

HIV and Adolescents

POSITION STATEMENT

Approved by the Board of Trustees, December 2004

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"Policy documents are approved by the APA Assembly and Board of Trustees...These are ... position statements that define APA official policy on specific subjects..." -- *APA Operations Manual*.

According to the Centers for Disease Control, teenagers represent one of the fastest growing groups of newly HIV-infected individuals. There are alarming rates of new infections among young male teens, particularly those of color, who have sex with older males. There are also disproportionately high rates of infection among girls and young women who abuse drugs and/or who have sex, or are forced to have sex, with older male partners (www.cdc.gov/hiv/stats/hasrlink.htm).

During the process of maturation and emancipation, adolescents are at increased risk for contracting HIV for several reasons:

- Adolescence is a time of experimentation. Sexual and drug-using behaviors can place them at risk for contracting HIV. Most intercourse between teenagers occurs without the use of condoms or consistent condom use. Few teenage pregnancies are planned. Drug and alcohol abuse further impairs judgment and decreases the likelihood that safer sex and needle exchange or cleaning will occur. Teenagers who inject drugs often share or do not clean their needles.
- Adolescents are particularly prone to peer influences to take risks and often have false beliefs about what peers are doing.
- Adolescents often believe they are omnipotent and invincible, and they may be unconcerned about future consequences.
- Adolescents may be the victims of sexual abuse, incest, and rape or trade sex in exchange for drugs, money, shelter, or other needs. These problems are particularly acute for homeless youth and those presenting with a conduct disorder. All of these youth should be evaluated for screening for HIV and other sexually transmitted diseases/infections (STD/STIs).
- Psychiatrically ill or developmentally disabled youth may have problems with impulse control, self-destructive urges, suicidality, poor insight and judgment, and hypersexuality and thus place themselves in encounters where they are at risk for contracting HIV. Comorbid substance abuse often further exacerbates risk.
- Youth who seroconvert are at risk for suicide attempts, running away or being thrown out of their homes, and not accessing appropriate medical services. This is especially true for gay, bisexual, and transgendered teen boys.
- Many parents are unaware of the extent of adolescent HIV risk behaviors or may not have the skills to help their teenagers. Some family dynamics may actually exacerbate risk-taking behaviors. Identification of such behaviors allows for early preventive interventions. Developmentally appropriate preventive interventions should focus most intensively on those groups of adolescents identified as having the greatest risk of HIV exposure, including males who have sex with males, minority youth, institutionalized youth, pregnant teens, youth with a history of sexual or physical abuse, homeless and runaway youth, youth with a history of STD/STIs, and those with multiple sexual partners. Implementation of appropriate HIV prevention strategies will also promote sexual health, reduce the incidence of STD/STIs, reduce teen substance abuse, and promote interpersonal self-protective skills such as refusal skills. It should be noted that teens may be able to obtain HIV testing without parental consent but then be required to obtain such consent for treatment.

Teens who have acquired HIV perinatally have special challenges. The neurological consequences of HIV infection can impair cognitive development and impact learning. Chronic illness can cause school absences and missed opportunities for socialization. Their parents may be ill, deceased, or unavailable. They are forced to confront possible premature mortality and cope with physical illnesses. They begin to negotiate their sexuality as an HIV-positive individual. HIV disclosure to sexual partners is particularly troublesome. Psychiatrists will frequently need to be involved in permanency planning, monitoring ongoing adherence to medications, and treating psychiatric disorders emerging during this period. Peer support and help with disclosure are crucial topics in dealing with this special population. Many of these issues will also be relevant for teens who seroconvert, or teens who acquired infection via a blood transfusion.

