

Summer 2009

# POSITIVELY WOMEN

Mental  
Health

The only **magazine** for positive women written by positive women

# contents

- 3-5 **The Myth of Madness**
- 6-7 **Mental Health and HIV**
- 8-9 **Hope Tomorrow is a Better Day**
- 10-11 **Prison and Mental Health**
- 12-13 **HIV and Mental Health – An Obvious Partnership?**
- 14-15 **Postnatal Depression**
- 16-18 **Treatment and Mental Health**
- 20-21 **Mind Gardner's World**
- 22-23 **Sexuality**
- 24-25 **HIV and Dementia**
- 26-27 **Lighter Shades of Blue**
- 28 **Cate's Column**
- 30-31 **Mental Health and Well-Being**
- 32-33 **HIV and Hypnotherapy**
- 34-35 **What's Happening Around the UK?**



When the editorial team met to discuss this issue on mental health we were concerned that perhaps it could be too 'depressing'. We think you will agree our concerns were unfounded, for while the subject is profoundly serious, the articles are thought-provoking and optimistic with the emphasis on hope and recovery.

However, while many women are able to work towards recovery through engaging with mental health services and/or self help in a myriad of ways, others are immobilised by such a crushing depression they feel unable to help themselves or seek help. Too often when they do find the will and courage to take the first tentative steps to reveal their distress to health professionals or others, they find their feelings are trivialised and ignored. One of the steps towards recovery is in 'being heard' by someone who acknowledges respects and validates your feelings.

I am inspired by the women who have bravely revealed their personal journey

of mental distress, their vulnerabilities, deepest feelings and fears, while sharing the many creative and beautiful approaches they use to help themselves recover and maintain their mental health. It is also inspiring to hear aspects of some of the beneficial support work that Positively Women carries out with women on mental health and related issues. There is a range of information from professionals in the field on some of the causes/effects of mental distress, in particular highlighting/exploring the impact and relationship between HIV and mental health, along with recovery methods.

I pay tribute to all women who somehow find the strength and resilience to hang on in there through their darkest periods, we are sisters of the 'Scar Clan'.\* I believe it is testament to the indomitable spirit in us all that we continue in the face of darkness, despite feeling that there is no reason to continue, we refuse to give in or give up. I would like to share with you a 'Celtic Blessing'. It can be spoken or sung as a mantra.

## CELTIC BLESSING

Deep peace of the running wave to you,  
Deep peace of the shining star,

Deep peace of the flowing air to you,  
Deep peace of the quiet earth,

May peace, May peace, May peace heal  
your soul,

Deep peace, Deep peace, Deep peace  
make you whole.

Love and Blessings,

Maureen xxxx

\*from *Women who Run With the Wolves, (Contacting the Power of the Wild Woman)* by Clarissa Pinkola Estes, Ph.D. (I highly recommend this book to all women).

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Positively Women is a national organisation providing support services to women living with HIV and their children  
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# The Myth of Madness

## A Feminist/Eco-Psychological Perspective



I was diagnosed with clinical depression in 1971 and more recently in 2007 with Bi-Polar II disorder. Initially I was relieved by this latest diagnosis as it enabled me to begin to explore unacknowledged parts of myself. What I didn't understand at that time was bi-polar along with many other mental disorders is considered to be a degenerative 'biological brain disease'. My response to this information was no, I don't think so, this did not fit with my personal experience, understanding and beliefs about the causes of mental distress. I began to examine what people across interconnecting fields were saying about mental health disorders and found that the relatively new field of eco-psychology very much reflected my feminist and spiritual beliefs, that is, that mental distress is a natural response to suffering.

