African American Women Living with HIV/AIDS: Mental Health Issues

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SUMMARY. The number of African American women infected with the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) is alarming. As with any other reaction to catastrophe or life threatening diseases, from the time African American women first learn of their HIV-positive serostatus they navigate various levels of acceptance and a multitude of mental health issues. This manuscript explores these issues related to African American women with HIV/AIDS. Careful consideration is given to the stages of adjustment and related mental health challenges that women might experience. Also explored are the reciprocal impact of children, other family members and significant others on the mental health status of African American women living with HIV/AIDS. Implications for clinical practice are also identified. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com].
The impact of HIV and AIDS among African American women has been devastating. Since the beginning of the epidemic, over 100,000 cases of AIDS have been reported among women, and 57% of these cases were among African American women (Centers for Disease Control and Prevention [CDC], 2000). Presently, 1 in 160 African American women are infected with HIV, and in 1999 alone, almost two-thirds (63%) of all women reported with AIDS were African American (CDC, 2000). Among all AIDS cases reported for African American women since the epidemic began, 42% were as a result of injection drug use and 38% resulted from heterosexual contact (CDC, 2001). Among these women, 43% were in their 30s, 22% were in their 40s, and 21% were in their 20s. A large number of women infected heterosexually were infected through sex with an injection drug user (IDU), and most women were unaware of their partners’ risk factors.

Nearly 90% of African American women infected are in the prime of their lives, and in their childbearing years. The diagnosis of HIV is perceived as a death sentence and results in a multitude of mental health issues. Not only are these women impacted by their HIV-positive diagnosis, families are deeply affected as well. According to Havens and Mellins (1996), HIV/AIDS commonly occur in families already struggling with substance abuse, psychiatric disorder, and multi-generational histories of victimization and trauma. Therefore, the added burden of HIV on a struggling family system is overwhelming to say the very least.

Scant literature exist regarding African American women living with HIV/AIDS, most of which is focused on medication and the multiple barriers to health care that confront these women. Literature has just begun to explore psychosocial issues associated with women living with HIV/AIDS. Ethnic and cultural differences among women infected with HIV mean different psychological reactions and require specific kinds of family support. Because the mental health of women can exacerbate symptoms of the disease (McCain & Zeller, 1994), psychosocial ad-
aptation and coping strategies are extremely important for African American women living with HIV/AIDS. In what follows we will discuss mental health issues related to African American women with HIV and AIDS. In so doing, we will explore the stages of adjustment and related mental health issues that occur during each stage. We will also address the impact of family and significant others on the mental health status of African American women living with HIV and AIDS, and explore implications for clinical practice.

**OVERVIEW**

A diagnosis of HIV-positive has social and psychological implications that are far reaching for women. In comparison to their HIV-positive male counterparts, women with HIV must deal with more stigma (Angell, 1991), a significant decline in quality of life (Atkins & Hancock, 1993; Sowell & Seals, 1997), and a greater incidence of psychopathology and psychiatric morbidity (Mellers et al., 1994; Vedhara, Schifitto, & McDermott, 1999). These issues are even more conspicuous for African American women living with HIV/AIDS. Researchers have noted that African American women living with HIV/AIDS reported more emotional distress and psychiatric symptoms as well as greater difficulty in coping with the disease (Bedimo, Bennett, Kissinger, & Clark, 1998; Kalichman, Williams, Cherry, Belcher, & Nachumson, 1998; Orr, Celentano, Santelli, & Burwell, 1994) than their HIV-positive male counterparts. For example, Van Servellen et al. (1998) studied HIV-positive women, many of whom where African American, and observed major levels of distress, anxiety, depression, limits on normal functioning, and disturbances to physical well-being. Linn, Poku, Cain, Holzapfel, and Crawford (1995) conducted a study on psychosocial outcomes of HIV illness in African American male and female clients. Results indicated that African American women living with HIV were more depressed than African American men regardless of the stage of their disease, had less support than men, and had low morale. In a study on perceived health, HIV illness, and mental distress in African American women attending AIDS counseling centers (Bright, Arnett, Blair, & Bayona, 1996), respondents indicated involvement in high-risk activities, depression, a lack of social support, stress, and under-recognition of their disease. They also requested assistance in building and maintaining social support networks. African American women who contract HIV from IDU, which is the primary mode of transmission among
this population, experience even higher levels of psychiatric distress than women who contracted HIV from heterosexual contact and male HIV-positive injection drug users (Rabkin et al., 1997).

