% of 13-19 year olds diagnosed with AIDS (CDC, 2000).

Today, most adolescents with HIV contracted it through sexual or drug-using behavior. Substance abuse is common in HIV infected adolescents, and rates in some studies are as high as 33% (Remafedi, 1998). Depression, anxiety, trauma histories, and behavior problems also occur among these adolescents at a higher than average rate (Brown, Lescano & Lourie, 2001). Some HIV infected adolescents have experienced abuse, and a small number were infected through sexual abuse or rape.

After HIV is diagnosed, many adolescents keep their diagnosis secret from peers, family members, and sexual partners. Teens fear rejection from family members and friends, and are concerned about being stigmatized by peers or potential partners. Consequently, many adolescents face their illness and treatment isolated from important sources of social and emotional support. Recently, Sherman and colleagues provided evidence that sharing one's diagnosis with friends can provide observable health benefits and may also improve psychological health, indicating the importance of disclosure for teens (Sherman, Bonanno, Weiner, & Battles, 2000).

Developmentally, adolescents often feel invincible and immortal, and many face their diagnosis of HIV with fear, denial and avoidance. Engaging HIV infected teens in care and eliciting compliance with complicated medical regimens present particular challenges. Many adolescents fail to adhere to medication regimens because they want

to establish a sense of themselves as “normal” and “not sick,” they don’t want to be different than their peers, and they don’t want the daily reminders of their illness.



## Children

In 2000, approximately 11,000 children (under age 13) had HIV diagnoses reported to the CDC (CDC, 2001). HIV transmission from mother to child accounts for 91% of all AIDS cases reported among U.S. children (CDC 1999). As a result of interventions that encourage HIV testing of pregnant women combined with the use of AZT and other antiretroviral agents as part of prenatal care for HIV positive women, the rate of maternal-to-infant transmission of HIV declined 66% between 1995 and 1999 (CDC, 1999).

There have been two general patterns of HIV disease in children. About 20% of children become seriously ill in their first year of life. Most of those children die by age four (CDC, 1999). The other 80% have much slower disease progression and may not be diagnosed with AIDS until age six or older (CDC, 1999). In a 1992 study, only about 50% of children born with HIV survived until the age of nine; however, the use of antiretroviral medication and prophylaxis for opportunistic infection has increased the number of children who survive into adolescence (CDC, 1998). Increasingly, HIV infection in children is treated as a chronic illness (Meyers & Weitzman, 1991).

Children infected with HIV are at risk for psychological complications due to both the direct effects of HIV infection on brain structures and the indirect effects related to coping with the range of medical, psychological, and social structures associated with

HIV disease (Brown et. al., 2001; Brouwers, Moss, Wolters & Schmitt, 1994). The impact of HIV on a child’s developing nervous system can be significant (Brouwers, van der Vlugt & Moss, 1995). Thus language and cognitive delays have been well documented among children with HIV. Although recent estimates of the prevalence of central nervous system manifestations range from 20-65%, many children with HIV have other risk factors for poor performance, including poor prenatal care, poor nutrition, neglect secondary to maternal drug use, and possible drug/alcohol exposure in utero (Bachanas & Noriega-Garcia, 1999). Because HIV is progressive and children’s neuro-psychological functioning may change over the course of the illness, frequent neuro-psychological evaluations are warranted (Bachanas & Noriega-Garcia, 1999).

Further, previous studies have shown high rates of emotional and behavioral disturbance in children with HIV. Anxiety and depression, as well as Attention Deficit Hyperactivity Disorder (ADHD), oppositional defiant disorder, and problems in social functioning are common among children with HIV (Papola, Alvarez, & Cohen, 1994; Moss, Bose, Wolters & Brouwers, 1998; Brown et. al., 2001). Many of these problems are likely linked to environmental as well as HIV-related stress. Children infected via perinatal transmission are more likely to have fewer economic resources, to be nonwhite, and to live with a single parent or a non-parent caregiver (Papola et. al., 1994).

Parental issues tend to be central to children with HIV. Most children with HIV have or had an HIV infected mother. Concerns over parental illness and death can be overwhelming to a child and often result in poor psychosocial functioning. Illness and fear

about their own mortality complicate bereavement in HIV positive children. In addition, substance abuse is a primary risk factor for HIV infection in U.S. women. Consequently, many children with HIV were exposed prenatally to drugs and may live with parents who are active in their substance abuse. When HIV related stressors are combined with parental depression and drug abuse, the child’s ability to cope with his or her illness and to maintain psychological well being may be reduced.

Their coping abilities may be further hampered by their fear of disclosure, which nearly all families affected by HIV live with. Many families fear that their child will not be able to keep the diagnosis a secret and that the family will be stigmatized in their neighborhoods and communities (Weiner, Battles, Heilman & Pizzo, 1996). As children with HIV infection survive longer, the need to have accurate information about their condition is critical. Caregivers often need guidance on how to tell their child the diagnosis in a developmentally appropriate way and how to assist them in coping with it.



## Treatment

Because the issues of HIV are complex, HIV related services are most effective when they are client-focused, culturally sensitive, coordinated, and comprehensive, regardless of the age or level of social support of the client. An approach to HIV care should include medical treatment, mental health, substance abuse evaluations, social services and education for adults, adolescents,

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and children. Successful treatment of mental health and substance complications removes barriers to medical intervention, lowers morbidity, increases adherence, and decreases HIV risk behaviors; treatment of the physical symptoms results in less depression and emotional distress (Low-Beer, Chan, Yip, Wood, Montaur, O'Shaughnessy & Hogg, 2000; Napravnik, Royce, Walter & Lim, 2000).

Comprehensive treatment of mental health issues must begin with assessment (McDaniel, Purcell, Farber, 1997). An assessment should identify current psychological symptoms, strengths and weaknesses, and coping style. This information can be used to choose the most effective treatment for the client. Case management, individual, couple or family counseling, medication, and inpatient services (when warranted) can be utilized to help remit and relieve psychiatric conditions. Substance abuse can often be successfully treated within a therapeutic drug treatment program, particularly by programs that incorporate harm reduction.

## ADOLESCENTS

Ongoing treatment for adolescents includes providing emotional support for coping with HIV disease and working to increase treatment adherence and decrease risky behaviors. Because emotional distress, depression and anxiety are associated with higher levels of drug use and unprotected sex among HIV positive adolescents, teen services should address mental health, sexual health, and substance abuse (Murphy, Duranko, Moscicki, Vermund, Uong, Schwartz et al., 2001; Bachanas & Golde, 1996). Empirically based inter-

ventions geared toward reducing or eliminating substance use may also reduce risk behaviors such as sharing needles and having unprotected sex (Brown et. al., 2001). Thus, sexual education and drug treatment can be used to reduce the spread of HIV to others and avoid infection with multiple strains of the virus.

## CHILDREN

Children's issues differ somewhat from those of adults and adolescents, and can best be treated in the context of their major systems (i.e., families and schools). The importance of assessing the family or household situation cannot be underestimated. Children's mental health can be highly influenced by the emotional well-being and coping style of caregivers, making a systemic evaluation especially critical (Bachanas, Kullgren, Suzman Schwartz, McDaniel, Smith & Nesheim, 2001). Directing services to families rather than to parents or to children also tends to increase the odds of compliance and cooperation (Bachanas & Golde, 1996). Family therapy and support are critical for managing the multiple stressors and challenges families with HIV must face. In addition, communication with school psychologists, counselors and teachers ensures optimal intervention for HIV infected children in the school setting.

Children benefit from supportive therapy to increase their ability to cope with the stress of living with HIV (Moss, Bose, Wolters & Brouwers, 1998). Interventions can include: preparing the child for hospitalizations or medical procedures by providing age-appropriate explanations, helping children talk about their concerns over their health and their caregiver's health, increasing children's knowledge and

understanding of HIV disease and the importance of treatment, and developing behavioral interventions to increase adherence with medications. In addition, as children approach adolescence, issues of secondary prevention become critical and need to be discussed. Because many HIV infected children cannot disclose their diagnosis to their peers and feel isolated, we have found that children's support groups are an effective way to address these issues.



## Conclusion

While the biopsychosocial stressors facing HIV positive women, adolescents, and children are great, interventions are clearly helpful to reduce psychological distress, promote social support, enhance medication adherence, and diminish high risk behaviors. A critical key to successful treatment is a level of collaboration among clients and health providers that promotes the continuum of care while enhancing the quality of life.

**Gwen Davies,**  
*Post-doctoral fellow in HIV/AIDS Research,*

**Pamela Bachanas,**  
*Assistant Professor of Psychiatry and Behavioral Sciences and Pediatrics, and*

**J. Stephen McDaniel,**  
*Professor of Psychiatry and Behavioral Sciences and Family and Preventative Medicine*

*Emory University School of Medicine, Atlanta, GA*

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**THE AIA RESOURCE CENTER PRESENTS  
A SYMPOSIUM ON THE ROLE OF PARTNERS IN WOMEN'S RECOVERY**

**August 1-2, 2002 • Berkeley, CA**

This 2-day symposium is a forum to share information and knowledge about the role of intimate partners in women's recovery from drug and alcohol abuse. The symposium has three primary goals: (1) To identify effective strategies for helping women to assess their intimate relationships and how those relationships impact their drug use; (2) to explore approaches to assessing and engaging intimate partners in women's recovery; and (3) to identify model programs and strategies for overcoming obstacles to successfully implementing such programs. Experts have been invited to stimulate discussion about these issues. However, the symposium is designed to be interactive, and all conference participants are strongly encouraged to share their experience and expertise.

The cost is only \$75, and 11 continuing education credits are offered through the Institute on Continuing Education.

**For more information or a registration brochure, contact:**

Margot Broaddus  
Training Coordinator  
AIA Resource Center  
1950 Addison St., Suite 104  
Berkeley, CA 94704-1182  
(510) 643-7018  
margotb@uclink4.berkeley.edu

## PSYCHIATRIC ISSUES IN THE MANAGEMENT OF PATIENTS WITH HIV INFECTION

*The following article was excerpted from the Journal of the American Medical Association. The entire 8-page article (with the same title) was originally printed in the December 12, 2001 issue of JAMA, Volume 286, Number 22, pages 2857-2864. This excerpt illustrates the complex medical and mental health needs of HIV infected women who also suffer from substance abuse and other mental illness, and it suggests approaches for working with this population. The full article also identifies, distinguishes among, and presents treatment strategies for four categories of psychiatric disorders common among people with HIV: psychiatric diseases (e.g., major depression), disorders of personality and temperament, addictions, and extreme reactions to life circumstances.*



### Case Presentation

A 41-year-old woman was referred to The Johns Hopkins Hospital AIDS Psychiatry Service by the Johns Hopkins HIV Clinic (the Moore Clinic), where she was receiving her primary medical care, and by an affiliated program where she was being treated for polysubstance abuse. The patient was referred for evaluation of possible depression, and she was in danger of being discharged from her substance abuse treatment program because of loud outbursts of temper, shouting at her drug counselor, and continuing illicit drug use.

Throughout her childhood, the patient had had violent outbursts and she had a history of stealing. She performed poorly in school and was expelled from 2 schools for truancy and violence. She reported that she had been “hyper” in school. She was told by physicians that she was “hyperactive” but they did not treat her with any medication. She quit school in the ninth grade when she became pregnant. She briefly held many service jobs but never had steady employment.

As a teenager, she began abusing both alcohol and heroin, and soon added cocaine. Her drug of choice became heroin; she was a daily intravenous heroin user through most of her adult life. She was admitted to more than 8 detoxification programs

but never remained abstinent for longer than 6 months. She was arrested countless times and served 3 prison terms. At the time of her first evaluation by the AIDS Psychiatry Service, she was unmarried and living in the home of an aunt with 2 of her 4 children.

The patient had human immunodeficiency virus (HIV) infection and chronic obstructive pulmonary disease. She had a history of thrombophlebitis, subacute bacterial endocarditis, multiple episodes of pelvic inflammatory disorder, and a closed-head injury with loss of consciousness. She had no known medication allergies. Her only current medication was methadone, prescribed by her drug treatment program. Mental health professionals at prison and at community mental health services had evaluated her and treated her briefly with psychological counseling and medication trials; the patient was uncertain about what medications she had tried, but reported that none of the treatments had helped her.

