

## Psychotherapy in HIV/AIDS

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### ABSTRACT

HIV/AIDS is a condition in which the immune system of the patient gets impaired and does not function properly so that the opportunistic infections occur in them which often causes mortality. It is caused by a retro virus which gets transferred through unprotected sexual intercourse with the person having the virus, through intravenous drug use, infected blood transfusion and other similar methods. Being infected with HIV is traumatic for the patient because the treatment of this disease is still in infancy they have to face lots of challenges in the treatment process. It creates an emotional and financial turmoil not just for the patient but for the whole family. Empirical and clinical work has shown that patients with HIV/AIDS experience lots of emotional and psychiatric issues. In India, these issues are often not focused by the treating physicians. However, recently these areas are being targeted and emotional and related issues faced by these patients have become the focus of interventions by the treating team. The current paper will focus on the various psychological issues faced by HIV/AIDS patients and psychological interventions which can be used to work on these issues. Since HIV/AIDS causes multitude of medical, psychological, social, economic and spiritual issues in the patients, holistic and biopsychosocio spiritual model of intervention need to be followed for better recovery and quality of life of these patients.

**Keywords:** HIV-AIDS, Psychotherapy

The first clinical cases of acquired immunodeficiency syndrome (AIDS) were identified in 1981. The human immunodeficiency virus (HIV), the causative agent of AIDS, was discovered in 1983. It is estimated that almost two million Americans have acquired HIV infection. Although AIDS was initially diagnosed in the United States in a group of gay men, groups recognized as at high risk for infection in this country include a wider sector of the population -- intravenous drug abusers (IVDAs), haemophiliacs and heterosexuals who have sex with patients belonging to high risk groups. ). In 1983 an infectious agent, the Human immunodeficiency virus

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## **Psychotherapy in HIV/AIDS**

(HIV) was identified as the cause of AIDS. Since then world wide more than 7 million people have been diagnosed with AIDS, 4.5 million have died from HIV associated conditions, and probably around 21 million have been infected with HIV.

India has the third highest number of estimated people living with HIV in the world. India has a population of one billion, around half of whom are adults in the sexually active age group. The first AIDS case in India was detected in 1986 and since then HIV infection has been reported in all states and union territories. The spread of HIV in India has been uneven. Although much of India has a low rate of infection, certain places have been more affected than others. HIV epidemics are more severe in the southern half of the country and the far north-east. The highest HIV prevalence rates are found in Andhra Pradesh, Maharashtra, Tamil Nadu and Karnataka in the south; and Manipur and Nagaland in the north-east. In the southern states, HIV is primarily spread through heterosexual contact. Infections in the north-east are mainly found amongst injecting drug users (IDUs) and sex workers. (National AIDS Control Organisation, 2008). According to the HIV Estimations 2012, the estimated number of people living with HIV/AIDS in India was 20.89 lakh, with an estimated adult (15-49 age group) HIV prevalence of 0.27% in 2011. India has demonstrated an overall reduction of 57% in the annual new HIV infections among adult population from 2.74 lakh in 2000 to 1.16 lakh in 2011, reflecting the impact of various interventions and scaled-up prevention strategies under the National AIDS Control Programme (NACP). The trend of annual AIDS deaths is showing a steady decline since roll out of the free Anti-Retroviral Therapy (ART) programme in India in 2004; it is estimated that around 1.5 lakh lives have been saved due to ART till 2011 (NACO,2008).

The central effect of AIDS is a dramatic depletion of a specific subset of T lymphocytes known as the CD4 T cells. AIDS, however, is not simply a virus affecting the immune system. It may also refer to a neuropsychiatric disorder. HIV and AIDS patients develop neurological and psychiatric symptoms which are believed to be due to a direct infection of the brain by HIV. AIDS patients may sometimes demonstrate affective, cognitive, and motor symptoms even before the diagnosis of AIDS is made. HIV disease is a chronic condition in which the asymptomatic phase, i.e., without symptoms, may last for many years. Although most medical interventions are directed towards the control of diseases which occur as a result of the lowered immune function, an increasing range of anti – retroviral drugs which inhibit the replication of HIV and thus tackle the virus directly is now available. Undoubtedly, medical advances in the treatment of HIV disease are being made, and many individuals live longer and survive repeated bouts of illness. However, the length of remission which the new anti- retroviral medications might bring is still unclear. The resulting uncertainty in prognosis increases the emotional burden for those with HIV, even in those who are clinically well and asymptomatic.