Western psychiatry has traditionally positioned mental health within the context of a bio-medical model, reasoning that the causes of mental illness are biologically based, unconnected from life and environment, i.e. brain diseases which cannot be cured, but can be controlled through the administration of drugs. However, there is no scientific evidence which supports this belief and Steven Morgan at Vermont Recovery questions whether psychiatric disorders are caused by brain diseases and chemical imbalances, and asks '...if they are, can the brain change, heal and grow out of them?' He goes on to say '...these hypotheses have always been problematic, for longitudinal studies have demonstrated again and again that a significant amount of people diagnosed with schizophrenia completely emerge from psychiatric symptoms and no longer use medications'. He informs us that this area of science is called neuroplasticity, which 'refers to the brain's natural ability across the

lifespan to form new connections and change its structure in response to experience. The message here is that the brain changes. This means that it is highly likely that whatever biological correlates underlie major psychiatric symptoms can change, too'.

Western Psychology has traditionally positioned mental health within the context of the social model, in an urban industrial society, unconnected from the natural world; many see this as a legacy bequeathed by Freud, who believed the earth to be 'eternally remote. She destroys us – coldly, cruelly, relentlessly'. Psychology has denied the importance of our environment and the earth to our mental health, holding to the view that if an individual is mentally distressed it is the result of disordered thoughts and emotions, which through various therapies may be restored to health.

Feminist theory recognises our innate connection to the earth and all its creatures. The separation of humans from our deep relationship with the natural world has long been of concern to many spiritual feminists such as Starhawk and Vicki Noble. In *Motherpeace*, 1983, Noble tells us 'most of us these days find ourselves less than fully well, physically or mentally – somehow out of balance. We can feel our disease, but don't ordinarily know the solutions to it. If we knew how to make ourselves well, we would almost certainly do so ...the harmony that comes with a recognition that we are all connected in spirit to this planet. We depend upon it for survival and we owe it the gift of life'. In *The Spiral Dance*, 1979, Starhawk implores us to remember our innate connection, asserting '...we must return to the circle. The circle is the ecological circle, the circle of the

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interdependence of all living organisms. Civilisation must return to harmony with nature’.

Eco-psychology is a relatively new field of study that endeavours to address what many concur has been a fundamental weakness in psychology, namely, it’s reluctance to link the human psyche with the natural world. Theodore Roszak, considered the founder of this field explains that ‘... if you look beyond the modern, Western schools of psychiatry, you find that in traditional societies among primary people ...that it is understood that sanity and madness have to be defined always in relationship to the natural habitat; and that to a very large extent, madness is understood to be an

imbalance between the individual and the natural environment or between an entire tribe or a people and its natural environment. That’s a much larger conception of what sanity and madness are’. Eco-philosopher, David Abram states: ‘When you drive traditional people off the land, you drive them out of their mind’. We should all remember that however ‘civilised’ (whatever that may mean!) many cultures have become, that we were once, all of us, indigenous peoples with our roots deeply bonded in a positive and sacred relationship to the world.

However the field of psychology has begun to address the far reaching implications of the psyches displacement from the natural world. Ralph

Metzner ‘reviewed several forms of psychopathology, including autism, post traumatic stress disorder, amnesia, and addiction, that each captured a distinct component of the modern alienation from nature. Common to many of these disorders is the psychological defence of dissociation, ...exploring ecological consciousness necessitates that we recognise the ‘numbing process’ of industrial society ...of overcoming psychic numbing by recognising and expressing the pain below the ‘armour’ of society. In this sense depression and grief must be valued as signs of profound human concerns’.

Mary Maddock (co-founder Mindfreedom, Ireland) in her review of ‘Alternatives Beyond Psychiatry’ (ABP) writes: ‘Human suffering, interpreted and packaged as a disease, only makes matters worse for those who suffer while it lucratively rewards some of those who work in the field, especially the pharmaceutical companies’. Kate Millet writes an excellent account on this point in the chapter ‘The Illusion of Mental Illness’.

Our suffering and the numbing process takes numerous forms which have become ‘normalised’ in many cultures, particularly Western, and our dissociation leaves us with a spiritual void which we fill with addiction to consumerism, entertainment, greed, sexualisation, drugs, celebrity and status to name but a few. We live in a world where increasingly those we once trusted have shown themselves repeatedly to be unworthy of trust. Who do we trust, bankers, doctors, car mechanics, fuel suppliers, plumbers, accountants, supermarkets, scientists, politicians, the media, our neighbours, each other, ourselves? We have become as numb and dissociated from each other as we are from the earth.

