FACT SHEET

RURAL CENTER for AIDS/STD PREVENTION

A Joint Project of
INDIANA UNIVERSITY, PURDUE UNIVERSITY, AND TEXAS A&M UNIVERSITY

Mental Health Needs of HIV–Infected Rural Persons

Since the initial appearance of HIV in the early-1980s, research has rigorously characterized the psychological aftermath of this unpredictable disease. In general, AIDS mental health research shows that people living with HIV disease experience more anger, hostility, hopelessness, suicidal ideation, and mood and adjustment disorders than their HIV-seronegative counterparts [1-4].

Unfortunately, AIDS mental health researchers have largely overlooked the psychosocial needs of people living with HIV/AIDS in small towns and rural areas, and the neglect of this group is regrettable for several reasons. First, through June 2000, more than 44,600 people were living in nonmetropolitan areas (i.e., communities of 50,000 residents or fewer) at the time of their AIDS diagnosis[5]. Second, HIV-related migration patterns from urban centers to rural areas [6] and the continued practice of high HIV-risk sexual behaviors among HIV-seropositive and seronegative rural persons portend that small towns will experience more "native infections" than ever before [7-8]. Finally, as new therapies (HAART) extend the life expectancies of HIV-infected persons [4], rural-based health care organizations will be required to provide care to more HIV-infected individuals for longer periods of time. Clearly, as AIDS impacts more small towns and rural areas, it will be imperative to better understand and address the psychosocial needs of rural men and women living with the erratic illness of HIV disease.

Research Findings to Date

Research examining the mental health needs of HIV-infected rural residents indicates that this group confronts many complex stressors that reduce their overall life quality [9-11]. Relative to their urban counterparts, HIV-infected rural persons experience:

- reduced access to medical and mental health care services,
- more difficulty coping with life stressors,
- less access to personal and public forms of transportation,
- more incidents of AIDS-related discrimination,
- greater personal fear that their HIV serostatus will be discovered by others, and
- less overall satisfaction with their life.

In fact, in a recent study of more than 200 HIV-infected rural persons recruited from eight U.S. states[12], data obtained via self-report surveys indicated that:

- 59% reported "moderate" or "severe" levels of depressive symptoms, a rate exceeding those reported in comparable research based primarily on urban samples of HIV-infected persons,
- 38% of participants indicated that they had considered taking their own life in the past week, and
- HIV-infected rural persons who had considered suicide in the past week reported more depressive symptoms, less coping self-efficacy, more frequently worried about transmitting their HIV infection to others, and experienced more stress associated with AIDS-related stigma.

These elevated levels of suicidal ideation and psychological symptoms are worrisome, not only because they demonstrate that many HIV-infected rural persons are struggling with difficult life conditions, but also because these conditions may lead to other health-injurious behaviors. For example, in the sample of 200-plus HIV-infected rural persons, 50% of participants prescribed HIV antiretroviral medications had missed one or more medication doses in the past week. Poor treatment adherence among this group was strongly associated with greater coping difficulties and higher levels of life-stress. This high rate of non-adherence is troubling, since research shows that even occasional non-adherence to HIV combination medication regimens greatly reduces the virological and clinical benefits of treatment [13]. The elevated levels of depressive symptoms, suicidal ideation, and poor HIV treatment adherence, such as those observed in this large and geographically-diverse sample, underscore the urgent need for mental health interventions for rural persons living with HIV disease.

Possible Solutions

Over the past decade, researchers and practitioners have conceptualized and evaluated mental health interventions to improve the coping and adjustment efforts of people living with HIV/AIDS. Most intervention approaches involve the conduct of face-to-face counseling sessions or psychotherapy delivered in either individual or group settings. In general, AIDS mental health interventions fall into three categories: (1) support groups; (2) cognitive-behavioral stress management interventions; and (3) coping effectiveness training. While each intervention approach is unique with regard to structure and amount of involvement required by the practitioner, all three interventions strategies share several core components, such as:

- sharing personal histories,
- developing a sense of universality, *(Continued on next page)*

(Continued from previous page)

- appraising the severity of life stressors,
- enhancing adaptive ways of coping and eliminating maladaptive coping responses,
- learning how to maintain and develop a network of emotional and informational supports,
- helping participants to engage in a variety of health-promotion behaviors that improve one's physical and emotional well-being (e.g., relaxation techniques, regular rest and exercise, and health habit change).

While HIV-infected individuals who have participated in these intervention approaches have evidenced improvements in psychological well-being, increases in CD4 cell counts, and slower progression to AIDS [14-16], rural-based mental health professionals may encounter considerable difficulty offering these interventions to their HIV-infected rural clients [17]. Rural persons living with HIV disease who wish to take part in mental health support services must overcome a host of barriers to participation, such as vast geographic distances between practitioners and clients, limited transportation, and physical disabilities that preclude many HIV-infected rural persons from traveling to face-to-face support services. In addition, heightened concerns regarding confidentiality prevent many HIV-infected rural persons from attending mental health support services.

