Understanding the Psychosocial and Psychodynamic Antecedents of Stigma in HIV Psychiatry

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Conflict of Interest Declaration

- Dr Alfonso serves on the Board of the World Federation for Psychotherapy and on the Executive Council of the American Academy of Psychodynamic Psychiatry and Psychoanalysis. He is Editor of the journal *Psychodynamic Psychiatry*.
- He has University Professorships in the USA and Asia.
- *He receives no compensation for these positions and reports no conflicts of interest.*

Learning Objectives

At the completion of this presentation, participants will:

- recognize how pervasive HIV stigma and discrimination remain throughout the world.
- understand the psychodynamic unconscious antecedents of stigma in HIV.
- understand the psychosocial dimensions of stigma in HIV.
- realize how negative attitudes lead to undertreatment and failure of empathy.

Definitions

- Joint United Nations Programme on HIV/AIDS (UNAIDS) **definition of HIV stigma** (2003): *"a process of devaluation of people either living with or associated with, HIV and AIDS*".

- UNAIDS **definition of HIV discrimination**: "*the unfair and unjust treatment of an individual based on their real or perceived HIV status"*.

- While stigma refers to negative attitudes or beliefs, discrimination is the behaviors that result from those attitudes or beliefs. HIV discrimination is the act of treating people living with HIV differently than those without HIV.

- **Structural stigma** – laws, policies and practices that cause or reinforce stigma.

Definitions

- **Structural stigma-Examples**
  - All persons living with schizophrenia are dangerous and should be institutionalized
  - All persons with addiction are sociopaths and criminals and decriminalization of drugs encourages addiction
  - Persons with HIV/AIDS belong to “risk groups”
  - Persons with HIV should not donate blood
  - Persons should be screened for HIV when seeking naturalization/citizenship
  - Treatment for substance use disorders should not be subsidized by governments since treatment outcomes are marginal at best

AIDSism

- Addictophobia
- Misogyny
- Homophobia/Heterosexism
- Transphobia
- Poverty-based stigma
- Xenophobia
- Racism

Despite progress in prevention, treatment, and prognosis, stigma is pervasive throughout the world.

Cohen MA (1989) *Am Med News* 32:43.

Although fear of contagion fueled these attitudes, there are other dimensions to stigma and discrimination to consider.

Psychometric Scales

Berger HIV Stigma Scale-HSS (University of North Carolina at Chapel Hill)

https://elcentro.sonhs.miami.edu/research/measures-library/hss/HIVSS_Items_Eng_Spa.pdf

Some people fear that they'll be rejected because of my HIV.
Algunas personas temen ser rechazadas porque tengo HIV.

People don't want me around their children once they know I have HIV.
La gente no me quiere alrededor de sus hijos una vez que se enteran que tengo HIV.

People have physically backed away from me when they know I have HIV.
Hay personas que físicamente se han retirado de mi cuando saben que tengo HIV.

Some people act as though it's my fault I have HIV.
Algunas personas actúan como si fuera mi culpa que tengo HIV.