On initial presentation to the AIDS Psychiatry Service, the patient complained only of extreme irritability. On examination, however, she was found to have a sleep disturbance, with early wakening every morning, daily mood variation, with mornings always being worse than evenings, and loss of pleasure in almost all the activities that she had formerly enjoyed. She was quite irritable during the interview, storming out of the room twice, only

to return moments later. Sometimes she refused to speak; at other times she answered questions with an uncooperative, monotonal “yes” or “no.” Her primary care physician later described this as typical for her, and said that she sometimes asked him for narcotics or benzodiazepines, but in an almost careless or insincere way.

The psychiatry team made diagnoses of major depression, possible attention-deficit/hyperactivity disorder (ADHD), and personality disorder with mixed antisocial and borderline traits. The team recommended desipramine hydrochloride, and the patient received a prescription for 25-mg tablets with direction to increase her dosage every 5 days as tolerated until she was taking 100 mg each day. She agreed to treatment only because of the threat of losing her place in the methadone treatment program and possibly her parole. She improved quickly on desipramine when her blood level reached the therapeutic range of 150 to 175 ng/dL. She became less irritable, she slept better, and her energy increased. She also reported better concentration and mood. She did well for about 1 year, but then relapsed to drugs and was lost to follow-up.

Three years later, at age 44 years, the patient was admitted to The Johns Hopkins Hospital for treatment of her third episode of subacute bacterial endocarditis. A Hickman catheter was placed because of poor venous access, and intravenous antibiotics were begun. Her first 3 hospital days were uneventful. Then she developed a fever after leaving the floor for a smoke break. A toxicology screen performed along with the fever workup showed evidence of opiate and cocaine use while results of an earlier screen had been negative. When the infectious disease team discussed this with the

patient, she insisted on signing out of the hospital against medical advice. Furthermore, she refused to permit removal of the Hickman catheter, insisting that the catheter belonged to her and she would use it to give herself her intravenous antibiotics at home.

Because the patient was cognitively intact and could not be shown to have either psychosis or a plan to harm herself or others, the infectious disease team felt obligated to discharge her; they feared, however, that she was at grave risk for severe sequelae from her endocarditis. Before allowing her to sign out of the hospital, they requested a psychiatric opinion. When the patient was told that she could not leave until she saw a psychiatrist, she called the AIDS Psychiatry Service office from her hospital bed and demanded to be seen immediately by the psychiatrist, so she could go home.

The resident on the consultation service evaluated the patient. He determined that she was indeed a risk to herself, because her opiate cravings and impulsive nature made it impossible for her to resist using opiates, even while in the hospital with a life-threatening illness.

Based on the resident's evaluation, the attending psychiatrist proposed a plan to the infectious disease and psychiatric consult teams and invited them to see the patient as a group. In the group meeting, the patient was told that her endocarditis was life-threatening and she had a mental illness that impaired her ability to make decisions. She was further told that after she recovered, she could make decisions about her health care, and the next time she was sick she could elect to be treated at another hospital, but for the acute phase of her current illness, at least for the next 5 weeks, she would have to complete her antibiotic treatment at Hopkins. If necessary, the

team would certify her for involuntary psychiatric and medical treatment to ensure that she received proper care. Then she was offered a choice: she could finish treatment in a locked psychiatric ward, or she could stay on the medical ward if she agreed to a methadone taper, restart of desipramine therapy, and restriction to the ward until she no longer craved opiates (she had long since been discharged from her methadone treatment program).

She chose to remain on the medical ward. Her desipramine was restarted and she was tapered from opiates using methadone. She did extremely well and her endocarditis resolved. She chose to resume treatment at both the AIDS Psychiatry Service and the Moore Clinic.

After discharge, she remained in treatment. She received weekly supportive psychotherapy aimed at helping her learn to manage her intense feelings without acting on them. Her desipramine level was monitored and adjusted regularly. Her urine was routinely screened for drugs. She rejoined her substance abuse treatment program.

She has been sober since that time. She is doing well on desipramine, with lithium added occasionally to control flares of her depressive illness, and she has no detectable viral load. She has worked part time, as a nursing assistant and providing peer counseling for drug-addicted patients with AIDS. When she received her first-ever income tax refund a year ago, she brought the check to the clinic to show to her therapist. She remains somewhat irritable and demanding, particularly when her depression recurs, but she works to control her temper because she now realizes that it impedes her effectiveness in dealing with patients.

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## Conclusion

This case presentation illustrates the complex and intense needs of people living with HIV. With the increasing emphasis on cost-saving and fiscal management, it is conceivable that this type of patient could be denied care because of high cost and intensive use of medical resources. Despite the expense, she is also the kind of patient who can respond to treatment and benefit from longer-term efforts at rehabilitation.

Psychiatric disorders increase risk behaviors for HIV infection. Data also suggest that HIV causes psychiatric disorders, not just by direct subcortical injury but also through the psychological and sociological repercussions of infection (Fishman, Lyketsos, Schwartz, & Treisman, 1998). Many HIV-infected patients have psychiatric disorders, including affective disorders (e.g., major depression), dementia, addiction, personality disorders, and demoralization. These disorders not only directly impair patients' quality of life, but they interfere with compliance with medical treatment and with modifying risk behaviors. Protease inhibitors and other antiretroviral therapies will have no benefit for patients who are too disturbed by mental illness to take them correctly.

Caregivers' empathic understanding can become a kind of clinical nihilism in which all psychological distress is interpreted as deserving of comfort measures such as support, sedatives, and narcotics, while treatable mood disorders are missed. It can be difficult to diagnose these disorders in HIV-infected patients, and in particu-

lar to distinguish major depression from the demoralization caused by the burdens of living with HIV; however, this distinction is crucial so that each disorder can be treated correctly.

Treatment improves mood disorders in HIV-infected patients, even those with advanced AIDS, dementia,

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or comorbid conditions such as addiction or personality disorder (Lyketsos & Treisman, 1995). Substance abuse responds to treatment. Personality disorders, though chronic, can be managed so that life can proceed less chaotically and treatment more fruitfully. Life's most trying events can be overcome with support, counseling, and care.

Furthermore, clinicians may raise their thresholds for tolerating bad behavior in the clinic as a result of a belief that kindness and acceptance are treatments for an underlying rejection that these patients feel as a result of their stigmatizing illness. This interpretation is the beginning of the slippery road to prescribing sedatives and other comfort measures in response to patient demands, and eventually shaping behavior to get rewards for more acting out. Systematic evaluation of temperamental vulnerabilities and treatment plans that set consistent, firm limits will serve to the greater benefit of the patient, and the expectation of progress and responsibility may be the highest form of acceptance these patients will achieve.

Patients infected with HIV benefit from therapeutic optimism and aggressive treatment of the whole person. Their management requires consultation and liaison relationships between specialties and must include those directed at mental health. With comprehensive care, the toughest patients can surprise even the most jaded clinicians, as we were surprised by this remarkable woman.

**Glenn J. Treisman & Heidi E. Hutton,**  
*Department of Psychiatry and Behavioral  
Sciences, The Johns Hopkins Hospital*

**Andrew F. Angelino,**  
*Department of Psychiatry and  
Behavioral Sciences, Johns Hopkins Bayview  
Medical Center*

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## “RIDING THE ROLLER COASTER” THE COMPLICATED GRIEF JOURNEYS OF HIV AFFECTED CHILDREN

*“I hated seeing my mom sick. She had changed so much. AIDS had changed her body, . . . her eyes. Then she couldn’t take care of us and me and my brothers and sister were all split up. I was lucky I got to see her each week. When I would leave I always said ‘I love you, see you next week.’ I just never expected that Monday to be the day, when I would find her dead. It’s like a damn roller coaster—I never knew what to expect and I still don’t.”*

– Shawn, a 17 year old HIV negative member of a teen grief group.

Children and youth, like Shawn, who have a family member who is living with HIV/AIDS or has died from AIDS complications, often struggle to cope with numerous losses that complicate the normal grief process. After incidents of loss, grief is healthy and natural. It is not a one-time event, but a process that takes time and is unique to each bereaved person. As a mourner moves through his/her grieving, there are four psychological tasks that are considered part of the standard, healthy process. These tasks, in order, are: understanding, grieving, commemorating, and establishing a “new normal.” Even after a child has initially traveled through these four tasks, grieving children often *regrieve* their losses as they move through developmental stages and during life cycle events (graduation, new births, weddings).

In addition to the loss experienced after a natural death, there are other multi-dimensional losses that a child

endures when HIV/AIDS is a part of their world. Some losses are tangible and, while difficult, they are more immediately apparent to helping caregivers. Secondary tangible losses that complicate a child’s grief include loss of homes, school, friends, and family members. Then there are numerous other losses that are more difficult to identify and comprehend. These include: loss of dreams, meaningful relationships, identity and role expectations, daily routines, childhood innocence, the sense of a safe world, and the future they once imagined for themselves. Often other losses occur in a ripple effect when a family member is diagnosed with HIV or an AIDS related death takes place. It cannot be overlooked that the largest population of HIV/AIDS affected children also experience disenfranchised grief because of their low socio-economic status, crime ridden neighborhoods that yield multiple deaths, drug exposure, and the predominant absence of the paternal figure.\*

### Role of Therapist

A critical task of professional caregivers is to provide opportunities that invite children to grieve each and every one of their losses. It is important to allow the children to guide us at their own pace. We should not assume that we always fully understand what a child needs at a particular moment because they could be experiencing any combination of multiple, intertwining losses. In her

book, *Breaking the Silence*, Linda Goldman (1996) refers to complicated grief “as if an unexpressed or unresolved important life issue—a frozen block of time—has created a wall of ice between the child and his or her grief. Our job is to help melt that wall.” As therapists we can respectfully accompany and support children through the ongoing process of resolving grief.

### Educating about HIV

One element that complicates the grieving process for children affected by HIV/AIDS is the unfortunate and irrational stigma that the disease still carries. Disclosure to family members, friends and colleagues remains a challenge. Once disclosure has been made, some caregivers *require* children to maintain it as a family secret, fearing that ridicule, rejection and discrimination will occur. This expectation can create feelings of isolation, anger, guilt, worry and resentment within children. The burden of keeping the “family secret” creates an obstacle to normal grieving. One of the greatest gifts we can give, as professionals, to an affected child is regular permission and a direct

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\* For the purpose of this article, the term *affected children* specifically refers to youngsters who have been diagnosed HIV negative. The unique needs of this population are often overlooked and not addressed.

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opportunity to acknowledge the virus and its impact. Often children, in an effort to avoid the pain, shame, guilt and confusion, will avoid mentioning HIV/AIDS specifically. Educating about HIV/AIDS related misconceptions, validating feelings, and using the language of illness, dying, and death in the therapy room remove the burden of carrying the HIV/AIDS secret alone. Affected children often carry the weight of survivor guilt: not only will they get to continue to live, but will do so free of the virus, medications, pain and suffering. Magical thinking on the part of the bereaved child can spiral, leading them to believe that their behavior caused the illness or death of a loved one. Part of the grieving and healing process is to reframe a child's fear and distortion into acceptance of human limitations and reality.



### Addressing Family Relationships

When HIV/AIDS infects one individual, it affects the working dynamics of the entire family. The dynamics shift and change, which in itself is a compounding loss. In working with the grieving affected child it is essential to recognize that other relationships within the family are also impacted as a result of HIV/AIDS. Often there are extended family members who have the virus as well, opening the possibility that sickness and death is not limited to the nuclear family. Acknowledging how illness has changed roles and expectations within the family validates the child's feeling of uncertainty of what is to come. Children often struggle with questions like: "Who am I now?" "Even though my brother died am I still a brother?" "Do I have to be the mom now?" As the professional we can also

legitimize the need to remember the positive and negative qualities of the ill or deceased individual. It is essential that professionals maintain a non-judgmental stance. Often when illness transforms a healthy individual into one whose body and mind has weakened, it is difficult to hold onto earlier, fond memories. Recognizing that the sick or deceased is much more than the diagnosis or label gives the child permission to grieve the loss of the relationship and all that accompanied it, while also reconstructing the relationship prior to death or the illness.