Fatigue is a common symptom of HIV that has been associated with psychological problems. While fatigue is consistent among all persons infected with HIV, research has shown that women living with HIV were significantly more likely to report fatigue than men (Breitbart, McDonald, Rosenfeld, Monkman, & Passik, 1998). In a study by Van Servellen et al. (1998), fatigue was the most frequently reported symptom and the worst symptom for 98% of women living with HIV. While fatigue is thought to be consistent among women across ethnic groups, differences between African American and White women have been reported on emotional distress and psychiatric symptoms.

African American women living with HIV/AIDS are overwhelmed with severe and multiple illnesses, decreased cognitive functioning, devastating weaknesses and limitations, weight loss, fevers, cancers, opportunistic infections, disfigurement, blindness, pain, and psychiatric disorders. They must also face the concomitant losses of health, fitness, attractiveness, strength, independence, family, and friends. The overwhelming issues of HIV/AIDS cause these women to review their life experiences and examine their values, beliefs, sexual behaviors, views of death and dying, relationship development, fears, hopes, dreams, religion, and more (Atkins & Hancock, 1993).

Some of the issues associated with the mental health status of African American women are consistent with the stages of psychosocial adjustment and acceptance. Nichols (1985) recognized a four-stage psychosocial process specific to persons with HIV/AIDS: initial crisis-catastrophic effect, transitional state, deficiency state, and preparation for death. Havens and Mellins (1996) developed a model that they use for HIV-infected women and affected children and families, which organizes HIV illness into specific predictable stages, taking into account the dynamic course of HIV illness. Among these stages are the diagnosis of HIV infection, illness progression, late stage illness, death, and family reconfiguration. Dunbar and Mueller (1995) developed a model for women living with HIV/AIDS known as The Process of Transcendence. Included are reckoning with death, life affirmation, creation of meaning, self-affirmation, and redefining relationships. Individually, none of these models appear to adequately address the myriad of mental health issues that are confronted by African American women living with HIV/AIDS and their families. The process proposed by Nicholas (1985) identifies the psychosocial stages of adjustment of all persons.
with HIV/AIDS. However, recognition is not given to the issues specific to women, particularly African American women, who experience innumerable mental health issues associated with their HIV-positive status. The model by Havens and Mellins (1996) provides an excellent overview of issues that are confronted by children and other family members that are affected by HIV/AIDS, but provides limited information on how persons overcome the mental health issues associated with their diagnosis. The Dunbar and Mueller (1995, 1998) model of transcendence, implicitly and explicitly communicated that within each woman exists the ultimate ability to transcend having HIV/AIDS, and all the negativity that accompanies this diagnosis. Additionally, this model provides a sound theoretical framework with which to understand mental health issues among women. However, scant information exists on the impact of HIV/AIDS on family and significant others. It is the belief of these authors that children, family and significant others must be included in order to have a holistic conceptual understanding of the mental health issues of African American women with HIV/AIDS. Collectively, these models provide detailed information in which to better understand African American women with HIV/AIDS. Using Dunbar and Mueller’s model as the primary theoretical framework, and adding supplemental information from the models of Havens and Mellins, and Nichols, we will explore mental health issues associated with African American women with HIV/AIDS.

**MENTAL HEALTH ISSUES AND STAGES OF ADJUSTMENT**

Prior to one’s HIV-positive diagnosis, most African American women communicated thinking, “It could not happen to me,” even though they were aware of the modes of HIV transmission and they were involved in a number of high-risk behaviors (e.g., injection drug users, sex exchange, unprotected sex) (Russell & Smith, 1999). Deering (1993) believed that these women might have been in denial as well as underestimated their personal vulnerability. Siegal, Ravels, and Gorey (1998) reported that the major obstacles to women recognizing their at-risk status is due to a lack of understanding of risk behavior patterns, ignorance of their sexual partner’s risk practices, a lack of information on HIV-related symptoms, and perceived invulnerability to infection. Therefore, shock and denial are the most common responses experienced by most African American women when initially diagnosed as
having HIV. Table 1 presents a description of the relevant characteristics of stages of adjustment for African American women.

