

HIV Infection, Sexual Abuse and Social Support in Jamaican Adolescents Referred to a Psychiatric Service

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ABSTRACT

Background: Children and adolescents with HIV/AIDS often have psychological/psychiatric issues that require specialist intervention. We explored whether HIV infection acquired through sexual abuse led to particularly negative psychiatric outcomes and whether good social support is a protective factor in the development of undesirable psychiatric sequelae.

Methods: This study consists of a case series of five persons referred from the Paediatric Infectious Diseases Clinic to the Child Psychiatry Clinic, both at the University Hospital of the West Indies (UHWI) in Jamaica, during July 1 to November 30, 2005. The patients were clinically assessed and diagnosed by a psychiatrist using the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM IV) criteria. Cases were compared according to gender, age, likely route of HIV infection, level of family/social support and nature of psychiatric outcome.

Results: Adolescents who acquired HIV infection through sexual abuse reported more intense feelings of sadness and suicidal ideations. Those with good social support reported less intense feelings of sadness with no suicidal ideations and were more optimistic about their future regardless of the route of acquisition. Two of three adolescents who acquired HIV infection through sexual abuse and one of two who was perinatally infected required ongoing supportive psychotherapy to augment their social support, the characteristic most associated with favourable outcome.

Conclusion: Both sexual abuse and HIV/AIDS are likely to have negative psychological consequences in children and adolescents. This psychological impact may be intensified when HIV infection results from sexual assault as opposed to other methods of transmission. The findings support the practice of providing HIV prophylaxis to all sexual assault victims of known or suspected HIV-positive perpetrators and of encouraging utilization of existing social support networks.

La Infección por VIH, el Abuso Sexual y el Apoyo Social en Adolescentes Jamaicanos Referidos a los Servicios Psiquiátricos

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RESUMEN

Antecedentes: Tanto niños como adolescentes que sufren de VIH/SIDA, tienen a menudo problemas psicológicos/psiquiátricos que requieren intervención especializada. El presente trabajo explora si la infección por VIH adquirida por abuso sexual condujo a resultados psiquiátricos particularmente negativos y si el buen apoyo social constituye un factor de protección en el desarrollo de secuelas psiquiátricas indeseables.

Métodos: Este estudio consiste en una serie de casos de cinco personas referidos a la Clínica Infantil de Psiquiatría desde la Clínica Pediátrica de Enfermedades Infecciosas, ambas en el Hospital Universitario de West Indies (HUWI) en Jamaica, desde julio 1 hasta noviembre 30 de 2005. Los pacientes fueron evaluados clínicamente y diagnosticados por un psiquiatra usando criterios del Manual Diagnóstico y Estadístico de los Trastornos Mentales, cuarta edición (DSM IV). Los casos

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fueron comparados de acuerdo con la edad, el género, la ruta probable de la infección por VIH, el nivel de apoyo familiar/social, y la naturaleza del resultado psiquiátrico.

Resultados: *Adolescentes que adquirieron la infección del VIH por abuso sexual, reportaron sentimientos más intensos de tristeza e ideas suicidas. Aquellos con buen apoyo social reportaron sentimientos menos intensos de tristeza sin ideas suicidas y no tenían optimismo acerca de su futuro con independencia de cual fuera la ruta de su adquisición. Dos de los tres adolescentes que adquirieron la infección del VIH por abuso sexual y uno de dos que estaba infectado perinatalmente necesitaron psicoterapia de apoyo continua a fin de aumentar su apoyo social, la característica más asociada con resultados favorables.*

Conclusión: *Tanto el abuso sexual como el VIH/SIDA tienden a tener consecuencias psicológicas negativas en niños y adolescentes. Este impacto psicológico negativo puede ser intensificado cuando la infección por VIH se produce como consecuencia de un asalto sexual, en comparación con otros métodos de transmisión sexual. Los hallazgos respaldan la práctica de ofrecer profilaxis de VIH a todas las víctimas de asaltos sexuales por parte de perpetradores de los que se sabe o sospecha que son VIH positivos, así como estimular la utilización de las redes de apoyo social existentes.*

