Stopping transmission of HIV to new partners has been the primary focus of HIV prevention for positive individuals. Yet, transmission acts among seropositive persons in the United States have dropped from 100% in the 1980s to approximately 5% of seropositive persons transmitting currently. Transmission acts among seropositive women are far less common. Only 30% of seropositive women have unprotected sex with an HIV-negative partner. Internationally, where 90% of the epidemic occurs from heterosexual transmission, transmission risk is even lower. Among HIV-positive women in Africa, 60% to 80% have only had 1 lifetime sexual partner; in Asia, more than 90% have had only 1 lifetime sexual partner. The challenge of reducing transmission is important, but the societal challenges to the families, partners, and caregivers of persons living with HIV are even greater. The goal of this article is to encourage a broader agenda for prevention for positive persons, considering imitative transmission, mental health consequences, and problematic adjustment with the infected person’s network.

IMITATIVE TRANSMISSION OF HIV

Globally, unprotected sex with a partner and sharing needles are the most common direct routes of HIV infection. There is suggestive evidence that adolescents are imitating their parents’ risk behaviors and contracting HIV, however. The negative societal consequences of HIV extend and radiate through the family, particularly to adolescent children. Among young people living with HIV (adolescents aged 12–23 years), 19% report parents who are also HIV infected. Families are the primary source of all health-related behavior patterns, and parents are perhaps modeling risky behavioral styles of coping with life stressors that may be imitated by young people. The New England Journal of Medicine recently reported 1 physician’s feelings of hopelessness in treating an HIV-positive adolescent mother after having cared for the daughter’s mother living with HIV 10 years earlier. Young women, primarily of ethnic minority heritage, who live in neighborhoods with high drug abuse are becoming infected by their 1 partner. These women do not prioritize caring for their HIV infection: survival and security needs (eg, housing, child care, food) are far more important. The emerging HIV infections among a second generation of families coping with HIV highlight the importance of addressing imitation of HIV transmission among families living with HIV.

MENTAL HEALTH AND OTHER ADJUSTMENT PROBLEMS

Most seropositive persons are linked and nested within their families, society’s basic social unit. Even among gay men, 30.4% of seropositive men live in households with at least 2 persons and 14.5% have been married or have children (J. A. Catania, PhD, personal communication, 2004). Among heterosexuals, the impact of HIV radiates to partners and extended family and intergenerationally from grandparents who must assume responsibility.
for their children to AIDS orphans who become young parents, having had no role models during their own childhood.10

Adults living with HIV, particularly parents, are at high risk of having psychiatric disorders.11 Among parents, 80% report mental health symptoms in the clinical range12 and improvement in their anxiety and depression is prospectively related to their survival.13 Over time, approximately 70% of adults relapse into substance abuse.14 Comorbid mental health and substance abuse problems15 highlight the importance of ongoing preventive interventions for HIV-infected adults so as to reduce the societal costs of the treatment of these disorders. In addition, mental health symptoms and substance abuse are highly likely to have a long-term negative impact on their children.16

Children of parents living with HIV do not initially report high levels of emotional distress12; yet, over time, the impact of coping with HIV is associated with high rates of psychiatric disorders (39% anxiety disorders, 20% depression, 45% 1 disorder).17 Adolescent daughters are at high risk of teenage parenthood,18 trying to provide a grandchild to a dying parent. These grandchildren also exhibit negative consequences of HIV transmitted intergenerationally: the rate of disorganized attachments is about 2 to 3 times that of comparative samples of similar socioeconomic status (38%), and their cognitive functioning tends to be lower than anticipated.18 During a parent’s HIV illness, adolescent children may assume the responsibility of monitoring and maintaining the parent’s health and emotional stability.19 When a parent dies, the children must cope with more than the interpersonal losses; children are often forced to leave their homes and schools because rent subsidies are discontinued.20 The design of services exacerbates survivors’ stress and society’s long-term costs of providing for families affected by HIV.

IMPLICATIONS

Even in the developed world, the intergenerational consequences of HIV illness have lasting repercussions for those left behind to pick up the pieces. Prevention for positive individuals must include reducing intergenerational imitation of HIV risk behaviors and mental health disorders, coping with HIV-related psychosocial challenges (eg, disclosure, stigma, custody, bereavement), and reducing problems such as substance abuse. Psychosocial interventions can help infected parents with HIV-related challenges with their children and partners as well as with their children and their children’s children.13,14,21 Yet, psychosocial interventions are not broadly implemented or prioritized within the medical settings that typically provide care for seropositive persons. To reduce the negative intergenerational impact of HIV, these interventions need to be recognized as critical and cost-effective, accepted by providers and consumers, and broadly implemented. With such an approach, the long-term costs of HIV can be minimized.

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