During my first deep depression in 1971, I was given anti-depressants, which I couldn’t tolerate so discontinued them. In 1973, the consequence of taking an overdose of sleeping pills (a cry for help, definitely not a suicide attempt) was that I was ordered to take

1. Mental health problems are rare.

Myth  Fact

2. People with mental health problems are violent.

Myth  Fact

3. People can recover completely from a mental illness.

Myth  Fact

4. On average, people with severe mental illnesses die ten years younger.

Myth  Fact

5. You can be open about mental health problems without fearing you’ll be treated differently.

Myth  Fact

6. There’s not much you can do to help a friend experiencing a mental health problem.

Myth  Fact

7. People can’t work if they have a mental health problem.

Myth  Fact

8. If you use a mental health service, there’s a one in three chance you’ll lose contact with friends.

Myth  Fact

# Mental health myth?

# Mental health fact?

Take our quiz and find out if you know the mental health myths from the facts.

**time to change**

let's end mental health discrimination

anti-depressants along with a weekly psychiatric session. These sessions were not positive or helpful, except I learned that the 'expert' was not so expert at all, and that despite my difficulties I wasn't going to allow myself to be fitted into a box. Again I couldn't tolerate the medication so discontinued it, but did attend sessions for a year as I was afraid not to because I knew that there was a possibility that I could be sectioned into a mental health ward. Since then I have struggled with varying degrees of depression, some so disabling that I seriously contemplated suicide. I have never been truly at ease socially, especially around strangers, and battle constantly to hide my internal distress. Peter Lehmann (Ed. ABP) speaks of 'the Herculean task of "appearing" normal... I did not manifest any of my internal distress'. I was subjected to early childhood sexual abuse and of course this impacted on my life, and I felt tainted from an early age. Like Chris Hansen (ABP) in her article 'What Helps Me If I Go Mad'; 'I became fixed in my identity as broken'. However I was fortunate to live close to nature where I and other children played and explored the fields and woods, it was a fascinating and interesting world of great beauty. The Bluebells Woods with its wee burn (small stream) were where I ran for comfort, felt safe, found peace and experienced a deep connection with what I felt to be the aliveness of everything around me.

There have been periods in my life when I have been well balanced and happy, more at peace and ease with myself and the people around me, predominantly those on a spiritual path. I was a member of a spiritual organisation from mid '70s and from the '80s became part of many women's circles. We celebrated and explored our spirituality through ritual and song, in sacred places connecting with nature, sharing our stories, acknowledging our wounds and deep feelings, and the wisdom of our reciprocal relationship with all of the earth's community. My involvement through much of my life with artists,

poets, singers, and musicians has also been a source of creativity, inspiration, and reciprocal healing. In the early '90s my world began to fragment under an overwhelming trauma, and in my despair, I moved away from all of the sources that nourished me.

It was around this time that I began to experience what I now recognise as fluctuating energy levels along with a mixing of low and high moods. These intensified following my HIV diagnosis in 2001 (10 years after infection) and as I struggled to come to terms with this new trauma I found support through ongoing Art Therapy and Psychiatric Psychotherapy. I have written previously about my positive healing experience with these therapies, their understanding, and insightfulness. Although my refusal to take medication did not overtly cause any conflict, I was always aware that my psychiatrist felt that I should take them. After my diagnosis the encouragement to take anti-psychotics and lithium carbonate became, I feel, more forceful. I do understand that my psychiatrist had what she felt to be my best interest at heart, and that if I took them I wouldn't be subject to such over sensitive emotions and mood swings. I don't have space to discuss here, but I know that there are many paths to recovery, and there is support in whatever you choose, and medication, for some, may be part of this. However, these medications are not for me, I trust myself implicitly on this.