In the Dunbar and Mueller (1995) model titled *The Process of Transcendence*, women are thought to experience emotions that vary from despair to fulfillment on a path that is conceptualized as spiraling rather than linear. The evolutionary process of transcendence is individualized and unique to each woman, with past experiences, perceived sense of control, role integration, social support, and spirituality as core factors influencing the transcendent process. While African American women living with HIV/AIDS experience horrendous challenges related to their physical and mental health, they are eventually able to understand their HIV-status as a growth-producing experience that helped to strengthen their sense of self.

**Reckoning with Death**

In everyday life, it is common to set goals for the future, typically without doubting that one’s life will progress to old age. Yet for African American women diagnosed with HIV, many of whom are between the ages of 20 and 39, future planning shifts drastically. Life has more of a finite meaning and becomes far more precious. One’s initial reaction to her HIV status begins with shock, denial and despair, and is characterized by a state of disconnection from the world (Dunbar & Mueller, 1995, 1998; Nicholas, 1985). The process of reckoning with death is

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<th>Stage of Adjustment</th>
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<td>Reckoning with death</td>
<td>Marks the beginning of healing and acceptance. Initial reaction begins with shock, denial, despair, and disconnecting. Life is perceived as finite.</td>
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<tr>
<td>Life affirmation</td>
<td>Begins with a realization of the choice to live or to give up, and is marked by a “fighting spirit” and a renewed sense of self-efficacy.</td>
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<td>Creation of meaning</td>
<td>Alters conceptions of life and creates new meaning by examining life, working through unresolved past issues, and reframing negative life experiences.</td>
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<td>Self-affirmation and redefining relationships</td>
<td>Involves reconnecting with others, making amends, and saying good-bye. Requires examining relationships and redefining each based on contributions, and reconnecting with the world and giving back to society. Concludes with tying together loose ends and making final plans.</td>
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very painful and is associated with feelings of hopelessness, depression, and rage. These feelings might be magnified and sustained as a result of the isolation most African American women usually experience after initially receiving the diagnosis. This baseline isolation can impede access to moral support from family, and social and mental health supports from health and human service providers (Havens & Mellins, 1996). In a study on HIV infected African American women, Bedimo et al. (1998) observed difficulty in disclosing HIV status to both family and significant others. The hidden or secretive nature of African American women diagnosed with HIV usually stems from fear of rejection and the stigma associated with the disease (Russell & Smith, 1999), and much of the shame and stigma that African American women feel results from being infected with a disease associated with promiscuity, illicit drug use, and death (Land, 1994). In addition, guilt and shame about behaviors associated with the acquisition of HIV can impede effective communication about their HIV diagnosis, further isolating women from social supports (Havens & Mellins, 1996).

Reckoning with death for African American women with HIV first requires engaging in self-analysis to examine beliefs, fears, strengths and desires, past choices, attitudes, and behavior. It is a time of reevaluation that can bring the individual to fuller conscious recognition of who they are as a person. The process initially involves feelings of confusion, distress, and self-devaluation (Nichols, 1985). The self-reflection that is involved can deepen their sense of psychological chaos and can seem counterproductive. African American women living with HIV/AIDS usually experience lowered self-esteem, shifts in identity and values, as well as estrangement and isolation from families and loved ones.

Reckoning with feelings of death is also critical to making choices that lead to transcendence. As women reckon with the realities of death, some of the feelings that they experience include dependence, fear, sadness, vulnerability, distrust, depression, hopelessness and anger (Kubler-Ross, 1969; Nichols, 1983, 1985). According to Dunbar and Mueller (1995), women might feel a lack of self-efficacy, a sense of helplessness, and self-loathing, each of which can lead to self-destructive behaviors. In accordance with the process of transcendence, reckoning with death marks the beginning of healing, and acceptance of having an HIV-positive diagnosis.