### Addressing "Lazarus Syndrome"

New technologies and medical advancements have reclassified HIV/AIDS from a terminal disease to a "chronic terminal" illness. It is cause for some degree of satisfaction, in that it may mean a potentially prolonged and fuller life. Yet it also brings treatment modalities that may be ineffective, more interventions from doctors, as well as highs and lows for the mind and body. The ill, as well as the affected, family members emotionally, physically and spiritually can feel plagued by what's called the *Lazarus Syndrome*. This occurs when death is so close that funeral arrangements are prepared only to be cancelled because a medication or procedure has helped the sick family member reclaim life in the last moments. When children are repeatedly exposed to loved ones near death, often they can become emotionally numb to avoid grieving all the time. The therapist can acknowledge the conflicting feelings and thoughts stirred up at this time. We can help normalize reactions felt by the child. By wondering aloud about the reality of conflicting feelings, we teach children that death and dying can be very confusing.



### Therapeutic Techniques

Providing children with the freedom to work through their grief using creative forms of expression (e.g., drama, art, play and music) is respectful of the painful emotions that accompany death and dying that are often difficult to verbalize. Children will express themselves more using projective techniques than by talking. It is often difficult for children to find the words to accurately, comfortably and completely convey what is happening for them. Play, music, drama and art allow them to remain children while working through their grief in a language that feels less threatening. As children work through their grief, we can bring meaning and understanding by being a witness to their experience. For some children affected by HIV/AIDS this might be the first time that they are able to communicate a full spectrum of emotional responses.

The therapeutic environment that you create can also bring rare coveted moments when an affected child can have his world be all about him. A portion of the grief work itself, particularly in the beginning, must center on helping the child recognize himself as an important, capable, unique individual with the ability to make choices. A child's core value of holding esteem for self and others might be stunted and become eroded by the continual stress of living with HIV/AIDS. In session, HIV/AIDS can vanish and the child's internal and external self can be recognized and celebrated.

Depending on your creativity and comfort level, many art and play therapy techniques can be used in a therapeutic session to allow grief work to take place. Below is a short list of interventions to consider:

**\*Picture Collage.** Prepare an array of cut-out pictures that represent all facets of life. Invite the child to choose pictures that reflect the relationship with the infected or deceased individual. Helping a child gain a greater understanding of the attachment and relationship with the sick or deceased provides opportunity to grieve changes and lost moments, while also honoring and appreciating the relationship. This technique helps separate the child's relationship with the sick or deceased individual from the HIV/AIDS.

**\*The Kinetic Family Drawing:** Invite the child client to draw a picture of the family before HIV/AIDS was disclosed or death occurred. Invite the child to draw a second picture of what the family currently looks like. This technique facilitates discussion about changes and losses, feelings associated with loss, and changes in role expectations. It also permits recognition of relationships and helps children identify areas of strength in themselves and within their families.

**\*Blowing Bubbles:** Using soap solution and a bubble wand is a simple fun way of teaching a child tempered breathing to decrease levels of stress and anxiety associated with illness, death, secrecy, shame and discrimination. As HIV/AIDS progresses, it alters the body, and can cause weight loss, fatigue, skin disorders, and inhibited lung capacity. Watching a parent's body literally transform forces the uninfected child to face the loss of a healthy, strong caregiver while also challenging and questioning the invincibility of his own body. "A child's concept of his/her body is one of the foundations for the child's concepts of illness and death." (Geballe, Gruendel & Andiman, 1995). Blowing bubbles is a playful way of helping a child get in touch with his own body and mind and learn a creative way of decreasing stress levels.

**\*Clay:** This medium is a powerful tool for grieving children. HIV/AIDS can make children feel out of control, angry, sad, powerless, resentful and helpless. By manipulating clay in their hands, children can create, destroy and recreate forms and images, which offers a sense of power and control. Banging, smashing, molding, and flattening are all ways that clay can serve as a means for affective release. Directive interventions using clay can include sculpting HIV, creating tombstones, or spirit figures in which notes to the sick or deceased are inserted.

**\*Meditation/Visualization:** Meditation and visualization are techniques that can be taught for children to use on their own. Meditation can help decrease anxiety and stress, relax the body, increase concentration and gain a real sense of control over the mind and body. The therapist can guide a child through breathing exercises, and into the creation of positive images of safe places, healthy family members, and strong and healthy bodies. Because meditation and imagery brings an individual into an altered state, it is critical for trust and safety to have been clearly established within the relationship before introducing this technique.

**\*The Written Word:** Written language is a form of projection that provides a child with an opportunity to express a wide range of thoughts and feelings associated with the challenges of their life. Whether using cut out magazine words or phrases to formulate a poem or word collage, writing a letter to AIDS or a deceased family member, or creating a play made up of fantasy characters dialoguing, writing offers a means of resolving unresolved conflicts, feelings and other concerns.



## Conclusion

As helping professionals it is not our primary task to have children get over their losses but rather to accompany them along their journeys. We can help them find ways to integrate their losses into their lives as they shape their present as well as their future. Through compassion, encouragement and soul soothing, we work together with children to build hope to have fulfilling lives. We gently walk with them, at their pace, acknowledging feelings and thoughts, validating relationships, honestly answering questions regarding the unknown, and helping to remember and honor individuals, as well as moments in time. For all these clinical techniques, it remains paramount to be fully present to the child, sometimes by simply offering a supportive hug.

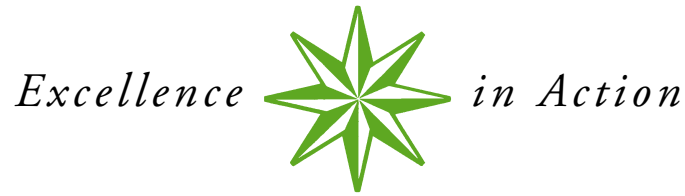
The HIV/AIDS roller coaster ride does not end suddenly. HIV/AIDS related losses and deaths are footsteps imprinted on the entire path of the life journey. The task and challenge for HIV/AIDS affected children is learning to identify and use healthy coping mechanisms to grieve losses while honoring both the living and life itself.

**Stephanie Handel, MSW,**  
*Children's Grief Therapist, Wendt Center for Loss and Healing, Washington, DC*

*This article was written in consultation with Emily Piccirillo, ATR, BC, an art therapist at Pediatric AIDS/HIV Care, Inc., which collaborates with the Family Ties Project in Washington, DC.*

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## DESIGNING MENTAL HEALTH SERVICES FOR FAMILIES AFFECTED BY LIFE-THREATENING ILLNESS

In 1994, The Family Center (TFC) was created to address the substantial increase in the number of children in New York City who were being orphaned as a result of parental AIDS and other illnesses. The Center provides fully integrated in-home legal and social services to help parents cope with serious illness and make plans for the future care of their children. The Family Center's multi-faceted approach focuses on serving the entire family.

In the last eight years, TFC has helped nearly 2,000 parents, children, and new caregivers deal with the changes brought about by illness and loss, develop custody plans and execute legal directives, and access necessary support services. Ninety-five percent of Family Center clients are of African or Latino descent and ninety percent of the families are headed by single mothers. Most families are Medicaid eligible. All Family Center services are free, confidential and bi-lingual. Abandoned Infants Assistance grants, from the Administration on Children, Youth and Families' Children's Bureau, support several of The Center's programs.



### Approaches for Addressing Mental Health Issues

A major focus of TFC in the last two years has been expanding its mental health service capacity. Since the inception of TFC, staff have found it difficult to engage families in traditional center-based psychotherapeutic services. Deep-seated reluctance on the part of consumers to identify and seek treatment for their depression and other mental health problems prompted TFC to re-name and re-design mental health services in order to attract parents and children alike. A service design that emphasizes recreation and fun activities, and program titles that do not mention mental health or counseling, are two keys to The Center's success.

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### FAMILY GROUPS

Increasing the support and stability within a family is at the core of all mental health services offered at The Family Center. Through multi-family therapy groups, family camping trips, holiday events and other recreational activities, families have a chance to

talk about their feelings and improve communication, build trust and understanding, and most importantly enjoy each others' company and have fun. Having fun together as a family, and with other families, is key to recruiting and retaining families in services.

One multi-family group program at TFC includes a recreational/camping component. The program, called *Family Pride*, works with five families with children, aged 9-12, in an eight-session structured program plus an additional weekend camping trip. All adults in the household involved with the children are encouraged to attend. The sessions focus on a range of topics affecting family life including: problem solving, communication, punishment/ discipline, feelings around illness and loss, barriers to change, relationship building and stress reduction/ relaxation. Parents and children meet separately and together depending on the topic.

The camping provides respite for families, time away from the city, and a new environment in which to experience each other. Family members learn new things about each other and network with other families. One parent who participated in a recent session of the *Family Pride* program said, "On our camping trip I saw how sensitive to others my children can be... to their needs and feelings... and it made me very proud of them." Research has shown the therapeutic benefit of recreational activities (Gass & Priest, 1999), and The Family Center's experiences with family camping strongly support these findings.

## YOUTH GROUPS

Faced with the conflicting tasks of establishing one's identity and gaining the acceptance of one's peers, adolescence is a time of great struggle and uncertainty. Most of the teens served by TFC lack a safe environment and peer network where they can express their feelings during this time of transition. Activity-based groups with structured content are less threatening to teens than groups organized and

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advertised as a place to share feelings and experiences. Indeed, the TFC staff has found that youth are much more likely to stick with a group organized around an activity. The added advantage of group loyalty and cohesion cannot be underestimated.

The activities around which the group is focused may be generated

from the group itself or may be tailored to the skills and interests of the social workers leading the group. TFC has developed activity-based groups specifically for boys and for girls, 12-18 years old. In these groups, young people are empowered to set their own agenda and are freer to speak frankly about their concerns than they may be with peers of the opposite sex, parents, and caregivers in a multi-family group setting. These groups enhance social skills and increase opportunities for friendship and development of peer-to-peer communication skills in a safe environment. They also serve as an important place for young people to share concerns about illness in the family. This helps to decrease isolation and normalize family situations that for many have been burdensome secrets.

One example of an activity-based group for teens is the Boys Boxing Group. Formed by a Family Center social worker with a strong interest in kick-boxing, this group brought 14-17 year old boys together to talk about sex and violence using boxing training as its activity focus. A local gym provided space and instructors, and the social workers led group discussions before the trainings on violence in society and in relationships, problem solving, and communication without violence.

Similarly, a Boys' Photo Group was started by a clinical social worker with an interest in photography and a photo industry contact who loaned cameras and provided free film developing to the group. Eight teenage boys, ages 13-15, participated in sessions structured around weekly photo assignments, such as "photographing the people most important to you,"

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“taking photos that show what a day in your life is like,” and “taking photographs that show sadness, anger and happiness.” The photos were used to facilitate dialogue about feelings and the many ways in which feelings can be expressed, both positively and negatively. Sharing about daily life activities and the important people in their lives also served as a basis for members to get to know each other quickly and recognize commonalities and differences among their experiences with family, school and friends.

In another example, a volunteer filmmaker from the community willing to donate his equipment and expertise served as the catalyst for forming a Girls’ Film Group. This filmmaker co-facilitated the group along with a clinical social worker. Nine girls, ages 14-18, participated in making a movie about their struggles to cope with the illness or death of a parent while experiencing the pressures and changes of teenage life. The group met weekly for 24 weeks getting to know one another, identifying life-defining moments to be highlighted in the film, developing the screenplay, scripting their roles, filming and editing. The film was well received by staff and families, and the girls felt a strong sense of satisfaction from their product and the experience. As one member of the group commented, “I wanted to play myself in the movie to learn about myself. I think that writing my lines, talking about it and seeing myself on video helped that. This group—being with all the other girls here—helped me understand how I cope with problems, and what my feelings are about everything that is going on in my life.”

In addition to these groups, TFC has sponsored a girls’ adventure

group, a boys’ adventure group, and a girls’ karate group. All the groups have had high retention rates, and at the conclusion of each group, the social workers have gone on to work individually with group members who wished to address issues that came up during the group.