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INTRODUCTION

HIV/AIDS is a global disease which poses a significant health threat to children and adolescents. The Caribbean has the second highest HIV prevalence rates in the world and HIV/AIDS is the leading cause of death in Caribbean people between the ages of 15–49 years (1, 2). Between 1986 and 2003, 751 paediatric and adolescent cases and 326 paediatric deaths were reported in Jamaica (3). In 2003, the country's cumulative total number of AIDS cases was 8097 with 1070 of these being newly reported. Sixty-seven of those new cases were children under 10 years old (3). In recent years, the epidemiological profile of HIV infection in infants and children has been transformed from a rapidly terminal condition into a chronic life-threatening illness (4). Child and adolescent sufferers of the condition have to deal with both the issue of having a serious chronic illness and the stigma associated with the disease which, although somewhat diminished, still persists today. The psychological landscape of young people living with HIV/AIDS becomes even more complex when frequently associated social factors are taken into account. Many of these youth have also to deal with poverty, family crises and inadequate social support (5, 6).

A few studies have explored the issue of psychiatric disorders among HIV positive children and adolescents. Eighty-five per cent of an adolescent HIV clinic sample were shown to have co-morbid psychiatric diagnoses (7) and depression and behavioural problems are the most common psychiatric problems found in HIV positive adolescents admitted to psychiatric facilities in the United States of America [USA] (6). Higher rates of anxiety have also been described in HIV positive children compared with children with other chronic illnesses (8).

In this paper, we consider two factors which may have an impact on psychological distress, and more specifically depression, in young persons infected with HIV: level of social support and history of sexual abuse. The former has

received some research attention (9, 10) along with other factors such as presence and type of disclosure (11, 12), death of parents (13), immune status (14) and the presence of reminders/ cues in everyday life (15). The psychological impact of the acquisition of HIV through sexual abuse has been less researched.

CASE SERIES

The cases presented below represent all adolescent patients referred to the Child Psychiatry Clinic at the University Hospital of the West Indies (UHWI) by the UHWI Paediatric Infectious Diseases Clinic between July and November 2005. Patients were referred on the basis of the paediatricians' evaluation or suspicion of some psychiatric or psychological disturbance and do not represent all patients seen at the Infectious Diseases clinic.

Case 1: A 19-year old male was confirmed to be HIV seropositive by haematological studies at age 15 years and it was deduced that he most likely acquired the HIV virus at age 9 years when he was sexually abused (anal; penetrative) by an unknown assailant. A lumbar puncture with microscopic examination of the cerebrospinal fluid extracted from this patient at age 15 years old confirmed a diagnosis of cryptococcal meningitis and he was subsequently placed on triple antiretroviral therapy.

His first psychiatric evaluation was at age 19 years when he reported a three-week history of very sad mood for most days, loss of energy, anhedonia and strong suicidal ideations with no organized plan to kill himself. He felt that his life was unfortunate and worthless. The patient had very little family support at the time of his psychiatric evaluation because his stepfather had evicted him from the family house two years previously and he was temporarily living with his maternal grandmother who also had reservations about him living with her. The patient reported that prior to his eviction

he had no feelings of depression despite knowing his status. He was diagnosed with an adjustment disorder with depressed mood.

He was placed on fluoxetine 20 mg once daily. After one month, he showed dramatic improvement in his depressive symptoms with almost complete remission. He continues to benefit from psychiatric and counselling support.

Case 2: An 18-year old female patient was sexually abused (vaginal; penetrative) at age 15 years old by an unknown assailant and was confirmed HIV seropositive a few months after the incident. It was felt that the abuse was the most likely route of transmission for this patient. The patient's mother was informed of her daughter's status after haematological confirmation but the client was told of her status one year later at age 16 years. Since being informed of her status, the patient has had no medical complications of her illness. At the time of her psychiatric assessment, the patient was living with her mother and sister whom she described as very supportive and helpful. She had no features of depression or any other psychiatric illness. She was a well adjusted young woman who was doing well academically and socially. She had no psychiatric disorder at the time of her evaluation; however, she continues to attend the counselling service to obtain psychosocial support for her illness. She remains symptom free.

Case 3: A 17-year old female had a confirmatory HIV seropositive result by haematological studies at age 14 years. The patient said that she was living in a residential children's home since age 15 years as she was removed from the family home after repeated sexual abuse (vaginal; penetrative) by her stepfather as well as other men in the community. As a result of the repeated acts of abuse, she became pregnant and at the time of the psychiatric interview, was the mother of a one-year old infant. The patient was separated from her child shortly after she gave birth. She lamented the loss of contact with her child and her family, especially her mother.