I had long understood that [my] mental distress was caused by traumatic life circumstances and the deep pain experienced in witnessing worldwide escalation of suffering on so many levels, and both therapies positively recognised and acknowledged these facts as causal. However, the implication of a bi-polar diagnosis has moved the goalposts a considerable distance in that these facts will no longer be seen by many professionals as being causative in my mental distress, rather, these are now seen as triggers for the bi-polar which then causes mental distress, and my life is now perceived through a bi-polar lens! Before I was

diagnosed with bi-polar I had begun to acknowledge that there wasn't going to be an epiphany for me, when suddenly I would be transformed and my mental distress would just stop. This was not an acknowledgement that there was something fundamentally wrong with me, it was an acknowledgement that my sacred and authentic self, *despite* many deep woundings and scars, remains in fact very much whole and healthy.

I have a deepening understanding of my emotions and am becoming more skillful and effective in dealing with them. I read, I paint, write poetry, sing with a women's choir, practice Tai Chi, and spend time in nature. I am more careful with myself, with my health, my diet, and the people I choose to be around. I am, at last, truly, madly, delighted to be me, and I now face the future with all of my idiosyncrasies, the pain, the lows, the highs, the joy and the passion in my soul. Blessed be.

Love, Maureen  
xx

### Bi-polar

bipolar [bɪ pəˈlɔːr]

adj

1. with two poles: having two physical poles or extremities
2. having two different ideas: having two completely different opinions, attitudes, or natures
3. geography relating to Earth's Poles: relating to, involving, or found at both the North and South Poles
4. psychiatry having manic and depressed periods: characterised by shifts between episodes of mania and depression

# Mental Health and HIV

Good mental health is important in individual ability to manage daily life and the challenges it presents. Being able to meet our own daily living needs – that is to eat, sleep, maintain safety, care for personal hygiene, work, socialise, express our sexuality and function and communicate with the wider world – is a daily challenge, which can be affected by disturbance in mental health. Issues with mental health can also impact on physical health and its management and vice-versa.

Issues with mental health and HIV can relate to everything from diagnosis and contemplating testing to long term disease management, including decisions about treatment and issues related to death and dying. These issues may be similar for men and women and pre-existing problems with mental health may be implicated in both risk taking behaviours that have contributed to individuals becoming positive, as well as the ongoing challenge of managing HIV. The World Health Organisation in a report by the Secretariat indicates that studies have demonstrated high levels of HIV in people with serious chronic mental illness.<sup>1</sup>

Mental health problems associated with HIV may present in any form but generally include issues with adjustment to diagnosis, depression, anxiety and underlying mental illness – both previously diagnosed and undiagnosed – plus general health anxiety related to disease management. In a recent study 'What do you need?'<sup>2</sup> it emerged that adults in the UK who are living with HIV highlighted their most pressing concerns as anxiety, depression, self-esteem, sleep and sex – issues all related to mental health rather than physical.

These problems may not always seem obvious but generally manifest in a disturbance in ability to cope with everyday life. There may be increasing feelings of stress and worry with difficulty meeting daily living needs on all levels. Symptoms of depression can include disturbed sleep or excessive sleeping, changes in appetite, lack of motivation and enjoyment, feelings of hopelessness, helplessness, and general fatigue plus thoughts of suicide and self-harm.<sup>3</sup> Anxiety is characterised by feelings of worry and uncertainty, inability to concentrate or think clearly, a sense of impending doom, tension and 'butterflies' in the stomach.

These various symptoms may not always be identified as psychological in origin and can be related to living with a chronic, potentially fatal illness. Indeed, they may stem from the physical aspects of HIV disease and associated treatments such as anti-retroviral medication plus the general stresses of daily life.

Following diagnosis of HIV and an ongoing issue is the challenge of who to tell and what to tell them and this can be a huge problem for all kinds of reasons. Stigma continues to be a big issue in HIV and in mental health. This will influence whom we choose to inform. There may be immediate family members and partners to inform and the issue of how this could affect them is of concern. If there are children or other dependants, the affect this may have on them will also need to be considered and may result in a decision not to disclose.