The culmination of emotions emanating from learning of their HIV-positive status can lead to either the internalizing or projecting of feelings. Internalized feelings lead to withdrawal, depression, and
sometimes suicide attempts. Women who project their feelings onto others may have anger that is directed towards family members, loved ones, and caretakers. Additionally, the overwhelming emotional reaction to an HIV-positive diagnosis can lead to sexually acting out, or an increase in intravenous drug use. However, researchers have indicated that the psychiatric distress that African American women living with HIV experience is correlated with the mode of HIV transmission. For example, Goggin, Engelson, Rabkin, and Kotler (1998) observed that women whose HIV risk factor was sexual contact were more than five times more likely to be diagnosed with Hypoactive Sexual Desire Disorder than women who contracted HIV through IDU. Hence, as African American women make a mental transition from a state of despair to acceptance of their HIV-positive status, their mental health status is very erratic. However, for many African American women, a strong sense of isolation accompanies the introspection that is required to accept one’s HIV status. The ability to directly confront issues associated with their HIV-positive status usually involves isolation from others and the fear of tomorrow. Moving through this process is the beginning of an awareness of one’s own power and inner strength. Also, African American women might reckon with the thought of dying whenever they have symptoms of AIDS or when friends or partners have these symptoms.

In addition to coping with the realities of testing HIV-positive, African American women living with HIV must also deal with the external realities of life, such as feeding their children, going to work, and managing their health care. Many women deal with this paradox by putting their day-to-day functions on “automatic pilot” while directing psychic energy inward (Dunbar & Mueller, 1995). The recognition and resolution of death as the inevitable consequence of HIV/AIDS requires African American women to shift from future-focus to present-focus, which typically involves reordering priorities. For example, Russell and Smith (1999) conducted a preliminary phenomenological study describing the experiences of five African American women diagnosed with HIV. Results from their research indicated that these women lived with no future, just a “now”; and their lives consisted of only the present and death. This awakened recognition of death resulting from an HIV-positive diagnosis sustains reconstruction of time (Dunbar & Mueller, 1998). Time becomes very precious and many African American women living with HIV/AIDS who were involved in unhealthy or nonproductive behavior see their status as an opportunity to “get their acts together.”
As the medical sequelae of HIV illness increase, so does the pressure to communicate with family members about their illness, and the need to plan for children’s future. According to Havens and Mellins (1996), mothers with advancing HIV illness commonly have difficulty communicating effectively with their children about their illness. For example, in a study of 40 HIV-infected mothers, Mellins and Ehrhardt (1995) found that the majority had not disclosed their serostatus to their children, particularly when children were 12 or younger.

**Life Affirmation**

At some point during the process of introspection there comes a realization of the choice to live or to give up, and life takes on a different meaning (Dunbar & Mueller, 1998). This begins life affirmation. “All you can think about when you’re first diagnosed is anger and sadness. Then you’ve got to make a choice. I chose to stick around...” (Kurth, 1993, p. 67). Dunbar and Mueller (1998) espoused that women who make a conscious decision to live a full life despite their HIV-positive status sometimes encounter the greatest amount of grief when reckoning with death. However, after reckoning with the realities of having a disease that ultimately ends in death, women commit to life redefined (Dunbar & Mueller, 1995). African American women living with HIV/AIDS who recognize their own strength and choose survival are moving through the levels of transcendence. This component is marked by a “fighting spirit” and a desire and willingness to regain control over life. Actions that manifest this sense of control include active involvement in the care of realities, and social activism. These behaviors emerge from a renewed sense of self-efficacy, and in turn, they enhance and strengthen one’s sense of self.

Dunbar and Mueller (1995) stated that as a result of having affirmed their will to live, many women have turned frustration into action in order to help themselves and others, and describe this component in terms of their frustration with the unresponsive medical community and social service system. However, the desire for action does not occur as quickly as the women infected would like, especially because time is of the essence for these women.