It was inferred that the most likely route of exposure to the HIV virus for this patient occurred as a result of her prolonged exposure to repeated acts of sexual abuse. She had a past medical history of genital warts for which she received treatment but she was not placed on antiretroviral therapy for HIV/AIDS. Her other haematological reports were normal.

She presented at age 17 years to the psychiatric service for an evaluation and reported a six-week history of very sad mood for most days, strong suicidal ideations with two acts of attempted suicide by hanging in the past. She expressed dissatisfaction with her life and reported that she felt punished. She had decreased appetite with weight loss and difficulty sleeping at nights. She reported feeling irritable for most of the day and for most days during the previous four weeks. She was diagnosed with major depression.

She was placed on fluoxetine 20 mg once daily and received cognitive behaviour therapy. After one month, she

showed some improvement in her depressive symptoms. Attempts were made to reunite her with her family and child. However, due to limited family support, this was not feasible. At follow-up visits, she still had feelings of sadness especially in relation to not seeing her child often. She continues to be seen by the psychiatric service for management of her psychiatric illness.

Case 4: A 13-year old male patient was confirmed HIV seropositive at age 11 years. It was felt that he most likely had a mother to child route of transmission. As an infant, he was breast fed for the first three years of life and had a history of bronchial pneumonia during that period. His mother and younger sibling were also confirmed seropositive previously and his sibling had succumbed to the illness. The patient was informed of his status at age 12 years, approximately five months prior to his psychiatric assessment. He was referred to the Child Psychiatry Clinic by the paediatrician at the request of his mother who wanted to ensure that her son was not suffering from a psychiatric illness such as depression which she understood could be caused by the HIV infection. At the time of his assessment, the patient had been noted to have generalized lymphadenopathy. He was living with his mother and older sibling both of whom he described as very loving and supportive. He had no features of a psychiatric illness and he was performing well academically and was very optimistic about his future. He is presently visiting the psychiatric service once every three months to facilitate counselling and symptom review. He remains symptom free.

Case 5: A 15-year old male patient was confirmed HIV seropositive at age 4 years and was informed of his status by family members some time afterwards. His mother was confirmed to be HIV seropositive while in the gestational period with this patient and it was assumed that the patient most likely had a mother to child route of transmission. The patient's mother succumbed to her illness when he was 7 years old. He continued to be cared for by his paternal grandmother and did well in school experiencing no psychological problems until age 12 years when he had a cerebrovascular accident which resulted in right hemiparesis and issues of short term memory recall. This affected his school performance and it was recommended that alternative placement be sought to support his learning challenges. He described his grandmother as very supportive and loving to him.

He presented to the psychiatric service for evaluation at the age of 15 years and reported mild feelings of sadness related to his impaired mobility. He also expressed feelings of loneliness due to loss of school placement. He denied any other features of a psychiatric illness. He was diagnosed with a dysthymic disorder. He received a course of cognitive behaviour therapy and at his last visit he was reported to be free of depressive symptoms.

DISCUSSION

Although it would be difficult to make generalizations from the small number of cases presented, there is some indication that adolescents who acquire HIV infection through sexual abuse may be at greater risk for negative psychiatric outcomes and that good social support may offset this type of risk regardless of the route of acquisition (Table).

Table: Characteristics of adolescents referred to the Child Psychiatry Clinic

Case Number	Age	Gender	Likely route of HIV acquisition	Level of social support	Psychiatric outcome
1	19	Male	Sexual abuse	Poor	Adjustment disorder with depressed mood
2	18	Female	Sexual abuse	Good	No psychiatric diagnosis
3	17	Female	Sexual abuse	Poor	Major depressive disorder
4	13	Male	Mother-child	Good	No psychiatric disorder
5	15	Male	Mother-child	Good	Dysthymic disorder

In a previous study, social support was found to be negatively correlated with behaviour problems in children infected with HIV (10). However, Murphy *et al* (9) have shown that although good social support is associated with lower levels of psychological distress in HIV-infected adolescents, it does not act as a buffer against the distress which results from stressful life events such as family problems or having to take medication. Similar findings have been demonstrated in a non-clinical adolescent population (16). It would therefore appear that social support is more beneficial for long-standing crises than for acute stressful events. However, this oversimplification belies the complex interactions among risk and protective factors for psychological distress in individual patients. In the cases presented, both chronic (*eg* coping with HIV infection) and acute (*eg* eviction) stressors were described. In all cases of good social support, psychological problems were absent (cases 2 and 4) or minimal (case 5).