### **Psychological issues in HIV/AIDS**

Many intense, negative psychological reactions have been reported in people with HIV disease (Hedge et al., 1992). The symptoms experienced subsequent to HIV/AIDS diagnosis are given

## Psychotherapy in HIV/AIDS

below. It can be seen that anxiety and depression are the most common reaction. Manifestations of anxiety and depression can be categorized as somatic, cognitive, affective and behavioral as shown below. People often, but not always experience some symptoms from each category.

### Common symptoms associated with Anxiety and Depression

Symptoms	Anxiety	Depression
Somatic (physical)	Increased heart rate fast breathing sweating nausea and diarrhea frequent micturition muscle pains headaches sleep difficulties	Sleep disturbance loss of libido anorexia
Cognitive (thoughts)	Reduced concentration preoccupation with problems catastrophizing	Failure worthlessness unlovable guilt hopelessness
Affective (feelings )	Fear loss of control painc restlessness	Irritability low mood despair lack of energy reduced activity levels

### Coming to terms with HIV disease

Even when people suspect the they may be infected with HIV, confirmation of their positivity can come as a shock. Many parallels can be drawn between fatal illnesses, but the former may have to face additional problems, such as the stigma and discrimination attached to gay sexual behaviors, drug use or racial intolerance (King, 1989a). The uncertainty attached to the course of HIV disease, its poor long- term prognosis and the ever- changing recommendations for optimum medication regimes can cause great distress. Many people are concerned that should they develop symptomatic disease they will not be able to cope with its physical symptoms, nor with the frank explanations or elaborate excuses necessary to explain their condition to friends, relatives or employers. So it does not seem surprising that psychological symptoms are frequently seen in those with HIV disease; indeed, it is more remarkable how well so many people cope for so long.

### Role of Informational and Mental Health Counseling

Pre- and post- time counseling has two major aims. The first is to prevent further transmission of HIV by helping the individuals maintain safer sex and drug using behaviors. The second is to minimize the distress attached to a positive result. These aims are intricately related, so counseling aims towards supporting an individual may well also benefit society in general. Counseling involves more simply giving information. Although the provision of accurate, up-to – date information about HIV infection is essential, the counseling process enables people to relate relevant information to their own behaviours and circumstances, and so help them to understand their own level of risk make informed decisions of whether to test. This can be achieved by guiding people through the problem solving process, i.e., fact finding exploring options, decision making, accepting consequences, finding practical assistance and providing

## Psychotherapy in HIV/AIDS

further support as necessary. The use of leaflets or videos to provide information may be beneficial, but cannot replace discussion.

Pre- test counseling aims to ensure that individuals are fully informed about the meaning of a positive test result and its implications and are prepared to cope should their result be positive. This information should be given to the patient by an expert who has been involved with the patient right from the beginning of the session. It is important to assess the internal resources and support system available to the patient before informing about the positive findings. It helps the patients to cope better with the disease.

Post- test counseling provides an opportunity for patients who test positive to explore ways in which quality of life can be enhanced while living with HIV infection, and for discussion of the prevention of further spread of infection. The need for confidentiality is of prime importance in testing for HIV, to maintain people's trust, to respect their rights and to prevent discrimination against them.

### *Goals of pre test counselling*

- Explain what the test means and what it does not tell
- Alert to possible ramifications of a positive test result
- Assess personal risk
- Discuss the advantages and disadvantages of knowing HIV status
- Develop coping strategies
- Identify social support, who to tell and why to be circumspect
- Educate in safer sex and safer injecting practices
- Explain confidentiality of test result.