**THE FAMILY CENTER  
EXPERIENCE SUGGESTS  
THAT ACTIVITY-BASED  
SERVICES ARE OFTEN  
THE GATEWAY INTO  
MORE TRADITIONAL  
SERVICES.**

All groups at The Family Center are led by teams comprised of two clinical social workers with strong group experience and skills at seizing therapeutic opportunities in activity-based settings. The team approach allows for more flexibility in addressing the needs of the group and provides much-needed support for the staff running the group. All groups are held in the late afternoon or early evening, and they always include food. Weekly supervision for the social workers monitors all aspects of the program including design, recruitment and engagement of participants,

group cohesion and bonding, session content, interactions between staff and participants, and closure and follow-up with referral as needed.

## **VOLUNTEER BUDDY SERVICES FOR CHILDREN**

Another strategy for engaging families in mental health services involves ancillary services for young children. The *Buddy Program*, based on the Big Brother/Big Sister model, matches a child with a volunteer adult “Buddy” for mentoring, friendship and fun. Buddies receive 30 hours of training before being matched with a child and are supervised individually and as a group by full-time TFC staff. Buddies and children typically see each other twice a month for one-on-one activities in addition to regular phone calls, and are invited to attend quarterly Buddy events organized by TFC to promote friendships among group members. For the fifty children currently matched with Buddies, the program has been an important opportunity to experience new things and to form a lasting relationship with a caring adult outside of the family. For parents whose children have Buddies, the program serves as an important source of respite and is a welcome positive influence in the child’s life. Over time, it is not unusual for a Buddy who knows a child and family well to identify the need for mental health intervention and to request follow up by The Family Center. In these situations, the Buddy becomes an important link to improving identification of children’s mental health needs and ensuring prompt response.

## HOME-BASED SERVICES

When the need is significant, The Family Center has also developed approaches that address the mental health needs of children and families head-on. The staff works intensively with a select group of young children who exhibit profound levels of emotional distress resulting in disrupted peer and family relations, at-risk behavior and failing school performance. These children often reside in families facing numerous challenges (e.g., multiple losses, inconsistent parenting, lack of stable community and family support, un-addressed multi-generational mental health needs). Stigma around receiving counseling, fear of possible child welfare involvement if family secrets are revealed, unresolved emotional needs of the parent, and family chaos and isolation make it difficult to serve children in these families.

The Family Center's approach is to offer home-based services by a social worker comfortable using a variety of tools and techniques to engage and work with the child and other family members as the need arises. Clinicians are trained and supported in supervision to be pleasantly relentless with families, maintaining phone contact between home-visits, promptly re-scheduling after no-shows, and addressing concrete service needs as they come up. Patience and persistence are key as the clinician builds the rapport and trust necessary before the family can begin to address their needs as individuals and as a group. Some of the strategies employed include: addressing the needs of the parent while working with the child; recognizing grief and loss as significant themes underlying the family's mental health needs, and

using play therapy tools and other creative ways to help children express themselves.

## PHONE SUPPORT GROUP

Over the last several years, TFC staff has identified a substantial need in the families served for both short- and long-term services that specifically address depression. Engaging clients who are depressed can be particularly challenging, especially when they may need medically based interventions that The Family Center does not provide. Recognizing TFC's strength in building rapport with clients and addressing their readiness for services, staff designed a *Depression Phone Group* as a way to provide education and information about depression and link people with additional psychological and psychiatric services. This is a six-week intervention, led by a clinical social worker, in which clients share their experiences and work together on difficult issues. Topic areas include: *What is Depression; How to Identify Feelings; Medication and Alternative Treatments; How Depression Affects Others; How Depression Affects Life Goals; and Mental Health Maintenance.*

The group provides consumers with the opportunity to move from a starting point of little or no recognition that they are depressed, to a point of recognizing their depression and its affects, to a belief that they can act to positively address and better cope with their condition. This borrows from the Prochaska readiness to change theory (Prochaska & Velicer, 1997) and builds on the strength of the bond formed between the consumers and staff. This phone group has proven to

be a very effective means of making successful referrals for other medical and mental health services.



## Conclusion

While TFC has had many successes with these various strategies, engaging clients in mental health services remains a very difficult task. The Family Center experience suggests that activity-based services are often the gateway into more traditional services. The staff have found that a trusting relationship formed with a social worker in the course of participating in a group often forms the basis for on-going individual or family work after the group ends. More traditional therapeutic services, e.g., individual counseling for children and adults, and couples and family counseling, can supplement group services. Finally, given the variation among clients' readiness to receive services and the stigma around mental health services, it is critical to offer a variety of services that are family focused and not labeled as "mental health" services, and that provide varying opportunities for families to engage in services.

**Jan Hudis, MPH/MPA,**  
*Director of Special Projects,*  
*The Family Center, New York City*

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## HIV INFECTED YOUTH: PERINATALLY VS. BEHAVIORALLY ACQUIRED

Since its discovery over 20 years ago, HIV has primarily manifested itself in the young adult population (25-44 year olds). However, there is reason to speculate that many of these persons had been infected since their youth. In fact, the AIDS case rate among adolescents (age 13-24) soared to a cumulative total of 31,293 as of 2000 (CDC, 2000). Perinatally infected youth who have benefited from improved HIV treatment regimens in the 1990's are now entering their teen years; and the numbers of behaviorally infected youth continues to climb despite prevention efforts. Youth of color, especially young men who have sex with men (MSM) and pregnant/ parenting young women, are at highest risk. Along with the psychosocial burden(s) of being HIV infected, these youth often present with the psychosocial issues typically associated with adolescence.

Generally, adolescence is a time when youth need and pursue increasing independence and self-responsibility and take risks in the process of achieving these ends. Body image, peer relationships, and sexual identity formation are challenges for all young people. Working with HIV- infected youth requires that the provider first be skilled in the identification, assessment, and treatment of a "normal range" of adolescent issues. Providers must be able to recognize those issues that are within the realm of expected behavior for all youth in order to

assess and treat those issues unique to and complicated by the presence of an HIV diagnosis. To that end, medical compliance, sexual risk taking, substance use and experimentation, and navigating peer and romantic relationships are all issues that must be addressed. The key for providers is to identify how individual youth will face these challenges and how to assist them to respond in a way that promotes healthy bio-psychosocial development.

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### PERINATALLY INFECTED YOUTH

Perinatally infected youth can be compared to youth with early onset chronic illnesses (e.g., hemophilia-A, sickle cell anemia, spina bifida, and cystic fibrosis). As is true with other chronic diseases, HIV infection can affect school attendance and performance because of absenteeism for medical visits and the need to take medications during the school day (Grubman, Gross, Lerner-Weiss, et. al, 1995). Familial and provider expectations may shift, impacting the infected youth and causing a referral for clinical intervention. For example, early in the epidemic, many HIV- infected children (now youth) may not have been required to attend school regularly due to disclosure issues, significant physical impairment from the disease, medication side effects or short life expectancy. However, as treatments

have improved and youth are living longer and generally have a better quality of life, parents, teachers and health care providers may expect the youth to attend school on a more regular basis, form appropriate peer relationships, and function as a "normal" adolescent. This represents shifts in response to, and in expectations of, the young person. However, youth may not be able or willing to make these changes that are so drastically different from those previously outlined.

Youth infected at birth (i.e., perinatally infected) are more likely than behaviorally infected youth to be at an advanced stage of illness and have multiple physical disabilities as a result of their infection. These young people may be more likely to live in a kinship or other alternative familial structures due to the loss of a parent, and are more likely to have parents or siblings who are also HIV- infected. When parents are present and HIV infected, young people may find themselves in a "parentified" role because of parental illness, substance use or other issues unique to their family's response to the multi-generational aspect of the disease (Bush-Parker, 2000).

## BEHAVIORALLY INFECTED YOUTH

Although youth with behaviorally acquired infection may be healthier when they enter care, other medical issues may impact their care. Anecdotal evidence suggests that they are more likely to be active substance users, have had several sex partners, and been treated for other sexually transmitted infections; and they are often parents of at-risk children. Their lack of recognizable HIV-related symptoms may affect their willingness to be compliant with difficult treatment regimens and multiple clinic visits. Many young MSMs practice unprotected anal intercourse and use alcohol and drugs to enhance sexual relations and accomplish a sense of identity with the young MSM community. Young women many times are the partners of older, HIV infected men and may be repeatedly re-exposed to the infection. Both young MSMs and young women may be vulnerable to physical and psychological abuse as a result of their involvement in relationships with older partners. Additionally, like perinatally infected youth, they too may be functioning in a “parentified” role due to parental absenteeism, substance use, mental illness or other family dysfunction.



### Issues of Independence

One fundamental challenge in working with HIV- infected youth is to help them move toward independence when they have been physically, psychologically, and emotionally dependent on their families and the health

care system. This is particularly true for perinatally infected youth who are often “infantalized” emotionally by families that have sought to protect them from society or the challenges of HIV infection. However, as youth develop, treatment decision-making and responsibility for adherence shifts from their parents and others to themselves. Many families struggle with this and with young people’s developmental

**YOUTH INFECTED AT BIRTH ARE MORE LIKELY THAN BEHAVIORALLY INFECTED YOUTH TO BE AT AN ADVANCED STAGE OF ILLNESS AND HAVE MULTIPLE PHYSICAL DISABILITIES AS A RESULT OF THEIR INFECTION.**

need for independence, especially given adolescents’ inclination to make decisions that may be different than their parents. For instance, young persons may feel that the immediate discomfort or inconvenience of treatment is too great and may therefore decide against more complex treatments that a parent may see as essential to longer-term survival.

For youth with behaviorally acquired infection, treatment options and decision-making are often solely in their hands. This, too, may be problematic in that maturity, substance use, role identity/confusion and lack of an adequate social support network may affect treatment decisions and compliance. For parenting young women, the demands of caring for young children, who may also be at risk of infection, as well as coping with poverty, social isolation, and limited resources may make medical compliance low on their list of priorities. For some young MSMs, accessing and remaining compliant with treatment may mean accepting a diagnosis that to many of their community members (i.e., older MSMs) has been a debilitating or life-ending diagnosis.



### Peer Relationships

HIV-infected youth also face a variety of challenges regarding relationships with peers. For example, young people who are perinatally infected may have only other HIV-positive youth as friends, have a peer group that is developmentally less mature than they are, or have no supportive friendship circle at all. The lack of diversity of each of these situations may prove problematic. The experience of having only other HIV-infected youth as friends, for example, can prevent youth from fostering interests outside of their world of HIV infection and interfere with important life

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challenges of peer group selection and rejection that will occur. Having a less mature peer group, which may happen because of delayed physical development or setbacks in school, can be harmful because it may affect the way a young person confronts issues of sexuality, love, and intimacy. Having no peer group outside the family can prevent a young person from developing important communication and negotiation skills.

Because a disproportionate number of youth with behaviorally acquired infection have been recipients of poor parenting, emotional/sexual abuse and social isolation, their peer group relationships may also be inappropriate. Because many are teen parents or young MSMs, the availability of peers may be limited, causing distress, social isolation, and lack of age appropriate social skills. Additionally, anecdotal evidence suggests that many heterosexual young women and young MSMs have been “victimized” by older, more experienced partners. Emotional and financial dependence and an uneven power/control dominate these relationships and impact the youth’s ability to form appropriate relationships with their contemporaries.



## Disclosure

Another important consideration relates to disclosure of infection status. The way in which a young person learns about his or her HIV

infection can have a significant effect on social and psychological well being. The caregivers of perinatally infected youth usually are aware of a child’s infection from soon after the child’s birth but may delay disclosing it for several years. Although not always the reality, a young person optimally will have learned about his or her infection as a result of a well-planned approach by family, medical providers, and mental health clinicians.

In contrast, behaviorally infected youth often face the challenge of having to disclose to parents or caregivers. Because many states and municipalities allow youth to be tested and receive treatment for HIV without parental consent or notification, these youth face the daunting challenge of deciding if and when to disclose. Further, they often have to disclose the fact that they have been sexually active, may be pregnant, engaged in a same sex relationship, or are a substance user.