In light of these geographic and psychosocial barriers, it may be necessary to deliver mental health support services to HIV-infected rural persons through more innovative technologies that can reach geographically-and psychologically-distant individuals living with HIV/AIDS. These technologies may include interventions delivered via teleconference technology, the Internet, CD-ROM, or video/audiotapes. While these technology-assisted interventions lose some of the interpersonal benefits of face-to-face work, they can provide the client and practitioner with a diverse variety of intervention activities. For example, computer-based interventions (e.g., CD-ROMs used via personal computers) can include the following features: frequently asked questions (FAQ) and answers; instant libraries; personal stories; and decision analysis. In addition, Internet-based interventions can deliver information, emotional support, and skills training through fact sheets, newsgroups, individual and group chat rooms, message boards, e-mail, video/sound clips, and many other interactive features. While these technologies have not yet been tested with HIV-infected rural persons, they do offer tremendous potential to provide compassionate and supportive services to HIV infected rural persons, a group rapidly increasing in size and whose mental health needs have been overlooked by contemporary AIDS mental health research.

References

1. Hays, R.D., Cunningham ,W.E., Sherbourne, C.D., Wilson, I.B., Wu, A.W., Cleary, P.D., et al. (2000). Health-related quality of life in patients with human immunodeficiency virus in the United States: Results from the HIV Cost and Services Utilization Study. *American Journal of Medicine, 108*, 714-722.
2. Ickovis, J.R., Hamburger, M.E., Vlahov, D., et al. (2001). Mortality, CD4 cell count decline, and depressive symptoms among HIV-seropositive women: Longitudinal analysis from the HIV Epidemiology Research Study, *Journal of the American Medical Association, 285*, 1466-1474.
3. Low-Beer, S., Chan, K., Yip, B., et al. (2000). Depressive symptoms decline among persons on HIV protease inhibitors. *Journal of the Acquired Immune Deficiency Syndromes, 23*, 295-301.
4. Kalichman, S. C. (1998). *Understanding AIDS*. Washington, DC: American Psychological Association Publications, Inc.
5. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 2000;12(No. 1):[11].
6. Buehler J.W., Frey, R.L., Chu, S.Y., and the AIDS Mortality Group (1995). The migration of persons with AIDS: Data from 12 states, 1985-1992. *American Journal of Public Health, 85*,1552-1555.
7. Heckman, T.G., Kelly, J.A., Somlai, A.M., Kalichman, S.C., & Davantes, B.R. (1999). High risk sexual behavior among persons living with HIV disease in small towns and rural areas. *Journal of Sex Education and Therapy, 24*,29-36.
8. Kelly, J.A., Sikkema, K.J., Winett, R.A., Solomon, L.J., Roffman, R.A., Heckman, T.G., Stevenson, L.Y., Perry, M.J., Norman, A.D., & Desiderato, L.J. (1995). Factors predicting continued high HIV risk behavior among gay men in small cities: Psychological, behavioral, and demographic characteristics related to unsafe sex. *Journal of Consulting and Clinical Psychology, 63*, 101-107.
9. Berry, D.E., McKinney, M.M., & McClain, M. (1996). Rural HIV service networks: Patterns of care and policy issues. *AIDS & Public Policy Journal, 11*, 36-46.
10. Heckman, T.G., Somlai, A.M., Kalichman, S.C., Franzoi, S., & Kelly, J.A. (1998). *The Journal of Rural Health, 14*, 138-146.
11. Rounds, K.A. (1988). AIDS in rural areas: Challenges to providing care. *Social Work, 33*, 257-261.
12. Heckman, T.G., Miller, J.G., Kochman, A., Kalichman, S.C., Carlson, B., & Silverthorn, M. (in press). Thoughts of suicide among HIV-infected rural persons enrolled in a telephone-delivered mental health intervention. *Annals of Behavioral Medicine*.
13. Montaner, J. S. G., Reiss, P., Cooper, D., Vella, S., Harris, M., Conway, B., Weinberg, M. A., Smith, D., Robinson, P., Hall, D., Myers, M., Lange, J. M. A. for the INCAS Study Group (1998). A randomized, double-blind trial comparing combinations of nevirapine, didanosine, and zidovudine for HIV-infected patients. *Journal of the American Medical Association, 279*, 930-937.
14. Antoni, M.H., Baggett, L., Ironson, G., et al. (1991). Cognitive-behavioral stress management intervention buffers distress responses and immunologic changes following notification of HIV-1 seropositivity. *Journal of Consulting and Clinical Psychology, 59*, 906-915.
15. Chesney, M., Folkman, S., & Chambers, D. (1996). Coping effectiveness training for men living withHIV: Preliminary findings. *International Journal of STD and AIDS, 7* (supp. 2), 75-82.
16. Lutgendorf, S.K., Antoni, M.H., Ironson, G., Klimas, N., Kumar, M. et al. (1997). Cognitive-behavioral stress management decreases dysphoric mood and herpes simplex virus-type 2 in symptomatic HIV-seropositive gay men. *Journal of Consulting and Clinical Psychology, 65*, 31-43.
17. O'Rourke, J.K. & Sullivan, P.S. (1994). Negotiating HIV infection in rural America: Breaking through the isolation. In *Therapists on the front line: Psychotherapy with gay men in the age of AIDS.* R.A. Burnham, Jr. et al (Eds.)., American Psychiatric Press, Inc.

For more information contact:

Rural Center for AIDS/STD Prevention
Indiana University
801 East Seventh Street
Bloomington, IN 47405-3085

Voice and TDD: (812) 855-1718
(800) 566-8644
Fax Line: (812) 855-3717
aids@indiana.edu
http://www.indiana.edu/~aids

The *FACT SHEET* is a publication of the Rural Center for AIDS/STD Prevention. The Center is a joint project of Indiana University, Purdue University, and Texas A&M University.