### *Goals of pre test counseling*

- Focus on the reason for the session
- Give clear, simple, unambiguous information
- Clarify the meaning of an HIV positive test
- Expect emotional reactions: shock, denial, anxiety, anger
- Address individual's immediate concerns
- Identify and address issues of immediate importance, e.g., who to and who not to tell; who to use for support; safer sex and injecting practices
- Provide a lifeline, e.g., 24- hour helpline telephone number and written information about HIV, giving details of services available
- Give a further appointment within a few days.

Psychological symptoms have been documented at all stages of infection. Following a positive HIV antibody test, patients commonly voice many fears and often show symptoms of psychological distress. To prepare people for receiving apposite test result and minimize associated distress, it is recommended that pre- and post- test counseling be available for all those considering having an HIV antibody test.

### **Stress, Coping Skills and Social Support**

A number of models have been proposed to explain how psychological and physical dysfunctions are related to induced stress. For example, Lazarus and Folkman (1984) conceptualize coping as constantly changing cognitive and behavioural efforts to manage external and/ or internal demands that are appraised as taxing or exceeding the resources of the person', and that stress occurs when the perceived biological, psychological and social resources available are not sufficient to meet the demands of the situation. It is well documented that stress, or non- coping, is frequently accompanied by various emotional reaction such as fear, anxiety, depression and anger. Lazarus and Flokman's model suggests that the costs and benefits of possible coping behaviors are evaluated, and that the coping behavior perceived a most beneficial is then adopted. There is evidence that an appraisal of the threat presented by a stressor could be 'buffered' by the availability and extent of social support systems (Cohen and Wills, 1985), the individual's perceived control over the situation and the coping style employed. According to this model, the way people deal with HIV disease will depend upon their understanding and interpretation of the event, stresses experienced, the coping options they perceive as available, and on meditating factors such as the perceived availability of social support and the coping strategies they finally adopt.

The role of precipitating factors in relations to stress is well established. Lovett et al., (1993) suggested that life events increase psychological distress in people with HIV disease. Hedge et al., (1992), examining individuals presenting in crisis to an HIV psychology service, found the most frequently reported preceding events to be personal illness (39 per cent), bereavement (30 per cent), fears concerning disclosure of HIV status (23 per cent), issues surrounding testing (17 per cent), dilemmas concerning medication (17 per cent) and child difficulties (10 per cent). Eighty0 nine per cent of crises were preceded by two or more major events or dilemmas. These data safest that it is the cumulative stress level which leads to an inability to copy, and emphasize the need to recognize the impact of multiple, concurrent problems even if not are directly related to HIV.

There is also evidence (Hedge et al., 1993) that strategies used to cope with HIV disease affect the psychological distress levels experienced. Adaptive coping styles included active coping strategies, such as the seeking of emotional support and problem focused coping and the maintenance of a high level of self- esteem. Increased denial, emotional and behavioral disengagement, hopelessness and less positive reframing experiences were associated with increased psychological morbidity.

### **Psychological Intervention Strategies**

Given the high levels of psychological distress experienced by individual with HIV disease, it is imperative to consider ways of minimizing the effects of stressors. This section will explore a cognitive- behavioral model, describe some intervention studies and consider some common issue and dilemmas which can lead to distress.

### **Cognitive – Behavioral Model**

There is a substantial body of evidence which suggests that therapy based on Beck's cognitive-behavioral model of treatment can benefit those with psychological symptomatology. This model rests on three assumptions.

- Thought determine emotions and behavior
- Unrealistic and negative thoughts lead to emotional disorder
- Decreasing unrealistic and negative thoughts and increasing realistic positive thoughts reduce emotional symptomatology.

A common misapprehension is that cognitive behavior therapy is the encouragement of positive thinking. In fact it comprises a number of techniques which address dysfunctional cognitions and behaviors within a structured therapy session. For example, because many realities for those with HIV infection are negative, the technique of 'decat-astrophization' is used. This is a process which attempts to separate the reality from the accompanying global negative feelings, and allows the person to explore coping alternatives, thought positive reframing. A thought such as 'I'll never be well enough to return to work' may be realistic when expressed by an individual with HIV disease. If the corollary is 'so I'll never be happy again', then though depressive could result, whereas the follow-up thought 'so I'll have plenty of time for reading' can be part of a positive, coping strategy. Thus, decatastrophization and positive reframing can play a major role in preventing a server depressive or anxiety response.