Worldwide Prevalence of HIV Stigma

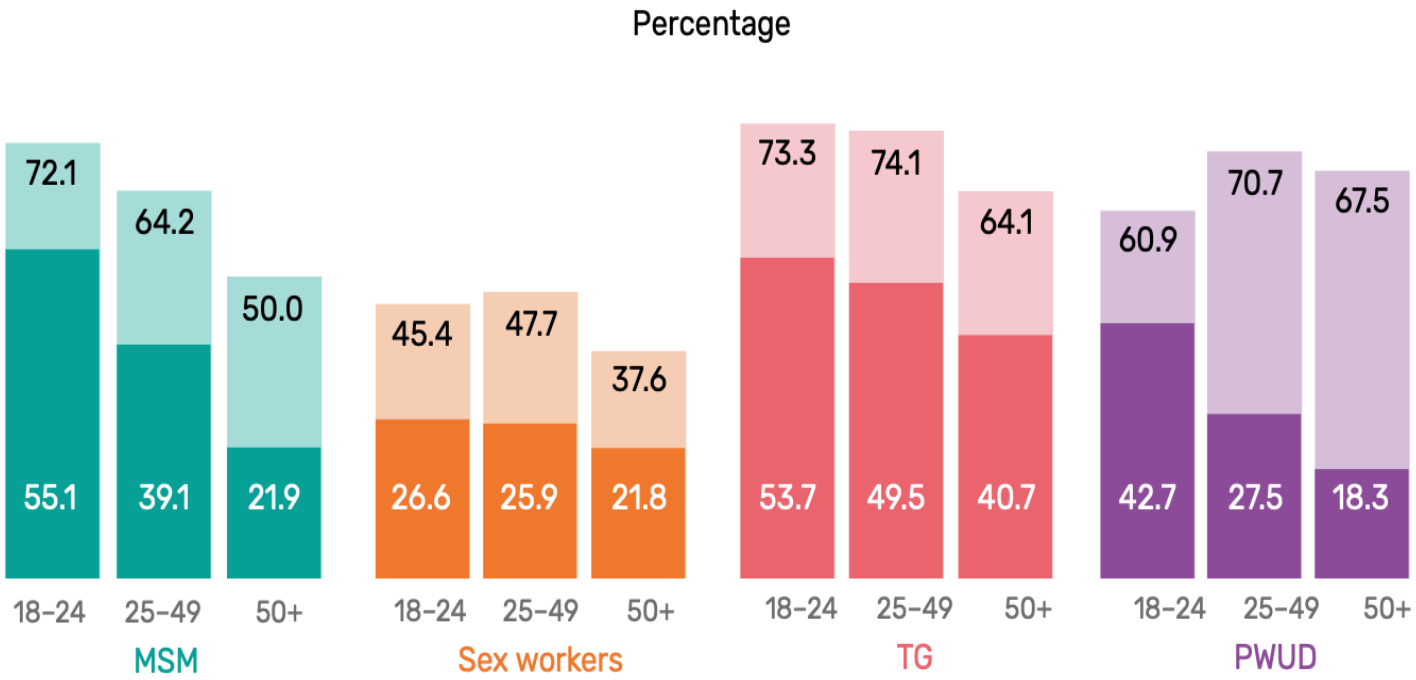
PLHIV Stigma Index

Developed by UNAIDS and other organizations – country specific.
Over 75 countries have been surveyed with 30K subjects assessed.

https://www.stigmaindex.org/wp-content/uploads/2023/11/PLHIV-Stigma-Index-Global-Report-2023-2.pdf

PLHIV Stigma Index

Figure 22. One or more experience of stigma and discrimination faced by key populations in the last 12 months (solid) and ever (tinted), by age



https://www.stigmaindex.org

PLHIV Stigma Index

Table 7. Experiences of HIV-related stigma and discrimination in community settings during the past 12 months and ever

	Past 12 months		Ever	
	n	**%**	**n**	**%**
Aware of people (other than family members) making discriminatory remarks or gossiping about you	4,019	14.2%	7,869	27.8%
Aware of family members making discriminatory remarks or gossiping about you	3,637	12.6%	7,249	25.0%
Verbally harassed you	3,440	11.8%	6,305	21.6%
Blackmailed you	2,505	8.6%	3,734	12.8%
Wife/husband, partner(s) or child(ren) ever experienced discrimination	2,168	8.2%	3,428	13.4%
Excluded from family activities	2,260	7.8%	3,961	13.6%
Physically harassed or hurt you	2,219	7.6%	3,102	10.6%
Excluded from social gatherings or activities	2,143	7.5%	3,669	12.8%
Refused employment or lost a source of income or job	1,949	7.3%	3,207	12.0%
Job description or the nature of job changed, or denied a promotion	1,626	6.7%	2,295	9.4%
Excluded from religious activities or places of worship	1,717	6.3%	2,335	8.5%

https://www.stigmaindex.org

Therapeutic Nihilism

- The negativism associated with the treatment of addictions may stem from unanalyzed countertransferences and psychosocial factors such as internalized negative societal attitudes and stigma.

  Alfonso CA (2023). Clinical Implications of Countertransference in the Treatment of Addictions. Psychodynamic Psychiatry, 51(2), 133-140.

Therapeutic Nihilism

- 11.1% of adults in the United States report ever having a substance use problem. (excluding cigarettes – cigarette smoking prevalence in the USA in 2021 is 11.5 %, down from 21% in 2001).
- Approximately 75 % of adults who report having a substance use disorder, report being in recovery.

Kelly JF et al. (2017) Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy, *Drug and Alcohol Dependence*, 181, 162-169.