In some populations, as many as 53% of paediatric HIV clinic patients have reported a history of sexual abuse (7). However, this does not necessarily mean that this is a principal route of disease transmission in young persons. In a large study in Washington DC, only 26 of 9136 children with HIV or AIDS had been sexually assaulted by persons suspected or confirmed to be HIV positive (17). In Jamaica, 8% of HIV-infected adolescent clinic attendees were found to have acquired the condition through forced sexual contact (18). A slightly higher rate of 10.4% was found in a North Carolina study (19). Three out of the five cases presented had sexual assault as the most likely mode of acquisition of

HIV infection. Two out of the three were diagnosed with depressive illnesses. The third patient, who had no psychiatric problems, had good social support.

Although sexual assault is not the principal route of transmission of HIV in children and adolescents, persons who contract the infection by this route have to deal with the intense psychological impact of both the trauma of sexual assault and having a life-threatening and highly stigmatized disease. The complications of child and adolescent sexual abuse are many and varied. Victims are reportedly more likely to be depressed (20, 21), suicidal (20, 22) and to engage in substance misuse (22). Sexually abused children also often exhibit sexualized behaviour (23, 24) and show a greater prevalence of HIV risk behaviour (25).

Separately, sexual abuse and HIV infection are associated with an increased risk of psychological disturbances. Having to deal with both is therefore particularly challenging. We theorized that the psychological impact is made even more severe when the HIV infection resulted from sexual assault as opposed to other methods of transmission. HIV infection as an additional outcome of sexual assault has the potential to significantly reinforce the maladaptive cognitive perspectives associated with depression as well as significantly worsen the sense of loss associated with that condition.

Cognitive theorists posit that cognition, the process of acquiring knowledge and forming beliefs, is a primary determinant of mood and behaviour. They view negative attitudes and expectations, beliefs that one's life is largely determined by external factors (external locus of control), learned helplessness and feelings of hopelessness as central to the development of depression (26, 27). In addition to feelings of stigmatization, Finkelhor and Browne (28) identified the cognitive position of powerlessness, which is very similar to learned helplessness, as being an important mediator of many of the negative sequelae of child sexual abuse, including depression, anxiety and self-destructive behaviour. Both powerlessness and stigmatization are likely to be magnified if HIV infection is acquired *via* sexual abuse. This is because the feeling of powerlessness would arise not only from the immediate and grossly tangible invasion of the victim's body but also from the mark of a lifelong burden of HIV infection which, far beyond the control of the child or adolescent, are left behind by the abuser. Additionally, the stigmatization of HIV infection would now be added to the stigmatization of having been abused. Clearly the risk for depression is multiplied in these circumstances.

Sadness is the emotional response of the ego to distress brought on by an experience or fantasy of loss or deprivation (29). However, perceived experiences of loss do not always evoke sadness. They may also trigger rage responses. When responses of rage are turned inward on the self, they become transformed into depression (29). Applying these concepts to the sexually abused HIV seropositive youth, the act of abuse may be viewed by the youths as a loss of autonomy and a

personal violation of their body and of themselves to which the response may be internalized anger which is experienced as depression. If that young person identifies the sexual abusive act as the cause of his/her HIV status, then the loss of health becomes an added and compounding loss, thus heightening the internalized rage and worsening the symptoms of depression.

Major limitations of the present study are the use of referred subjects only, not a random sample of the HIV-positive adolescent clinic population and also the small number of subjects. Therefore, the results obtained in this project may be completely by chance, depending on whom was referred during the study period.

CONCLUSION

Sexual abuse is an important mode of transmission of HIV infection in the paediatric population. The psychological effects of HIV infection are likely to be particularly high in this group of youth. Making use of existing social support networks is valuable for minimizing mental health problems in patients with HIV acquired through sexual abuse or otherwise and should be encouraged. HIV prophylaxis as advocated by Steel-Duncan *et al* (30) should be made available to all sexual assault victims of known or suspected HIV positive perpetrators in order to avert significant physical harm and mental anguish. Supportive counselling following sexual abuse, with or without HIV infection, should also be routinely offered to ameliorate the risk of adverse psychological effects.

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