### ***List of Cognitive – Behavioral Intervention***

- Relaxation training and breathing exercises
- Activity scheduling
- Thought stopping
- Reality resting
- Decatastrophization
- Positive reframing
- Problem solving
- Development of long- term and intermediate goals

The problem solving approach aims to support individuals in making informed decisions about their present difficulties and to equip them with the general skills and strategies necessary for dealing with future problems.

### **Intervention Studies on CBT**

George (1988) examined patients with HIV disease 6-12 months after individual, cognitive-behavioral interventions. She found a significant reduction in distress and sustained improvements in anxiety, and depression. Similarly, Hedge et al., (1993) reported increases in self- esteem and decreases in anxiety and depression following an intervention aimed at

increasing coping skills. A number of group interventions have been successful in reducing stress, improving coping skills and improving quality of life (Lamping et al., 1993; Kelly et al., 1993). Hedge and Glover (1990) showed that educational groups not only provided information, but also relieved distress and enhanced mutual support.

### **Coping with Grief**

There is no 'correct' way to grieve, nor any set time after which the grieving should have ceased. Models of the normal grieving process (Kubler-Ross, 1970; Worden, 1992) have been built from descriptions of common reactions to death and the tasks, stages or phases which individuals typically encounter while learning to live with the realities of death. However, the reaction of an individual to a particular death will be affected by the circumstances in which it occurs. Consideration of the models suggests that some ways of coping with death may be more beneficial than others.

Bereavement in the context of HIV presents some unique features. For example, those who die are usually young and the highest rate of mortality is in the age range of 20- 40 years. Furthermore, death is often the last of many losses, as HIV infection may have already brought the loss of relationships, sex, employment, control, a future, hope and health. In addition, those bereaved by HIV frequently are themselves HIV-positive. If bereavement or its psychological sequelae has an adverse effect on the immune system, then it could prove hazardous to health. Folkman *et al.* (1994) have described the patterns of distress experienced by caregivers during illness and death. They found that prior to the death of a partner, HIV positive caregivers were less distressed than those not infected, while after the death the infected partners showed more distress. A possible explanation is that those who are HIV positive view the experience as a model of their own death. First, they empathize with the patient; afterwards they realize they may face a similar experience alone, as their own infection makes it less likely that they will find a new partner. Lennon, Martin and Dean (1990) report the intensity of grief during bereavement to be related to the involvement in caretaking during end-stage disease, and to the adequacy of practical and emotional support given to the caregiver during this time.

Most people experiencing grief will not need professional help; the support of friends and relatives and general guidance from the social or health care providers who have given support to the recently deceased will be adequate. Reassurance that it is natural to grieve, together with an explanation that this may involve exploring positive and negative feelings about the deceased, dealing with emotions such as anger, guilt and hopelessness and anticipation of the problems and necessary changes which the death may bring about, can be useful. For people bereaved through HIV, peer support groups for partners, friends and relatives, organized by volunteers and community groups, complement services provided by health professionals and social workers.

When the stigma attached to HIV leads people to fear rejection and so hide their losses, isolate themselves and not make use of available social support, there is an increased chance of

## Psychotherapy in HIV/AIDS

abnormal grief response. Abnormal grieving is usually categorized by grief reactions of abnormal intensity which persist over time with little evidence of change. Guided mourning (Mawson, Marks and Ramn, 1981), increasing adaptive coping skills and increasing appropriate social support can assist the grief process. Occasionally, a death will precipitate a frank psychiatric response. Appropriate psychiatric intervention, e.g. for a depressed or psychotic state, as well as grief management will then be necessary.