**Creation of Meaning**

Once a woman has chosen life, it is necessary to alter conceptions of how long they will live and what this life will be like, oftentimes with
finding new meaning. Dunbar and Mueller (1998) identified a period of life review as the first step in finding new purpose. This stage involves examining and working through unresolved past issues, which means reviewing past histories of trauma and abuse and reframing these painful incidents into experiences that have helped to shape them into stronger women. The initial stage of this process can be very painful. It involves letting go of previously held goals and dreams, and forces them to examine based on quality of life rather than longevity. African American women usually experience a resurgence of spirituality, a redefined sense of self, and a renewed sense of purpose (Cohen, 1990). Nichols (1985) described this stage as one in which African American women have a new stable identity characterized by the acceptance of HIV/AIDS and the limitations associated with this illness. Many women describe a greater appreciation for life, having come through the grief.

**Self-Affirmation and Redefining Relationships**

It is very difficult to discuss what occurs in the stage of self-affirmation for African American women with HIV/AIDS in isolation of their relationships. This is particularly because self-affirmation and self-affirming behaviors for these women require that they examine the positive and negative aspects of each relationship, and redefine each relationship in light of the attributes that contribute to quality of life.

African American women at this stage of transcendence experience a more positive sense of self. Some women view their positive status as a time to take care of themselves, whereas in the past their focus had been on the care and well-being of others. This also requires accepting care from others and sometimes asking others for help. Self-affirmation is also a time of life review, which sometimes involves reconnecting with others, making amends, and saying good-bye. These women cope with this disease by living one day at a time, and with a reassessment of the values of courage, commitment, concern for others, and an appreciation for quality rather than quantity of life (Dunbar & Mueller, 1995). In addition, “individuals begin to feel less victimized by life and less egocentric, deriving satisfaction from altruistic and community activities” (Cohen, 1990, p. 100). Ultimately, African American women living with HIV/AIDS who are on the path of transcendence grow to accept death in the context of accepting life as they have lived it.

With their new outlook on life, African American women must work on resolving and re-clarifying relationships with family, friends, and
acquaintances (Dunbar & Mueller, 1998). This component also refers to the knowledge of one’s profound connection to the world. It incorporates the dualities of strength in the context of need for help and support; insight, often greater than those who provide help; and aloneness, yet connection to all living things (Dunbar & Mueller, 1995), which requires the ability to both give and take. For women living with HIV, this connection takes many forms. For some, this connection is within a small community—the neighborhood picnics, PTA meetings, church, etc. For other women the community is larger. It is within this stage that African American women embrace the concept of public speaking and educating others regarding the behavioral risks of HIV/AIDS. Additionally, women in this stage begin to see themselves as survivors rather than victims.

From the day of diagnosis, African American women with HIV/AIDS are confronted with the terminal nature of their illness. Women might require assistance in completing unfinished business, tying together loose ends, writing wills, and making plans for their funerals. In the final stage of HIV illness, loss of parental functioning becomes paramount as the care of younger children might be left to older adolescents or young adult family members (Havens & Mellins, 1996). At this stage, parents should identify and designate friends or family members as guardians of their children, and identify appropriate and safe times associated with their physical and mental health when primary care of children should be shifted. Havens and Mellins (1996) reported that an existing marker for when the care of children is transferred is of greatest importance in those parents who develop AIDS-related dementia. Often, children experience the changes in their mothers’ mental status without a clear understanding of the etiology or implications of these changes. If parents develop AIDS-related psychiatric disorders (such as mania or psychosis), their disinhibited or disorganized behavior can be dangerous to children in their care.

**IMPACT OF SIGNIFICANT OTHERS ON MENTAL HEALTH**

Just as African American women living with HIV/AIDS are impacted by the disease, so are family members and significant others. These women must cope with mental health issues associated with their illness as do their family members and significant others, especially since it is from these networks that African American women with HIV/AIDS must draw strength and support. In addition to being in-
formed of the HIV-positive status of their loved ones, family members must also cope with the terminal effects of the virus, and the possibility of having to be physically and financially responsible for meeting the health care needs of their loved ones and their children.