Jones, C.M., Noonan, R.K., Compton, W.M. (2020). Prevalence and correlates of ever having a substance use problem and substance use recovery status among adults in the United States, 2018. *Drug and Alcohol Dependence*, 214.

Therapeutic Nihilism

- Among adults with a substance use disorders, receiving treatment was associated with being in recovery.
- *Only 9% of persons in the United States access evidence-based treatments for addiction*, and among these, rates of access to care are three times greater in Whites than in Hispanics or Blacks.

Wu, L. T., Kouzis, A. C., & Schlenger, W. E. (2003). Substance use, dependence, and service utilization among the US uninsured nonelderly population. *American Journal of Public Health*, 93(12), 2079–2085.

Countertransference

- Countertransference is defined as the totality of emotions experienced by the clinician while caring for a patient.

- Countertransferences are commonly classified as positive or negative, creating pleasurable or unpleasurable feelings in the therapist.

- Negative countertransferences that create tension include shared helplessness, hopelessness, sadness, anxiety, fear, anger, rage, shame, and guilt.

- Complex emotional states such as perceived burdensomeness and thwarted belongingness are of relevance when working with persons living with HIV.

- Negative countertransferences may lead to fatigue, avoidance, emotional detachment, and aggressive acting out.

Concordant Countertransference

- Intrinsic emotional reactions triggered by clinical encounters that any clinician would feel when faced with the same situation.

- There is a quantitative aspect of emotional reactions, where countertransferences may accumulate exponentially over time when treating hundreds or thousands of patients with complex psychopathology over the course of the clinician's career trajectory.

- Negative therapeutic reactions can accumulate, and emotional memories triggered by clinical interactions may result in a surge of emotions that is destabilizing to the therapist.

- The allostatic overload and psychic erosion caused by unprocessed concordant countertransferences that accumulate over time may interfere with the therapist's stamina, neutrality, and attention, leading to failure of empathy.

McCann L., Pearlman L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims, *Journal of Traumatic Stress,* 3,1, 131-149.

Inadequate Analgesia- Psychodynamic Insights

- Perry worked with patients in a burn unit at New York Hospital-Cornell, trying to improve pain management. Pain management in-service seminars did not suffice.

- Perry concluded that overwhelmed clinicians felt an unconscious need to remain separate from patients—to defend against overwhelming distress and maintain a safe space and emotional distance.

- Defenses of isolation of affect and states of dissociation are common adaptive measures of clinicians in distress. These could lead to avoidance and withdrawal of care.

Perry, S. W. (1984). Undermedication for pain on a burn unit. *General Hospital Psychiatry*, *6*(4), 308-316.

Alfonso CA (2011). Understanding the Psychodynamics of Nonadherence. *Psychiatric Times*, May 2011, p.23.

Clinical Vignette

A 35-year-old civil rights activist is admitted to a medical unit at a major metropolitan area in a high-income country for presumed recurrent pneumonia during the COVID pandemic, and presumed tinea corporis and psoriatic plaques. Routine tests showed pancytopenia and follow up tests showed CD4 under 100 and HIV seropositivity with a VL >100K. Biopsy of skin lesions was consistent with KS.

The infectious disease specialist was perplexed when sharing the HIV test results with the patient and stated: *But I thought you said you are married and have five children? I am surprised your HIV results are positive.*

The patient jokingly responded – *Yes, I have five children, which means that I had unprotected sex at least six times, doctor.*

Case details have been disguised to protect confidentiality.

Internalized Negative Societal Attitudes

- Even the most sophisticated clinicians struggle to contain internalized negative attitudes.

- These can surface in the form of micro-aggressions, treatment avoidance, undertreatment, delaying medical care, and failure of empathy.

- Examples include negative attitudes towards persons who use drugs, men who have sex with men, transgendered and non-binary individuals, persons living in poverty, and commercial sex workers.

- Unconscious negative attitudes lead to avoidance and aggression, hence the importance of awareness of countertransferences.

Jiménez, X.F., Thorkelson, G., Alfonso, C.A. (2012). Countertransference in the General Hospital Setting: Implications for Clinical Supervision. *Psychodynamic Psychiatry*, 40(3), 435-49.