Another facet of AIDS-related bereavement, the social loss, was described by Dean *et al.* (1988), who reported multiple bereavement in a large cohort of gay men in San Francisco. Ninety-five per cent of the sample reported HIV-related loss, with an average of 6.2 HIV-related deaths each. With increasing numbers of AIDS related deaths, McKusick (1991) reported increasing distress involving:

- Psychological and emotional numbness
- Shrinking away from friends and resources
- Symptoms of complicated bereavement (inordinate guilt, calcified anger, rage, indifference)
- depression.

He described a cycle of negative impact: deaths led to a decrease in the available social support which resulted in higher levels of depression in those with HIV disease, which had the effect of less self-care which increased the likelihood of mortality, etc. To combat the effects of multiple bereavement, the adoption of a community-wide coping programme to enable people to stay involved rather than distance themselves from the problem, and to find some form of social support which promotes discharge of anxieties and renewal of vigour. The use of public ritual, e.g. annual candlelight ceremonies to mourn the people lost to HIV, can support communities in reaffirming their capability to overcome these feelings of loss and to remain empowered.

### **Burnout**

The term 'burnout' is used to characterize a syndrome which can develop when stresses are not recognized and addressed (Maslach, 1982). Maslach and Jackson (1981) defined burnout as a combination of emotional exhaustion, depersonalization and a reduced sense of personal accomplishment.

Factors which have been identified as increasing the levels of stress staff experienced while working with people with HIV disease are as follows

- Younger age of the patient
- Stress level of the patient
- Number of his/her dependents
- Younger age of the staff
- Identification with the patient



## Psychotherapy in HIV/AIDS

- Involvement of the patient
- External coping resources of the staff
- Lack of internal coping resources like knowledge and skills of the staff
- Organizational stressors
- Stigma of working with HIV/AIDS patients and
- Disagreement over patient treatment

The question of whether AIDS presents unique burdens to health care staff is not easily answered. Many of the factors contributing to stress are experienced by care workers in other fields such as oncology and cystic fibrosis. The greater patient dependency in HIV units necessitated the need for greater contact between the nurse and patient, and increased the emotional intensity of the work. Bennett et al (1992) investigated factors which could be associated with burnout. They found grief not to be predictive of burnout, but that greater work-related grief was experienced when carers identified closely with patients. Burnout was associated with an absence of internal coping strategies, and with a reliance on external coping strategies, e.g. excessive alcohol or drug usage. Older, more experienced carers were less likely to experience burnout.

### *Strategies to Minimize Burnout*

To minimize burnout, strategies are needed to focus on both the individual's coping skills and on the organization's attempt to minimize stressors. In line with the findings that intensity of work rather than overall length of time working on an HIV unit contributed to stress levels (Bennett, Michie & Kippax, 1991), time out techniques (e.g. rotating with staff in the genito-urinary medicine clinic) could be adopted. To utilize the coping strategies of those who are older and who have more experience, increasing the opportunities for informal sharing of problem might be beneficial. Alternatively, the provision of staff support groups could facilitate exchange of information and coping strategies between experienced and inexperienced staff".

When patients are seen for a long time by a relatively small group of care staff, close emotional involvement with patients frequently occurs. Specific training in strategies aimed at expressing warmth and empathy while maintaining professional boundaries has been suggested to reduce emotional stress (Bennett *et al.*, 1991).

To facilitate carers in the above, organizational change may be required. This may include

- Assessment of job requirements and available resources
- Task planning
- Staff development, education and training
- Enhancing communication systems
- Provision of formal support
- Enhancing informal communications and appreciation
- Reviewing job structure and workload.

## **NEUROPSYCHOLOGICAL COMPLICATION OF DISEASE**

The neuropsychological effects of HIV disease are many and varied (Grant, 1990), and can result from either the direct effect of HIV on the central nervous system or from secondary complications of immune deficiency (e.g. cerebral opportunistic infections such as toxoplasmosis, progressive multi-focal leuconencephalopathy and lymphoma).