Some of the stress African American women living with HIV/AIDS experience is partially due to the impact of their diagnosis on their children. The cyclical impact and effects that African American mothers living with HIV have on their children and vice versa has profound health and mental health implications. For example, according to Key and DeNoon (1996), children with an HIV-positive mother were significantly more withdrawn, had more problems with attention, and were more frequently depressed. Additionally, compared with children with asymptomatic mothers, the children of symptomatic mothers were significantly more anxious and/or depressed. As such, a mother’s concern about the mental status of her children compounds the physical and mental health-related problems. According to Land (1994), if children are infected as a result of the mother’s HIV-positive status, the guilt can be overwhelming. If their children are healthy, women feel guilty about the prospect that they will die and leave their children behind.

The placement of children following the death of their mother is a particularly challenging task for families and all persons involved. Havens and Mellins (1996) identified this process as permanency planning, and concluded that communication about HIV illness and permanency planning is closely intertwined with difficulties in one area being reflected in the other. Effective permanency planning requires the disclosure of HIV-positive status to the individuals selected to assume the children’s care. Havens and Mellins (1996) found that “family-based permanency planning that actively involves the children, particularly teenagers, is much more likely to have a successful outcome than that which ignores or excludes the affected young people” (p. 220).

Disclosing one’s HIV-positive status to other family members and significant others is a very difficult process, especially for African American women who struggle more than White HIV-positive females and HIV-positive African American males (Bedimo et al., 1998; Evans, Kell, Bond, & McRae, 1998). Disclosure means informing parents, children, siblings, extended family members, and friends about one’s HIV status. Responses to and feelings of families of African American women with HIV vary tremendously. Cohen (1990) explained that families and significant others experience feelings that are very similar to those of African American women infected with HIV/AIDS. Bonuck (1993) identified six possible reactions of family members to a loved
one’s diagnosis: social stigma and isolation, fear of contagion, fear of infection, fear of abandonment, guilt, and psychological and physical fatigue.

Much of the social stigma that African American family members experience comes from their communities. Many African American communities have been reluctant to acknowledge the threat of AIDS. Land (1994) believes that this reluctance is due to the majority culture’s tendency to associate Black communities with deviant behavior, and the conservative stance that the church takes on matters of sexual behavior and drug use. Additionally, acknowledging the existence of HIV/AIDS and its methods of transmission tends to affirm racist stereotypes associating African American communities with such criminal behavior as substance abuse and prostitution. As a result, the lack of support in many African American communities to infected women and affected families causes these individuals and families to secretly shoulder the caregiving responsibilities.

Family members are usually placed in the role of caregivers for African American women infected with HIV/AIDS. There are times when family members are required to provide health care and psychological support to African American women who are gravely ill. Psychological and physical fatigue are common reactions among family members with caregiving responsibilities of women with HIV. The manifestations of HIV/AIDS present a myriad of physical and psychological challenges. As a result, family members spend a significant amount of time visiting social service agencies, medical specialists, and health care facilities for assistance with treatment and medication. Because African American families have a strong desire and commitment to care for their own, family members are the primary care takers who assist with all activities of daily living of their loved ones. These day-to-day demands are overwhelming if respite is not available from other family members or community resources.

In order to provide optimal assistance and sustain the support of African American women infected, support services within and outside of the community are required to assist caregivers. Also, families must be relentless in their pursuits of seeking requisite resources to aid in the care of their loved one and to assist with the day-to-day caretaking responsibilities. Financial assistance programs, individual and family therapy, support groups, and home-care services are only a few resources that are essential to meeting the physical and mental health needs of African American women with HIV/AIDS. These resources
help to alleviate stress on the women infected and caregivers, and contribute to optimal family structuring.