## Intervention Strategies

Youth identified as HIV-infected are likely to be referred for and engaged in case management services. The case management relationship can be used to build rapport and may serve to legitimize a health care system that is foreign or intimidating to clients. Social work case managers can identify mental health issues to be addressed and create an environment in which mental health intervention can begin. The case manager serves as the first line of assessment and intervention for positive youth, identifying past and current issues which will affect medical compliance, adjustment to diagnosis, and risk of re-infection. The *Home,*

*Education, Activities, Drugs, Sex and Suicide* (HEADSS) tool can be useful for psychosocial assessment. It structures questions to maximize communication and minimize stress (Cohen, MacKenzie, & Yates, 1991; Goldenring & Cohen, 1988).

Specific issues that should be explored in an assessment include: other acute and chronic illnesses, coping skills, familial relationships, relationships with health care providers, and other factors that may affect development and coping (e.g., a parent’s substance using history). Completing family genograms is also useful in identifying multi-generational patterns of dysfunction that may affect the client’s functioning and impact care. These patterns may not be easily recognizable by the client; however, a visual presentation may assist them in confronting long-term maladaptive behavior patterns through introspective processes.

Because some families affected by HIV are disorganized, impoverished, and reactive rather than proactive, they provide youth with little practical experience in making and adhering to plans. Taken together, these conditions cause clients to operate from crisis to crisis (Abdalian & Wright, 2000). This may make engagement in more formal mental health services challenging since these services require that youth schedule appointments, attend them on time, and work on “issues” between sessions. Professionals may be viewed as withholding services and youth may “shop” for desired answers or services by moving from one professional to another (Abdalian & Wright, 2000). Case managers often have greater flexibility in meeting clients where they are in a more literal sense. They can engage clients during home visits, at

medical appointments, and at community-based social service agencies. Due to this flexibility, they may have increased opportunities to provide crisis intervention counseling and short-term mental health treatments than more traditional mental health providers. Furthermore, clients may feel they have greater power with this model since they can decide locations of meetings and control time investment.

Once a client's psychosocial situation has been stabilized, case managers may create opportunities to link them with more formalized mental health therapy such as individual, group and family counseling. The case management role at that point will be to encourage client engagement in therapy, support the relationship with the mental health worker, provide concrete services such as child care and transportation to encourage compliance, and assist clients with therapeutic assignments between sessions.

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### INDIVIDUAL THERAPY

In individual therapy, youth may benefit from exploring such issues as social isolation, grief and loss, anger and guilt about HIV infection, sexual decision making, and methods of coping with various challenges. Past physical and sexual abuse, poor interpersonal relationships, abandonment/attachment issues, and substance use must all be explored. One of the greatest challenges of the therapist is to encourage healthy sexuality as well as sexual responsibility and decision making. This entails looking at issues of disclosure to sexual partners and issues related to safer sex. Techniques such as confrontation, reframing,

journaling, role-playing, and art projects can be useful, but must be employed in the context of each client's psychological development and with sensitivity to cultural factors. A final goal of the individual therapist may be to assess the client's appropriateness for group intervention.

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### GROUP THERAPY

In group settings, therapeutic goals include helping youth gain peer support, enhance interpersonal relationship skills, and reduce depression and social isolation. The facilitator's role is to develop and sustain relationships with each client and among clients (Corey & Corey, 1997). Modeling for clients, the facilitator must instill hope, provide realistic encouragement, and identify ideas that are common among members.

Approaches such as role-playing, predetermined discussion questions, and therapeutic board games are useful in establishing rapport and trust. Group activities may include creating a written group history to which every member contributes. If members agree to do so, visiting peers in the hospital, or holding groups at alternative sites also can be useful in preparing members for the departure of peers. Poetry, video composition and other art projects enable clients who may have difficulty verbalizing feelings to express them in other manners.

These therapeutic processes may have themes directly or indirectly related to issues that the therapist would like to explore. For example, a Mother's Day card making activity may allow clients to make cards for their mothers who may or may not be

present in their lives and to discuss feelings around this holiday. It may allow members who are currently parenting to verbalize their feelings about parenthood and its implications and challenges. Although issues discussed may not always be obviously or directly related to the clients' HIV status, they all have implications for treatment.

The group environment allows youth to revisit and address past relationship difficulties. Youth may have never had an opportunity to establish peer to peer relationships, have meaningful interaction with adults or authority figures, experience positive conflict resolution, or establish a sense of belonging. Care must be taken so that the group experience does not become a substitute for real life experiences and relationships. Youth must be encouraged to establish friendships and romantic relationships outside of the group experience and transfer newly acquired skills learned within the context of group to "real life".

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### FAMILY THERAPY

In some cases, sustaining long-term client progress may require family therapy. Even if family intervention is ultimately warranted, providers should meet with family members separately to determine appropriateness of family intervention, engage each member in treatment, and establish a care plan. The provider must model strategies that help families learn new ways of looking at their infected child or sibling. For example, if a family is resistant to allowing their adolescent to make

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age-appropriate treatment decisions, the therapist might allow the child, during therapy sessions, to make a major decision regarding the course of treatment. "Tony, it seems that your family would like to address your difficulty taking medications, your brother's behavior problems, and the conflict between you and your parents. What do *you* think is most important for us to address immediately?" In this way, parents can begin to have an altered perspective or world-view about their "helpless" child who is, in reality, an adolescent who is able to think critically and make age-appropriate decisions.

Providers should be attuned to the risks families may represent to the client as well as the strengths of the family system. If clients have not been engaged in individual therapy, completing a genogram may be useful.

### TRANSITIONING ISSUES: A NEW BEGINNING

Successful intervention with adolescents should always include transition to adult services. The level of client success in moving to this different model of care will depend upon a variety of factors. The most pertinent will vary from client to client, but agencies should establish clear guidelines for staff and clients so that problems can be foreseen, when possible, and expectations clearly understood by all. Sudden changes in expectations can be avoided by allowing sufficient time for appropriate care transfer.

Clients should be adequately prepared in order to minimize the chance of client avoidance and disengagement from care. Successful transition programs include, for example, a specific treatment plan, concluding with a graduation program. Teamwork must be clearly visible to the client who should be made to feel (and actually is) integral to the success of the transition process. Resistance to change can often be seen in these clients who, for the first time, may be engaged in a healthy, therapeutic relationship. Endings and termination may remind clients of previous negative life experiences and must be explored fully within the context of the therapeutic relationship, whether individual or group.

### PROVIDER ISSUES

Providers are likely to have a variety of feelings while working with infected youth. These feelings may include value judgements about a client's decisions, especially those related to treatment choices and sexuality, and there is a risk that these feelings will be particularly acute in light of the temptation for providers to "parent" adolescent clients. It is crucial for providers to recognize resistance, transference, and counter-transference in these cases.



### Conclusion

The key to working with adolescents is balance. Balancing professional intervention with client initiative is particularly delicate. Providers must monitor and support client efforts at change. In the ever-changing HIV epidemic, ongoing provider education is key to effective therapeutic intervention with infected adolescents.

**Tracey Bush, MSW, LCSW,**  
*Case Management Supervisor,  
Project Lagniappe—Family Advocacy,  
Care & Education Services,  
Children's Hospital, New Orleans, LA*

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## GOOD BETS



### BOOKS

#### Active Treatment of Depression

This book argues that people with depression need a different approach to treatment than any available today—an active treatment. By actively playing mentor, coach, cheerleader, and nurturer, therapists can engage patients' emotions, mitigate the effects of shame, and help them see connections between what happens in their lives and how they feel inside. Cost: \$35.00.

*R. O'Connor, 2001. 286 pages. Available from Norton Professional Books, W.W. Norton & Company, 800 Keystone Industrial Park, Dunmore, PA 18512-4601. Ph: (800) 233-4830. Fax: (800) 458-6515. www.npbcatalog.com.*

#### AIDS and Mental Health Practice: Clinical and Policy Issues

Primarily written for clinicians, educators, and health professionals, this book includes a wide variety of perspectives and topics from various contributors to provide insight into the clinical and policy issues related to AIDS and mental health practice. Cost: \$24.95.

*M. Shernoff (Ed.), 1999. 381 pages. Available from The Haworth Press, 10 Alice Street, Binghamton, NY 13904-1580. (800) 429-6784. www.getinfo@haworthpressinc.com*

#### Children Who Grieve: A Manual for Conducting Support Groups, Rev. Ed. and accompanying workbook It's Okay to Feel

This manual, written for both professionals and families, provides techniques for helping a grieving child to understand what has happened, what they are feeling and why. Included are tools for facilitating insights and communications, developing and facilitating

support groups for children, and using art therapy. A special chapter for parents is also included along with many real life examples and stories. The accompanying workbook contains 24 exercises and suggested readings for both children and adults. Cost: Manual and Workbook \$24.95.

*R. Beckmann, 2000. 103 pages. Available from Learning Publications, P.O. Box 1338, Holmes Beach, FL 34218-1338. Ph: (800) 222-1525. www.learningpublications.com.*

#### Depression in Context: Strategies for Guided Action

This book reviews preliminary findings from one of the largest clinical trials for depression, comparing behavioral activation to cognitive therapy and medication. The authors explain the theory behind their model of behavioral activation, describe strategies and techniques for successful therapy, and bring treatment to life with many clinical examples as well as two complete case illustrations. Cost: \$32.00.

*C.R. Martell, M.E. Addis, & N.S. Jacobson, 2001. 223 Pages. Available from Norton Professional Books, W.W. Norton & Company, 800 Keystone Industrial Park, Dunmore, PA 18512-4601. Ph: (800) 233-4830. Fax: (800) 458-6515. www.npbcatalog.com.*

#### Developing Outcome Strategies in Children's Mental Health

As the authors share the realities of developing and sustaining outcome-based evaluation strategies, they discuss various methods used to capture information, to adapt existing databases to meet individual needs, and to apply collected information by linking processes and outcomes. These real-life challenges and successes provide readers with the tools to gain valuable insight into what their own programs accomplish in order to improve outcomes for the children they serve. Cost: \$34.95.

*M. Hernandez & S. Hodges, 2001. 270 pages. Available from Paul H. Brookes Publishing, P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax: (410) 337-8539. www.brookespublishing.com.*

#### HIV and Depression: Context and Care

Providing clarification for the confusion that often surrounds assessment and treatment of depressive symptoms in the context of HIV disease, this book offers practical advice for front-line providers. It emphasizes the contexts in which depression care occurs, including discussions of normal sadness versus clinical depression, the cultural context in which each client lives, and the clinical contexts in which depression unfolds. Cost: \$11.95 plus \$2.00 shipping and handling (CA residents add 8.5% sales tax).

*F.J. González, 2001. 106 pages. Available from UCSF AIDS Health Project, P.O. Box 0884, San Francisco, CA 94143-0884. Ph: (415) 502-7270. ccrawf@itsa.ucsf.edu. www.ucsf-ahp.org.*

#### A Place to Call Home: Adoption and Guardianship for Children in Foster Care

This document, written primarily for clinicians, researchers and policy makers, provides insight into the three cornerstones of child welfare policy—safety, permanency, and developmental need—as they relate to children in the foster care system. It also examines what some states have done to increase the number of children adopted out of foster care and to expand available permanency options through the use of legal guardianship. Cost: \$25.00.

*S. Christian & L. Eikman, 2000. 60 pages. Available from the National Conference of State Legislatures, 1560 Broadway, Suite 700, Denver, CO 80202. Ph: (303) 830-2054. Fax: (303) 863-8003. books@ncsl.org.*

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### How to Conduct a Workshop for the Bereaved: A Leader's Manual

Written for therapists, this manual outlines a 10-session support group for people who have lost a loved one. Under each meeting section, the author describes thought-provoking activities, the goal of the meeting, and an outline of the process. This manual is an easy-to-use resource for practitioner, who are conducting their first bereavement group or don't have time to organize their own curriculum for a bereavement support group. Cost: \$6.96.