Psychosocial Determinants of Stigma and Discrimination

- Criminalization of drug use.
- Criminalization of commercial sex work.
- Lack of legal protection for marginalized and oppressed persons.
- Discriminatory policies in health care systems.
- Use of stigmatizing language, such as risk groups, promiscuous behavior.
- Faith-based organizations not welcoming LGBT+ persons.

Structural Barriers Contributing to Stigma

- Not testing in a timely fashion (in the US, the average person is diagnosed 3-4 years after infection).
- Expensive treatments not readily available to uninsured (average cos for antiretroviral medications in the US is $3-4K/month).
- PrEP is still not mainstream in primary care unless prescribed by a specialist.
- Limited accessibility of information on prevention and treatment.
- https://www.cdc.gov/nchhstp/newsroom/2017/HIV-testing-and-time-from-infection-to-diagnosis-press-release.html

Structural Barriers Contributing to Stigma

- One-third of countries lack laws that prohibit HIV discrimination.

UNAIDS (2008) *2008 UNAIDS Annual Report: Towards Universal Access*, [Online] http://data.unaids.org/pub/Report/2009/jc1736_2008_annual_report_en.pdf

Discrimination at the Workplace

International Labor Organization Report

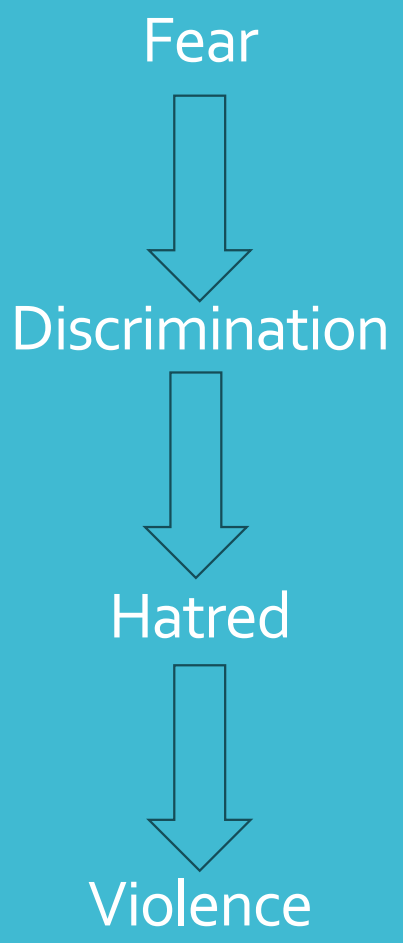
- Information collected from more than 55,000 people in 50 countries, worldwide.

Views varied between continents and regions.

- Asia - lowest tolerance for working directly with people with HIV, where 40 percent of respondents PLWHIV should be allowed to work with people who do not have HIV.

- Middle East and North Africa- 42 percent of respondents said PLWHIV should be allowed to work with people who do not have HIV.

https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_830267.pdf



- Emotions drive actions – and fear has been hypothesized to generate stigmatizing thoughts and discriminatory attitudes. These attitudes could rise to the level of violence towards those we fear, alienate, and hate.

- Viewing a hated face resulted in increased activity in the medial frontal gyrus, right putamen, bilaterally in premotor cortex, in the frontal pole and bilaterally in the medial insula. These areas of activation are like those of viewing the face of a lover.

Zeki S, Romaya JP (2008). Neural Correlates of Hate. *PLOS One* . Published: October 29, 2008. https://doi.org/10.1371/journal.pone.0003556

Bartels A, Zeki S (2004) The neural correlates of maternal and romantic love. Neuroimage 21(3): 1155–1166.

Clinical Implications and Improved Outcomes

- Since fear is linked to stigma and discrimination, and fear may lead to avoidance and aggression, stigma prevention should start by making the unconscious conscious and developing the courage to accept otherness as nonthreatening to the clinician's sense of self.
- Awareness of negative countertransferences reduces treatment avoidance and aggressive attitudes.
- Negative societal attitudes are internalized and trickle down affecting clinical care.

Advocacy

- Advocating for disenfranchised, marginalized, and minoritized persons is based on the bioethical principle of social justice.
- Clinician passivity when faced with circumstances that result in discrimination of patients deviate from the bioethical principles of beneficence and nonmaleficence.
- We need to speak up when witnessing micro aggressions and could do so with equanimity and serenity.
- HIV clinicians are in a unique position to participate in hospital ethics committees and support political actions against stigma and discrimination.

Thank you for your attention!

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