Bereavement, in conjunction with family reconfiguration, is very important process that begins when women enter the final stage of AIDS and persist long after the loved one has died (Havens & Mellins, 1996). With parental death, grieving children and adolescents help to reconfigure existing families, during a time when extended families are also mourning the loss of the loved one. Much of the social support services that were available to families by virtue of the parent’s HIV/AIDS diagnosis either diminish or disappear following the parent’s death. Usually, African American children and adolescents who are orphaned by AIDS are moving from one situation of poverty to another, with the responsibility for the care of these children falling on families with limited financial resources. In situations where children and adolescents move into non-family foster care, they are required to make the difficult adjustment into new and unfamiliar families with life styles that are sometimes totally different from those to which they are accustomed. Both reconfigured and foster families must assume the care and responsibility of children who are experiencing substantial emotional trauma and behavioral problems, and some of whom exhibit failing academic function.

**IMPLICATIONS FOR PRACTICE**

Service efforts for African American women living with HIV/AIDS must be systematically and carefully designed (Land, 1994). Clinicians working with women infected and families affected by HIV must draw from service models emphasizing empowerment in outreach and psychoeducation, both of which should be conceived and designed within the context of African American women’s culture. Culturally relevant treatment should provide messages that are tailored to the specific needs and concerns of this population. Clinicians must also have expertise in the mental health concerns associated with the course of HIV illness among African American women and be aware of issues associated with substance abuse and other high-risk behavior specific to these women.

Culturally sensitive programs should be designed to decrease isolation, self-blame, and guilt. Support groups have the potential to empower African American women living with HIV/AIDS by reducing isolation and facilitating the development of strong relationships.
among members. Because time is required to build authentic relationships, groups should be ongoing. Sessions should be interactive, using techniques such as behavior rehearsal, role-plays, and guided imagery. Participants should be encouraged to teach and listen to one another. In addition to group content, group cohesion is very crucial to the success of the support group, which should be contextually relevant to the lives of the participants. To the extent possible, an HIV-positive African American woman should serve as a co-facilitator of the group. The group process should not be limited to designated parameters, but include the varying issues of participants involved.

Clinicians might also be required to assist African American women with preparing for death. This can be done by developing video or audio tapes, letters, and/or poems to leave for their loved ones. Women might also want to discuss their funeral arrangements. As African American women prepare for death, clinicians should encourage them to involve at least one family member or significant other with whom they feel close and who would like to be informed of their wishes. Planning for final arrangements can be a very difficult and emotionally draining experience; however, women should be encouraged to openly discuss their thoughts and feelings about death and dying, and of becoming dependent on others for care.

Individual therapy and support groups should also be formulated and available for children, other family members and significant others as well. These resources are especially important because these are the individuals who are called upon to provide caregiving tasks, and deal with many of the physical and mental health related issues that confront African American women living with HIV/AIDS. As such, culturally sensitive services are needed. Land (1994) proposed support groups for caregivers that provide information on the disease course and care of the HIV-infected individual, as well as other social supports that might be helpful. As mentioned above, these groups should fit the needs of those involved and should not be limited by any set parameters.

Because of the mental health implications that exist for children, it is important that they are placed in a therapeutic setting that would allow them to process their feelings and concerns. This can include individual therapy or family therapy that includes their mother. Additionally, children would benefit from being in social situations that involve other children whose mothers are living with HIV/AIDS. In addition to children being able to develop friendships, they are also able to understand that there are others who are living with similar situations.
CONCLUSION

African American women are confronted with myriad physical and mental health issues after learning of their HIV-positive diagnoses. Not only does having this disease affect the mental health of these women, but their mental health has been proven to have an impact on the course of the disease (Land, 1994). For example, depressed women are far more likely to get colds which can ultimately lead to pneumonia. Therefore, it is extremely important that clinicians have an understanding of the various issues that exist and have a working knowledge of ways to assist these women in navigating psychosocial pitfalls that usually accompany HIV. Hence, mental health clinicians working with African American women living with HIV/AIDS and their families must have the following specialized skills:

1. an understanding of the natural history of HIV infection in women, including potential nervous system effects of illness progression;
2. an understand of psychiatric co-morbidity in African American women who are drug dependent; and
3. an empathetic understanding of the impact of HIV on family structure and mental health functioning.

Clinicians with these requisite skills can assist in enhancing the quality of life for African American women living with HIV/AIDS, their children, other family members and significant others.

REFERENCES