*R. Temes, 1999. 54 pages. Available from Learning Publications, Inc., 5351 Gulf Drive, P.O. Box 1338, Holmes Beach, FL, 34218. 1-800-222-1525 ext. M11. Ph: (800) 222-1525. www.learningpublications.com.*

### Nonfinite Loss and Grief: A Psychoeducational Approach

This book will assist practitioners in providing therapy that recognizes and addresses the particular needs of individuals experiencing nonfinite loss and grief. It explains the various theories on loss and explores how the grieving and therapeutic processes for dealing with nonfinite loss differ from finite loss. It also provides clinicians with the background, tools and strategies to help clients reach their goals and learn to manage and live with their loss. Cost: \$29.95.

*E.J. Bruce & C.L. Schultz, 2001. 258 pages. Available from Paul H. Brookes Publishing, P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax: (410) 337-8539. www.brookespublishing.com.*

### Treating Psychological Trauma & PTSD

This volume presents an innovative psychobiological framework, incorporating the latest theory and clinical research for understanding and treating PTSD. It brings together leading treatment experts to describe and illustrate their respective approaches, facilitating the selection and implementation of the most effective interventions for individual patients. The editors identify 65 PTSD symptoms contained within five (rather than the traditional three) symptom clusters, and they spell out 80 target objectives for treatment. Cost: \$36.00.

*J. P. Wilson, M.J. Friedman, & J.D. Lindy (Eds.), 2001. Available from Guilford Publications, Inc. 72 Spring Street, Dept. 5C New York, NY 10012-9902. Ph: (800) 365-7006. www.guilford.com.*

### Working with Families in the Era of HIV/AIDS

This book encourages professionals to become involved in family-oriented services to prevent the spread of HIV and its consequences. It is packed with programs and strategies for mobilizing family resources in the prevention of HIV and adaptation to living with HIV and AIDS. Based on sound scientific principles and community collaboration, the prevention programs in this volume are currently being tested through rigorous, controlled trials in communities across the country. Cost: \$29.95.

*W. Pequegnat & J. Szapocznik, 2000. 342 pages. Available from Sage Publications, 2455 Teller Rd., Thousand Oaks, CA 91320. Ph: (805) 499-0721. Fax: (805) 499-0871. www.sagepub.com.*

### Dual Diagnosis: Counseling the Mentally Ill Substance Abuser, 2nd Edition

This book offers a thorough introduction to clinical work with mentally ill substance abusers, providing a synthesis of chemical dependency and mental health models. It is fully compatible with DSM-IV, and includes discussions on a range of effective counseling strategies, the latest developments in treatments for adolescents and adults, as well as clinical vignettes and sample treatment plans. This book also incorporates information on how to integrate 12-step concepts into mental health interventions and a new section on trauma-based disorders in addicted female adolescents. Cost: 25.00.

*K. Evans & J. M. Sullivan, 2001. 290 pages. Available from Guilford Publications, Inc. 72 Spring Street, Dept. 5C New York, NY 10012-9902. Ph: (800) 365-7006. www.guilford.com.*

### The Link Between Childhood Trauma and Mental Illness: Effective Interventions for Mental Health Professionals

This book is designed specifically to help mental health professionals who are not child

abuse specialists work with their patients that have been abused. It focuses on direct practice issues, including how to ask clients about child abuse, the nature and power in the helping relationship, the full recovery process, effective treatment, models, client safety issues, and ways to listen to clients' stories. Cost: \$23.95.

*B. Everett & R. Gallop, 2000. 330 pages. Available from Sage Publications, 2455 Teller Road, Thousand Oaks, CA 91320. Ph: (805) 499-9774. Fax: (805) 499-0871. Email: order@sagepub.com.*

### Psychotherapy with African American Women

This book is designed to help clinicians develop a broader understanding of what is useful and what is problematic when applying psychodynamic concepts to their African American female clients. Chapters confront longstanding stereotypes and myths, replacing them with nuanced depictions of African American women's daily struggles, intrapsychic conflicts, and coping strategies. Cost: \$35.00.

*L.C. Jackson, and B. Greene, Ed., 2000. 298 pages. Available from Guilford Publications, Inc., 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006; Fax: (212) 966-6708. Email: exam@guilford.com. www.guilford.com.*

### The Supervisory Relationship: A Contemporary Psychodynamic Approach

This book provides the reader with a comprehensive contemporary model of psychoanalytic supervision. Using examples and vignettes, the authors show how working within the vicissitudes of the supervisory relationship can allow the supervisee to gain a deeper understanding of the treatment method being taught. Issues discussed include; power and authority, regression in the relationship, and rethinking the "teach/treat" question. Cost: \$28.80.

*M. G. Frawley-O'Dea & J. E. Sarnat, 2001. 240 pages. Available through Guilford Publications, Inc., 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006; Fax: (212) 966-6708. Email: exam@guilford.com. www.guilford.com.*

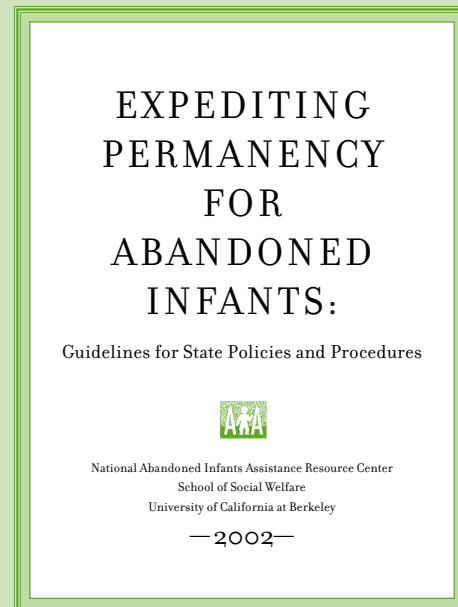
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## EXPEDITING PERMANENCY FOR ABANDONED INFANTS: GUIDELINES FOR STATE POLICIES AND PROCEDURES

A new publication available from the AIA Resource Center

**E**xpediting Permanency for Abandoned Infants: *Guidelines for State Policies and Procedures* is a 30-page monograph written and produced by the National Abandoned Infants Assistance (AIA) Resource Center, in collaboration with the National Resource Center on Foster Care and Permanency Planning and the National Child Welfare Resource Center on Legal and Judicial Issues. It is intended as a resource for policy makers, administrators, attorneys, judges or others who are interested in developing or revising policies and programs to expedite permanency for infants and young children who are abandoned or at risk of abandonment. Specifically the monograph:

- Reviews state policies and practices concerning abandonment, and makes recommendations in regards to intent to abandon, diligent searches, and time frames for making an abandonment determination;
- Suggests a definition for permanency, and reviews state policies vis-a-vis this definition;
- Recommends time frames and procedures for terminating parental rights in the case of an abandoned infant or young child; and
- Identifies promising practices in expediting permanency for infants and young children who are abandoned or considered at risk for abandonment.



Copies of *Expediting Permanency for Abandoned Infants: Guidelines for State Policies and Procedures* can be purchased for \$10.00 from the National AIA Resource Center. Please send your request with a check, made payable to UC Regents, to:

**AIA Resource Center**  
1950 Addison St., Suite 104  
Berkeley, CA 94704-1182  
Attn: Publications

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The complete document is also available on-line at <http://socrates.berkeley.edu/~aiarc/projects/projects.htm>.

**For more information, contact:**

Amy Price at 510-643-8383 or [amyprice@uclink4.berkeley.edu](mailto:amyprice@uclink4.berkeley.edu).

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### Hope Meadows

This book tells the story of Hope Meadows, the intergenerational community built on a former Air Force Base that provides permanent homes for foster care children who otherwise would be considered unadoptable. At Hope Meadows, seniors find a renewed sense of purpose as foster grandparents while the meaning of community is rediscovered and networks of caring people work collectively to piece shattered childhoods back together again. Cost \$24.95.

*W. Smith, 2001. 210 pages. Available from The Berkley Publishing Group, 375 Hudson Street, New York, NY 10014. (800) 788-6262.*

### Building Your Baby's Brain: A Parent's Guide to the First Five Years

This book, full of illustrations and charts, explains in simple language what scientists know about brain development, showing a few simple things parents can do every day to make a big difference in the brain development of their children. This book is written at a fifth-grade reading level and is available in both English and Spanish. Cost: \$29.50 for a set of 10.

*D. T. Dodge & C. Heroman, 1999. 46 pages. Available from Teaching Strategies, Inc., P.O. Box 42243, Washington, DC 20015. Ph: (800) 637-3652. www.TeachingStrategies.com.*

### Reading Right From the Start: What Parents Can Do in the First Five Years

This book, written for parents whose children may be a risk for future school success, provides parents with concrete information on how their daily routines can help children build vocabulary, learn about conversations, and discover meaning from the written word. Parents can learn the value of talking, singing, and reading to their children through this book which is rich in illustrations and written at a fourth grade reading level. The book is available in both English and Spanish. Cost: \$29.50 for a set of 10.

*T. S. Bickart & D. T. Dodge, 2000. 62 pages. Available from Teaching Strategies, Inc., P.O. Box 42243, Washington, DC 20015. Ph: (800) 637-3652. www.TeachingStrategies.com.*

## JOURNAL PUBLICATIONS/ REPORTS/MAGAZINES

### The Complete Practitioner

This monthly newsletter provides highlights from clinically oriented journals of studies examining the effectiveness of psychological/behavioral and pharmacological treatments. Also included are news highlights from the Food and Drug Administration, resource listings, and a variety of screening and assessment tools (subscribers can access tools from previous issues on the website). The newsletter also provides a Continuing Education (CE) program for practitioners to earn CE credits by completing the quiz included with each edition. Costs: Individual Subscription \$89, Institutional Subscription \$129.

*Available from The Complete Practitioner Subscriptions Department, P.O. Box 40907, Nashville, TN 37204-0907. Ph: (800) 300-0971. www.completepractitioner.com.*

### Journal of Behavioral Health Services and Research

This interdisciplinary and peer-reviewed journal incorporates research and articles from the nation's leading behavioral health researchers, providing practical applications of the most current research in alcohol, drug abuse, and mental health. Cost: \$69.00.

*Available from Aspen Publishers, Inc., P.O. Box 911, Fredrick, MD 21704. Ph: (800) 638-8437. Fax: (301) 417-7650. www.aspenpublishers.com.*

### Positive? How Are You Feeling?

This publication is a special issue of WISE Words, a three-times yearly publication of Project Wise, Project Inform's interdepartmental program focused on HIV/AIDS treatment information and advocacy for women. This special issue is designed to help women living with HIV to recognize feelings and signals that may be related to HIV disease. It provides ideas about how to respond, e.g., getting more rest, eating better, going to the doctor, or taking anti-HIV medications. Cost: Free.

*Available from Project Inform, 205 13th Street, Suite 2001, San Francisco, CA 94103-2461. Ph: (800) 822-7422. Also available online at www.projectinform.org.*

### POZ

This monthly magazine provides information and resources for people who are HIV positive, and it creates a common media context for everyone in the HIV/AIDS community. POZ is engaging and accessible, providing information to treatment activists, patients, and the larger community of people impacted by HIV/AIDS. From its inception, POZ has been made available at no cost to any person who is HIV positive and unable to afford the subscription fee. POZ also has a Spanish version called POZ en Español. Cost: \$19.97/yr; \$32.97/ 2yr.

*Available from POZ, 349 West 12th Street, NY, NY 10014. Ph: (800) 9-READ-POZ. Fax: (212) 675-8505. www.poz.com.*

### Sexual Assault Report

Sexual Assault Report is a bimonthly newsletter that provides information about innovative programs for working with survivors of sexual assault, and key developments in law, medicine, counseling, prevention and advocacy. Designed to help in identifying, documenting, and prosecuting sexual assault crimes and protecting and supporting sex crime survivors, Sexual Assault Report is written by practicing professionals for practicing professionals utilizing a multi-disciplinary approach. Cost: \$152 for annual subscription.

*Available from Civic Research Institute, Inc., P.O. Box 585, Kingston, NJ 08528. Ph: (609) 683-4450. Fax: (609) 683-7291. http://civicresearchinstitute.com.*

## VIDEOS

### Addiction & Mental Illness

Designed for counselors, hospital personnel, and mental health workers, this video uncovers the gray area for persons battling substance abuse and mental illness. It addresses questions such as: "Which illness came first?" and "How can both be treated effectively?" The video presents the stories of two dually diagnosed individuals to suggest modalities for working with individuals lost between the different philosophies of mental health and substance abuse treatment. Cost: \$149.