Cognitive impairment has been reported in people with asymptomatic HIV but this is unusual. Most cases being seen in advanced disease states (McArthur et al., 1993). The pattern of cognitive deficits which emerges in late stage disease shows impairment consistent with some features of sub cortical dementia, including memory impairment and decline in fine motor speed, concentration, problem solving and visuo-spatial ability (Navia 1990). The incidence of HIV associated dementia is reported to be around 7 per cent (Janssen et al, 1990) and the prevalence cited as ranging from 2.6-16 per cent (Meadows et al., 1993a).

### ***Family Interventions***

In most instances, an individual's AIDS diagnosis affects family members. This group may include a spouse or partner, children, extended family, support network and family of origin. Family systems risk fractures as they attempt to manage the enormous impact of AIDS on their lives. Lack of social and financial support risk the family disruption. The overall goal of family intervention includes enhancing the ability of the family to support each other, to focus on immediate crises, to assist grieving process, to encourage resolution of long standing conflicts and to decrease each member's isolation by facilitation social support outside the family system. Psychotherapists utilize individual therapy, couple therapy family therapy, home visits and group interventions to address these goals.

## **SPIRITUALITY AND HIV/AIDS**

Facing the mystery and suffering of HIV illness, both patient and therapist may turn to religion, spirituality and concepts of God in their efforts to find solace, understanding and emotional healing. Often, the issues of connection to a greater reality, blame, shame or guilt based on religious beliefs and the role of God become prominent issues in psychotherapy. The patient may long for connections with higher powers like God and try to search for new senses of meaning. These efforts can provide a sense of belonging and connection to a larger reality. And can create new emotional hurts or remind clients of old strictures and messages of guilt and punishment. It is important to explore the patient's religious life in the context of pre HIV life and culture to understand his/her religious feelings in the context of HIV. Spirituality can help the patient to foster forgiveness and healing if there is a strong guilt in the patient. Spirituality can help the patient to develop hope in them and finding new meaning in experiences becomes pro active and altering one's attitude and cognitions. Maintaining hope requires reframing and redefining. The hope needs to be associated with day to day accomplishments, mastery skills and events to enhance feelings of being hopeful.

## **DETOXIFYING DEATH AND DYING**

Thoughts of death and dying evoke primitive and intense feelings in everyone. Most people, however, use a "functional denial" to put these emotions aside so that they can continue to live their lives. Despite their constant presence, patients invariably try to avoid these topics, because they are so painful and frightening. Well-meaning (but equally terrified) family and friends usually collude with this avoidance due to their own anxiety about losing a loved one. Consequently, patients are left alone with their worst fears and fantasies. In the absence of a place where the patient can reveal and contemplate these terrifying images, they will inevitably experience negative emotions that will compromise their emotional well-being. Patients who are left to ruminate about their death are unable to fully participate in life or enjoy much of living. Addressing death and related issues in a direct manner has the effect of decreasing the fear and anxiety that normally go along with it. Through addressing these fears and anxieties, patients learn that they can both tolerate such thoughts and that there may be things they can do for themselves to moderate their anxiety. Patients frequently find it an immense relief to simply be able to talk about death and dying in an unrestrained, explicit way. Helping patients break this particular subject down into smaller, more manageable parts diminishes the fear and anxiety associated with it.

## **HIV/AIDS AND BEHAVIOR CONTROL AS PREVENTION STRATEGY**

Prevention of infection with the AIDS (Acquired Immunodeficiency Syndrome) virus requires people to exercise influence over their own motivation and behavior. Social efforts designed to control the spread of AIDS have centred mainly on informing the public on how the human immunodeficiency virus (HIV) is transmitted and how to safeguard against such infection. It is widely assumed that if people are informed adequately about the AIDS threat they will take appropriate self-protective action. Heightened awareness and knowledge of health risks are important preconditions for self-directed change. To achieve self-directed change, people need to be given not only reasons to alter risky habits but also the means and resources to do so. Effective self-regulation of behavior is not achieved by an act of will. It requires certain skills in self-motivation and self-guidance (Bandura, 1986). Moreover, there is a difference between possessing coping skills and being able to use them effectively and consistently under difficult circumstances. Success, therefore, requires not only skills, but also strong self-belief in one's capabilities to exercise personal control.