Specific Recommendation:

1. Psychiatrists who work with adolescents have a responsibility to educate themselves and consider consultation as needed with regard to medical, psychosocial, ethical, and legal aspects of HIV infection particularly as they relate to youth.
2. Psychiatry training programs have a responsibility to assure that HIV-related training needs are formally and appropriately addressed for all trainees and include specific information relating to HIV's effects on youth.¹
3. A psychiatric evaluation for adolescents should assess current level of sexual behavior and alcohol/drug use. Those deemed at risk for HIV infection should have a culturally competent, comprehensive sexual history and risk assessment covering such topics as coerced and consensual acts; unprotected oral, anal, or vaginal intercourse; reproductive planning and contraception; barrier protection, including condom usage (male and female); a history of prior STD/STIs and HIV testing; assessment of current risk for STD/STIs and HIV; and alcohol/drug-using behaviors, including alcohol/drug use during sex, injection drug use, and the sharing of injection paraphernalia. Sexual and substance use behaviors should be continually reassessed as teens' sexual and substance use behaviors evolve and change.
4. When adolescents live in families, these relationships significantly influence adolescent behavior. Thus, culturally competent family assessment needs to be a central part of the evaluation process, and education must be directed to these families as well as adolescents. Where appropriate, education should be broadly targeted to involve concurrent organizations such as schools, clubs, YMCA/YWCA, and religious organizations.
5. Youth whose behaviors put them at risk for HIV infection need individualized prevention strategies that may require a team approach (e.g., other mental health practitioners and/or larger community interventions such as teen safer sex groups). Goals include the reduction of alcohol/substance use and unprotected intercourse as well as the treatment of any psychiatric disorders and any psychosocial and/or family problems that may influence high-risk behavior. Teenagers need to be considered within the context of their family system to determine whether dysfunctional family dynamics are contributing to high-risk behaviors. Crisis family services are frequently indicated.
6. In areas of HIV testing, sexual activity, reproductive planning, contraception, and access to medical treatment, psychiatrists should be familiar with state and local statutes regarding minor consent, age and criteria for emancipation, limits of confidentiality, notification requirements, and rights in emergent medical and psychosocial situations (e.g., acute general mental status changes or sexual trauma).
7. Psychiatrists should recommend (and assist in obtaining) HIV testing and counseling for those whose behavior puts them at risk for contracting HIV and for pregnant teens. HIV testing should never be ordered routinely (e.g., at the time of psychiatric hospitalization) but on a

case by case basis. Before HIV testing is done, psychiatrists should be aware of notification requirements (both parental and public health), which vary widely from state to state, and take this into account when deciding how to test for HIV. Anonymous testing, the results of which are not reportable, may be advisable when disclosure of HIV status would result in harm or discrimination to the teenager. (See *Position Statement on HIV Antibody Testing*, 2003.)

8. Psychiatrists should ensure that teens understand the complex implications of an HIV test result (whether positive or negative), assist them in accessing appropriate medical and obstetrical care as needed, and support them with the complex issues surrounding disclosure of HIV infection and notifying sexual and/or drug injection partners. Psychiatrists should guide teens to the appropriate resources, including emergency hotlines and emergency mental health services. Psychiatrists should be alert to the possibility of suicidality after notification of test results, regardless of the test outcome.

9. HIV infection must not be a source of restriction in attendance at school, participation in group activities, or hospitalization. Issues of possible spread of infection should be addressed by the practice of

universal precautions and appropriate educational interventions. Disclosure of diagnosis to teachers, counselors, coaches, or staff should be on a "need-to-know" basis and within the limits of applicable legal statutes.

10. Adolescents, whether themselves HIV positive or not, may be affected by HIV-positive family members, peers and/or partners. Psychiatrists should, as appropriate, address issues of grief, abandonment, adoption/placement, and/or survivor guilt in individual, group, and/or family therapy.

¹The American Academy of Child and Adolescent Psychiatry's *Policy Statement on HIV/AIDS and Children and Adolescents* specifically recommends that child and adolescent psychiatry training programs "include a training component on HIV/AIDS and children/adolescents" and "provide clinical experiences with HIV/AIDS infected or affected children, adolescents and families."