1994. 27 minutes. *Aquarius Health Care Videos*, 5 Powderhouse Lane, P.O. Box 1159 Sherborn, MA 01770. Ph: (888) 440-2963. [info@aquariusproductions.com](mailto:info@aquariusproductions.com). [www.aquariusproductions.com](http://www.aquariusproductions.com).

### Hepatitis C: The Silent Epidemic

This video explores every aspect of hepatitis C (HCV) including diagnosis, symptoms, treatment and side effects, as well as lifestyle issues specific to people in recovery living with HCV. It provides pertinent information through the testimony of a well-known hepatologist and individuals currently living with the virus. Part 1 of the video stresses the importance of getting screened and seeking medical attention; part 2 shows viewers various ways of managing the disease. Cost: \$225.

2000. 29 minutes. Produced by the Hazelden Foundation. Available from *Hazelden Video*, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. Ph: (800) 328-9000. [www.hazelden.org](http://www.hazelden.org).

### Kids to Kids: When Someone Special Dies

In this short video designed for 4-to-12 year olds, young kids share their stories of grief and losing a loved one. They talk about their feelings, about worrying that other loved ones will die, and about how they got through it all. This is a program for children to help them realize that they are not alone in their feelings of isolation, sadness, and anger. Cost: \$125.

1999. 12 minutes. Available from *Aquarius Health Care Videos*, 5 Powderhouse Lane, P.O. Box 1159 Sherborn, MA 01770. Ph: (888) 440-2963. [info@aquariusproductions.com](mailto:info@aquariusproductions.com). [www.aquariusproductions.com](http://www.aquariusproductions.com)

### Positively: Adults Coping with HIV and AIDS

This video explores some of the struggles that adults with HIV/AIDS face (moving through denial, adhering to difficult medication regimens), and how three HIV+ adults have found the support they needed. The video also shows the benefit of support groups, individual counseling and other support services, and reveals some of the stresses

of caring for someone who is HIV+. A booklet is included that contains additional information about mental health services, professionals and places to look for help. Cost: \$99.

2001. 36 minutes. Available from *Aquarius Health Care Videos*, 5 Powderhouse Lane, P.O. Box 1159, Sherborn, MA 01770. Ph: (888) 440-2963. [info@aquariusproductions.com](mailto:info@aquariusproductions.com). [www.aquariusproductions.com](http://www.aquariusproductions.com)

### Positively: Caregivers of Children Coping with HIV and AIDS

This video shares the stories of three different families and how they cope with HIV and AIDS. Focusing on caregivers of HIV positive children 14 and under, the video gives concrete suggestions about where to find information and support. Caregivers who are HIV positive and those who are not discuss the medical and emotional challenges they face daily and the benefits of support groups and counseling. Also included is a small booklet with additional information about mental health services, professionals and places to look for help. Cost: \$99.

2001. 36 minutes. Available from *Aquarius Health Care Videos*, 5 Powderhouse Lane, P.O. Box 1159, Sherborn, MA 01770. Ph: (888) 440-2963. [info@aquariusproductions.com](mailto:info@aquariusproductions.com). [www.aquariusproductions.com](http://www.aquariusproductions.com)

### Positively: Young Adults with HIV and AIDS

This video contains interviews with three HIV+ young people who talk about their stories, the struggles they faced coping with their diagnosis, and the importance of seeking support around mental health issues. Sources of support that are identified include: counseling, working with HIV/AIDS-focused organizations, and using one's faith to get through difficult times. The video is targeting young adults living with HIV/AIDS, those who care for/about them, and professionals working with HIV+ clients. One of the main premises of the video is that a person's emotional and mental health have an impact on his/her ability to cope and manage the disease. Also included is a booklet with additional information about mental health, professionals and places to look for help. Cost: \$99.

2001. 34 minutes. Available from *Aquarius Health Care Videos*, 5 Powderhouse Lane, P.O. Box 1159, Sherborn, MA 01770. Ph: (888) 440-2963. [info@aquariusproductions.com](mailto:info@aquariusproductions.com). [www.aquariusproductions.com](http://www.aquariusproductions.com)

### Restless, Irritable & Discontented: The Basics of Relapse Prevention

Primarily designed for people in recovery, this video examines the attitudes and behaviors that warn of relapse. Through personal stories, the viewer learns how to identify and minimize high-risk situations, how to cope with cravings, and the importance of staying connected to the community of other recovering addicts and alcoholics. Cost: \$225.

2000. 18 minutes. Produced by the Hazelden Foundation. Available from *Hazelden Video*, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. Ph: (800) 328-9000. [www.hazelden.org](http://www.hazelden.org).

### The Tomorrows Children Face When a Parent Dies: Children Sharing Their Insights and Feelings

Through personal stories, this video explores the complex feelings and reactions children might have when they lose a parent. For example, it looks at children's views of spirituality, going back to school, grieving as a family, surviving the holidays, and grief over time. Cost: \$195.

1997. 47 minutes. Available from *Aquarius Health Care Videos*, 5 Powderhouse Lane, P.O. Box 1159, Sherborn, MA 01770. Ph: (888) 440-2963. [info@aquariusproductions.com](mailto:info@aquariusproductions.com). [www.aquariusproductions.com](http://www.aquariusproductions.com)

### Women & Depression

This video explains that depression is a diagnosable and treatable illness that affects 19 million Americans, two thirds of whom are women. Experts in the field discuss many available options for women with clinical depression, and women and their families share stories about their experiences with depression and treatment. Cost: \$149.

2000. 28 minutes. *Aquarius Health Care Videos*, 5 Powderhouse Lane, P.O. Box 1159 Sherborn, MA 01770. Ph: (888) 440-2963. [info@aquariusproductions.com](mailto:info@aquariusproductions.com). [www.aquariusproductions.com](http://www.aquariusproductions.com).

## THE TIES THAT BIND

### New Materials for Kinship Caregivers and Professionals Who Work with Them

The *Ties That Bind* materials were developed to help kinship caregivers understand and cope with the impact of parental substance abuse in their lives. Filled with real-life case studies and practical advice, these easy-to-read materials help caregivers make sense of what has happened, and better understand how to cope with the bio-parents and children in their care.

- Topics covered include:**
- Dealing with complicated feelings
  - Where to go for support
  - Preserving your marriage
  - Helping the child talk about what has happened
  - Getting support for children
  - House rules and safety procedures
  - Visits with parents
  - The possibility of reunification
  - Talking with children about substance abuse
  - Encouraging a bio-parent to try treatment
  - Caregiver's own use of alcohol or other drugs

#### The materials come in three forms:

1. The *Ties That Bind* 91-page **handbook** is appropriate for caregivers with medium to strong reading skills who have the time to review a book. Cost: \$7.
2. The *Ties That Bind* **Fact Sheets** include 25 single-topic fact sheets written at a 6-7th grade reading level. These straight-to-the-point fact sheets are intended to be reproduced by professionals to share with caregivers when problems arise. Cost: \$10 for one set of 25.
3. Extensive information for caregivers and professionals is available on-line at [www.coaf.org/Kinship/kinmain.htm](http://www.coaf.org/Kinship/kinmain.htm).

To order the handbook or fact sheets, call 800-488-DRUG or send a check or money order to COAF, 164 West 74th Street, NY, NY 10023.

**For more information, contact:** Kiki Samuels  
Director, Kinship Care  
Children of Alcoholics Foundation  
164 West 74th Street  
New York, NY 10023  
(212) 595-5810 x 7763  
[ksamuels@phoenixhouse.org](mailto:ksamuels@phoenixhouse.org).



# CONFERENCE LISTINGS



## 10th Annual National Colloquium on Child Abuse and Neglect

This conference will provide a range of interdisciplinary, skills-based training seminars on all aspects of child maltreatment, providing the latest data in scientific and legal research as well as practice knowledge.

**DATE:** May 29-June 1, 2002

**LOCATION:** New Orleans, LA

**SPONSORING AGENCY:** American Professional Society on the Abuse of Children

**CONTACT:** Heather Newton, P.O. Box 26901, CHO 3B3406, Oklahoma City, OK 73190. Ph: (405) 271-8202. Fax: (405) 271-2931. Email: heather-newton@oubsc.edu. www.apsac.org.

## Building on Family Strengths: Research and Services in Support of Children and their Families

This annual conference brings together family members, youth, researchers, service providers and advocates. Participants will share research findings and program strategies that promote family-centered services and enhance the quality of life for families and their children who are affected by emotional, behavioral, or mental disorders. Topics will include: developments in family-centered research; family-centered, culturally competence services; and building the capacity of communities to support children and families.

**DATE:** May 30-June 1, 2002

**LOCATION:** Portland, OR

**SPONSORING AGENCY:** Research & Training Center on Family Support and Children's Mental Health, Portland State University

**CONTACT:** Rachel Elizabeth, Public Information and Outreach Coordinator, Research and Training Center on Family Support and Children's Mental Health, Regional

Research Institute, Portland State University, P.O. Box 751, Portland, OR 97207. Ph: (503) 725-8118. Email: elizabr@rri.pdx.edu. www.rtc.pdx.edu.

## 14th Annual National Conference on Social Work and HIV/AIDS – HIV/AIDS 2002: The Social Work Response

This conference draws approximately 500 AIDS-care social workers from across the country. The theme for 2002 is "Entering the Third Decade of HIV/AIDS: Roles, Challenges, and Opportunities for Social Work." Major speakers include Angela Powell, and Evelyn Tomaszewski.

**DATE:** May 30-June 2, 2002

**LOCATION:** New Orleans, LA

**SPONSOR:** Boston College Graduate School of Social Work

**CONTACT:** Dr. Vincent Lynch, Conference Chair, Boston College Graduate School of Social Work, 140 Commonwealth Avenue, Chestnut Hill, MA 02467. Ph: (617) 552-4038. Email: lynchv@bc.edu.

## National MultiCultural Institute's 17th Annual National Conference

The theme of this conference is Thinking Globally: Broadening the Context of Multicultural Dialogue and Action. The conference will include workshops on: Training of Diversity Trainers; Cultural Competency; Workplace Diversity and Organizational Development; Cross-cultural Conflict Resolution; and Multicultural Education.

**DATE:** May 30-June 2, 2002

**LOCATION:** Washington, DC

**SPONSORING AGENCY:** National MultiCultural Institute

**CONTACT:** NMCI, 3000 Connecticut Ave., NW, Suite 438, Washington, DC 20008-2556. Ph: (202) 483-0700. Fax: (202) 483-5233. Email: nmci@nmci.org. www. nmci.org.

## 2002 Family Group Decision Making Roundtable

The theme of this annual event is "Revolutionizing practice with children and families: Sustaining and growing the FGDM movement." Families, practitioners, policy-makers, administrators, researchers, and juvenile and family court professionals will have an opportunity to engage in thought-provoking, planful discussions about the implementation of FGDM and help to develop local, state and national strategies to maintain and bolster FGDM practice.

**DATE:** June 2-5, 2002

**LOCATION:** Monterey, CA

**SPONSOR:** National Center on Family Group Decision Making

**CONTACT:** 2002 FGDM Roundtable, c/o Ann Morales, American Humane Association, 63 Inverness Drive East, Englewood, CO 80112-5117. Ph: (303) 925-9421. Email: ann@americanhumane.org.

## American Bar Association 10th National Conference on Children and the Law

The Conference will address many of the tough issues facing today's lawyers, judges, non-attorney CASA and guardians ad litem, social workers, health professionals, agency administrators, and others, through 4 special pre-conferences, 4 plenary sessions, and 40 workshops. Those from allied fields can enhance their understanding of law, legal practice, and court-related issues in their efforts to serve children.

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**DATE:** June 6-8, 2002

**LOCATION:** Washington, DC

**SPONSORING AGENCY:** American Bar Association

**CONTACT:** Conference Coordinator, ABA Center on Children and the Law, 740 15th Street, NW, Washington, DC 20005. Ph: (202) 662-1721. Fax: (202) 662-1755. [www.abanet.org/child](http://www.abanet.org/child).