Numerous studies have been conducted linking perceived self-efficacy to health-promoting and health impairing behavior (Bandura, 1986, 1989; O'Leary, 1985). The results show that perceived efficacy can affect every phase of personal change—whether people even consider changing their health habits, how hard they try should they choose to do so, how much they change, and how well they maintain the changes they have achieved. In addition to influencing health habits, perceived coping inefficacy increases vulnerability to stress and depression and activates biochemical changes that can affect various facets of immune function.

## Psychotherapy in HIV/AIDS

In managing sexuality, people have to exercise influence over themselves as well as over others. This requires self-regulatory skills in guiding and motivating one's actions. Self-regulation operates through internal standards, affective reactions to one's conduct, use of motivating self incentives, and other forms of cognitive self-guidance. Self-regulatory skills thus form an integral part of risk-reduction capabilities. They partly determine the social situations into which people get themselves, how well they navigate through them, and how effectively they can resist social inducements to potentially risky behavior. It is easier to wield control over preliminary choice behavior that may lead to troublesome social situations than to try to extricate oneself from such situations. This is because the antecedent phase involves mainly anticipatory motivators which are amenable to cognitive control; the entanglement phase includes stronger social inducements to engage in high-risk behavior which are less easily manageable.

The ability to learn by social modeling provides a highly effective method for increasing human knowledge and skills. A special power of modeling is that it can transmit simultaneously knowledge and valuable skills to large numbers of people through the medium of videotape modeling. Knowledge of modeling processes identifies a number of factors that can be used to enhance the instructive power of modeling. Applications of modeling principles to AIDS prevention would focus on how to manage interpersonal situations and one's own behavior in ways that afford protection against infection with the AIDS virus. Both self-regulatory and risk-reduction strategies for dealing with a variety of situations would be modeled to convey general guides that can be applied and adjusted to fit changing circumstances.

### CONCLUSION

The emotional reactions to infection with HIV have been well documented. HIV is associated with multiple stressors including physical illness, bereavement, psychological issues like depression, anger, anxiety etc and medication dilemmas. An individual's ability to cope is associated with the cumulative stress experienced and the perceived available social support. Further work on the interaction between stressors and the functioning of the immune system is needed. There is evidence that psychological strategies which develop coping skills and which enable people to mobilize social support are beneficial in the short term. In relation to this, it is important to recognize the effect which bereavement from HIV related deaths is having on communities, traditionally those who have provided social support. It becomes essential to address the coping skills of the care givers and providing psychological interventions to HIV/AIDS patients along with medical interventions for better recovery and improving quality of life of these patients.

### REFERENCES

- Dilley, J.W., Pies, C., & Helquist, M. (1989). *Face to Face: A guide to AIDS Counseling*. AIDS Health Project Publication, San Francisco, CA
- Hedge, B., Patrak, J., Sherr, L., Sichel, T., Glover, L., & Slaughter, J. (1992). 'Psychological crises in HIV infection' *VIII International AIDS Conference*, Amsterdam.

## Psychotherapy in HIV/AIDS

- King, M.B.(1989a). Psychological status of 192 out patients and HIV infections and AIDS. *British Journal of Psychiatry*, 154, 237-242
- National AIDS Control Organization. (2008). Report by the Indian government's AIDS organization. Retrieved from [http// www.avert.org/india-hiv-aids-statistics](http://www.avert.org/india-hiv-aids-statistics) on Feb 2<sup>nd</sup>, 2011.
- National AIDS Control Organization: Annual Report (2013-2014). Department of AIDS Control, Ministry of Health and Family Welfare, Government of India
- Rabkin, J., Remien,R., Katoff,L., & Williams, J. (1993). Suicidality in AIDS long term survivors: What is the evidence? *AIDS Care*,5, 410-411
- Winiarski, M.G.( 1991). *AIDS-Related Psychotherapy*, Pergamon Press: New York