### Managing the Workforce Crisis: Promising Practices and Emerging Research

This national showcase focuses on proven and promising practices for recruiting, developing and retaining productive workforces in public and private agencies. Workshops will be offered in five tracks: leadership development, human resource management, retention, professional development, and research and policy.

**DATE:** June 10-12, 2002

**LOCATION:** St. Louis, MO

**SPONSOR:** CWLA Walker Trieschman Center

**CONTACT:** Finding Better Ways 2002, CWLA Walker Trieschman Center, 200 Congress St., Suite 305, Quincy, MA 02169-0907. Ph: (617) 769-4003. Fax: (617) 770-4464. Email: [nrau@cwla.org](mailto:nrau@cwla.org).

### 14th International Congress on Child Abuse and Neglect

This congress will look at past and future international efforts to combat child abuse and neglect.

**DATE:** July 7-10, 2002

**LOCATION:** Denver, CO

**SPONSOR:** International Society for the Prevention of Child Abuse and Neglect, the Kempe Children's Foundation, and the Kempe Children's Center

**CONTACT:** Kempe Children's Center/2002 Congress, 1825 Marion St., Denver, CO 80218. Fax: (303) 315-8002. Email: [2002@kempecenter.org](mailto:2002@kempecenter.org). [www.kempecenter.org](http://www.kempecenter.org).

### 2002 Training Institutes

These institutes will focus on developing local systems of care for children and adolescents with emotional disturbances and their families. They will address both public policy and clinical practice, reflecting the importance and interdependence of both. They will also include a special emphasis on family involvement and cultural competence in systems of care.

**DATE:** July 10-14, 2002

**LOCATION:** Washington, DC

**SPONSOR:** National Technical Assistance Center for Children's Mental Health; Child, Adolescent and Family Branch of the Federal Center for Mental Health Services; and SAMHSA

**CONTACT:** NTACCMH, Georgetown University Child Development Center, 3307 M St., NW, Suite 401, Washington, DC 20007-3935. Ph: (202) 687-5000. Fax: (202) 687-1954. Email: [institutes2002@mindspring.com](mailto:institutes2002@mindspring.com).

### 16th Annual Conference on Treatment Foster Care

Over 700 treatment foster care professionals and foster parents attend this conference each year. It offers a wealth of expertise, information and talent in this unique field, featuring over 70 workshops for every type of treatment foster care professional. It is the only North American-based annual conference developed by and for treatment foster care professionals and foster parents.

**DATE:** July 21-24, 2002

**LOCATION:** Chicago, IL

**SPONSOR:** Foster Family-based Treatment Association

**CONTACT:** FFTA, 1415 Queen Anne Rd., Suite 200, Teaneck, NJ 07666-3521. Ph: (800) 414-3382. Fax: (201) 862-0331. Email: [ffta@ffta.org](mailto:ffta@ffta.org). [www.ffta.org](http://www.ffta.org).

### NIMH Conference on the Role of Families in Preventing and Adapting to HIV/AIDS

This conference is designed to present research findings on family processes and HIV disease. Primary objectives are focused upon: family processes associated with the epidemiology of AIDS and high-risk behaviors of family members; family configuration and

functioning as predictors of adaptation at different stages of HIV/AIDS; stress and coping strategies mobilized by families infected and affected by HIV and AIDS; family issues of multiple losses, death, bereavement, child custody and permanency planning; models for mental health services for families with a life-threatening disease; and strategies for analyzing family data.

**DATE:** July 24-26, 2002

**LOCATION:** Miami, FL

**SPONSORING AGENCY:** The Center for Mental Health Research on AIDS, National Institute of Mental Health

**CONTACT:** Willo Pequegnat, Ph.D., Center for Mental Health Research on AIDS, NIMH, NIH, 6001 Executive Boulevard, Room 6209, MSC 9619, Bethesda, Maryland 20892-9619. Ph: (303) 443-6100. Fax: (303) 443-9719. Email: [wpequegn@nih.gov](mailto:wpequegn@nih.gov). [www.nimh.nih.gov](http://www.nimh.nih.gov).

### A Symposium on the Role of Partners in Women's Recovery

This interactive forum will provide administrators and clinical staff with an opportunity to share information about innovative models and strategies for helping women understand the role partners play in their recovery process, and for engaging partners as active supports in that process.

**DATE:** August 1-2, 2002

**LOCATION:** Berkeley, CA

**SPONSOR:** National Abandoned Infants Assistance Resource Center

**CONTACT:** Margot Broadus, AIARC, 1950 Addison St., Suite 104, Berkeley, CA 94704-1182. Ph: (510) 643-7018. Fax: (510) 643-7019. Email: [margotb@uclink4.berkeley.edu](mailto:margotb@uclink4.berkeley.edu). <http://socrates.berkeley.edu/~aiarc>.

### 5th Annual National Respite and Crisis Care Networking Conference

The theme of the 2002 conference is *Across the Lifespan and Across the Country - Respite Makes a Difference!*

**DATE:** August 1-3, 2002

**LOCATION:** Pittsburgh, PA

**SPONSORING AGENCY:** ARCH National Respite Network and Resource Center

**CONTACT:** ARCH, Chapel Hill Training-Outreach Project, 800 Eastowne Drive, Suite 105, Chapel Hill, North Carolina 27514. Ph: (888) 671-2594 or (919) 490-5577. Fax: (919) 490-4905. [www.archrespite.org](http://www.archrespite.org).

### NACAC's 28th Annual Conference

This conference consists of more than 100 workshops, institutes, and general sessions presented by leaders in the adoption field. Topics include adoptive family recruitment, adoption support and preservation, permanency planning, family life, advocacy, and more. It is open to everyone interested in the welfare of children and families, including adoptive and foster parents, child welfare professionals, and other child advocates. The theme of the 2002 conference is *Winds of Change: New Directions for Families and Children*.

**DATE:** August 1-4, 2002

**LOCATION:** Chicago, IL

**SPONSORING AGENCY:** North American Council on Adoptable Children

**CONTACT:** NACAC, 970 Raymond Avenue, Suite 106, St. Paul, MN 55114. Ph: (651) 644-3036. Fax: (651) 644-9848. Email: [info@nacac.org](mailto:info@nacac.org). [www.nacac.org](http://www.nacac.org).

### Rediscovering the Other America: A National Forum on Poverty and Inequality

This national forum will include a keynote by Frances Fox Piven, as well as paper presentations, interactive workshops, and a panel discussion of national policies and practices about poverty and inequality.

**DATE:** August 18, 2002

**LOCATION:** Chicago, IL

**SPONSOR:** *The Poverty, Class and Inequality Division of the Society for the Study of Social Problems, the Journal of Poverty: Innovations on Social, Political & Economic Inequalities, the Society for the Study of Social Problems, Sociologists for Women in Society, and the Center for Urban Research and Learning.*

**CONTACT:** Keith Kilty, College of Social Work, Ohio State university, 2947 College Rd., Columbus, OH 43210. Ph: (614) 292-7181. Email: [Kilty.1@osu.edu](mailto:Kilty.1@osu.edu).

### The National Humane Conference 2002

This conference is a professional development event for animal welfare and child welfare professionals. The theme of the 2002 conference is *From 1877 to 2002*.

**DATE:** September 19-22, 2002

**LOCATION:** Denver, CO

**SPONSORING AGENCY:** American Humane Association's Children's Services and Animal Protection Services

**CONTACT:** Mickey Shumaker, American Humane Association, 63 Inverness Drive East Englewood, CO 80112-5117. Ph: (800) 227-4645. Fax: (303) 792-5333. Email: [mickey@americanhumane.org](mailto:mickey@americanhumane.org). [www.americanhumane.org](http://www.americanhumane.org).

### 2002 National Conference on Health Care and Domestic Violence

The theme of this biennial conference is *Prevention and Response Strategies: Pushing the Envelope*. It will provide valuable professional education on the latest research, innovative health care prevention, and clinical responses to domestic violence for all health care professionals.

**DATE:** September 26-28, 2002

**LOCATION:** Atlanta, GA

**SPONSOR:** Family Violence Prevention Fund's National Health Resource Center on Domestic Violence

**CONTACT:** Family Violence Prevention Fund, 383 Rhode Island St. Suite #304, San Francisco, CA 94103-5133. Ph: (415) 252-8900. Fax: (415) 252-8991. Email: [peter@fvpf.org](mailto:peter@fvpf.org). [www.endabuse.org/health](http://www.endabuse.org/health).

### Lifetime Connections: Achieving Excellence in Adoption Conference

The conference will feature workshops and information on all facets of adoption: special needs adoption, domestic (private infant agency) adoption, and intercountry adoption. It is designed to provide high quality training for beginning and experienced frontline staff and supervisors, administrators of child welfare and related programs, and professionals in related disciplines.

**DATE:** November 6-8, 2002

**LOCATION:** Fort Lauderdale, FL

**SPONSORING AGENCY:** Child Welfare League of America

**CONTACT:** Ada White, Director of Adoption Services, CWLA, 440 First Street NW, 3rd Floor, Washington, DC 20001-2085. Ph: (202) 942-0255. Fax: (202) 638-4004. Email: [awhite@cwla.org](mailto:awhite@cwla.org). [www.cwla.org](http://www.cwla.org).

### International Society for Traumatic Stress Studies - 18th Annual Meeting

This annual meeting is the premiere trauma conference, with presentations and workshops on a wide variety of trauma-related topics offered by researchers, clinicians, and others. The 2002 meeting will focus on complex psychological trauma and its psychosocial effects. In addition, in the wake of the September 11th terrorist attacks, a special track will address clinical response to mass trauma.

**DATE:** November 7-10, 2002

**LOCATION:** Baltimore, MD

**SPONSORING AGENCY:** International Society for Traumatic Stress Studies

**CONTACT:** ISTSS, 60 Revere Dr., Suite 500, Northbrook, IL 60062 USA. Ph: (847) 480-9028. Fax: (847) 480-9282. Email: [conf@istss.org](mailto:conf@istss.org). [www.istss.org](http://www.istss.org).

### 4th National Harm Reduction Conference

Conference highlights include: harm reduction efforts in Latino and African-American communities, with a Spanish track; user-to-user interventions, education, organizing and advocacy; practical interventions for methamphetamine and crack cocaine users; new research on drug use, AIDS, hepatitis C, syringe exchange and harm reduction; methadone information and advocacy; workshops on advocacy and community organizing, including the faith community; how to start and maintain a syringe exchange program; and overdose intervention and response. The theme of the 2002 conference is *Taking Drug Users Seriously*.

**DATE:** December 1-4, 2002

**LOCATION:** Seattle, WA

**SPONSORING AGENCY:** Harm Reduction Coalition

**CONTACT:** Harm Reduction Coalition, 22 West 27th St., 5th Floor, New York, NY 10001. Ph: (212) 213-6376. Fax: (212) 213-6582. Email: [conference@harmreduction.org](mailto:conference@harmreduction.org). [www.harmreduction.org](http://www.harmreduction.org).

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# The Source

**EDITOR:** Amy Price

**DESIGN:** Betsy Joyce

**PRINTING:** UC Printing

**CONTRIBUTING WRITERS:**

Andrew Angelino  
Pamela Bachanas  
Tracey Bush  
Gwen Davies  
Stephanie Handel  
Jan Hudis  
Heidi Hutton  
J. Stephen McDaniel  
Glenn J. Treisman

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## AIA RESOURCE CENTER

1950 Addison St., Ste. 104  
Berkeley, CA 94704-1182  
Tel: (510) 643-8390  
Fax: (510) 643-7019  
<http://socrates.berkeley.edu/~aiarc>

**PRINCIPAL INVESTIGATOR:** Neil Gilbert, Ph.D.

**DIRECTOR:** Jeanne Pietrzak, M.S.W.

**ASSOCIATE DIRECTOR:** Amy Price, M.P.A.

**POLICY ANALYST:** John Krall, MSW

**TRAINING COORDINATOR:** Margot Broaddus, B.A.

**RESEARCH ASSISTANTS:** Deverie Demornay  
Stephanie Glezos  
Heather Weisbrod  
Lauren Wichterman

**SUPPORT STAFF:** Linda Way



**Resource Center**

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