Having someone to share the diagnosis with is however, an important part of coping with HIV and can ease the



**Psychiatry – field of medicine: a medical specialisation concerned with the diagnosis and treatment of**

**disorders that have primarily mental or behavioural symptoms and with the care of people having such disorders**

**[Mid-19th century. French psychiatrie  
Greek psukhē ‘mind’ + iatreia ‘cure’]**

challenges and sense of burden that keeping the diagnosis from people (for good reason) can bring. This may initially be a professional and a few close friends and it is important at this stage to try and be clear about who to tell as once people are informed they cannot be uninformed and this obviously has implications for confidentiality. Stigma issues related to work situations might also have to be considered and can highlight confidentiality issues further. Cultural issues will also further challenge disclosure and this seems particularly so for African communities where both HIV and mental health can be seen as very stigmatising.

The issue of exposure to HIV may in itself be one that requires further investigation and understanding. Are there underlying problems such as, for example, low self-esteem, depression, mental illness, vulnerability and drug-use which have resulted in exposure, or has the diagnosis followed unknowingly being put at risk or sexually assaulted? Each individual situation is different and will present different challenges. Whatever the individual circumstances a diagnosis of HIV comes with many challenges and not just those associated with the diagnosis of a chronic disease.

So what can we do to meet our mental health needs and be able to cope with daily life?

Access to support is a major need and can take many forms. Psychological well-being should be an integral part of routine care when attending medical appointments and this can be an initial point of contact and discussion regarding psychological needs.

Not all departments will have the same support services in place but there are generally counsellors, mental health nurses, psychologists and psychiatrists and access to support from anyone of these may be helpful and part of ongoing care needs – and will depend on the particular problem the individual is facing.

Having a good support network is important and this can consist of family, friends and peer support, either individually or in group settings. It is also necessary to have support with practical things such as housing and income as without these essential needs being met it is very difficult to address other issues. Understanding your own needs and situation and your view of mental health and well-being will also influence how you approach things. Previous experience of how you cope with stress and life's challenges is another influence and old emotions and unresolved conflicts may emerge when facing new challenges of adapting to living with HIV.

There is an increasing focus on mental health on recovery<sup>4</sup> and the journey the individual makes in this process. In this approach,

it is about taking more individual responsibility and control, identifying what is helpful in your journey towards recovery and not just the absence of symptoms of disease. This will involve many different things for each of us and is a different approach to what has been more traditionally seen in mental health – in the medical model of care.

In the early years of HIV before access to treatment, there was more of a focus on holistic and so called alternative therapies. Since the advent of anti-retrovirals this has changed and the focus is much more on access to these treatments... This is of course vitally important but brings new challenges such as coping with the daily regime and side effects, making decisions about treatment and coping for the rest of your life with medication. This will ultimately challenge personal strengths and capabilities and influence mental health and this must be acknowledged and be part of ongoing care. Motivation is not always the simple solution but part of a much wider set of individual needs.

In adopting a recovery focused approach, the focus is on individual coping strategies and tailoring them to meet all your needs; what works for you and helps you cope, who shares the journey with you and is helpful and supportive? What choices do you have and do you feel in control of things? This will also involve examining self-awareness and self-esteem issues. These may be challenging in their own right but with the right focus and support can be addressed over time and enable individuals to feel more in control of their situation – which will ultimately enable them to cope more readily with daily living.

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4. [www.workingtorecovery.co.uk](http://www.workingtorecovery.co.uk)

# Hope Tomorrow

What a year it has been so far, and it is only May! I have been battling with depression and the most horrible mood swings I have ever experienced! Why? I am sure it is linked to my HIV status. I am aware that many of my fellow positive friends are fighting depression. I have suffered many bouts of depression since my diagnosis.

I shouldn't be surprised really, it is a heavy burden to carry and live with. I have been living with HIV for 25 years now. I was not supposed to survive this long. I put my life on hold and now feel like I am stuck in this waiting room – waiting for what? I was waiting to die, but death eludes me. I am caught in a 'no man's land' – not fit enough to work but neither am I knocking at death's door. I have considered suicide, then I feel so guilty for even allowing that insidious thought to slip inside my head when so many people less fortunate than me have fought so hard to live. Well-meaning friends and family tell me I should be happy with my lot, all things considered. I have a lovely home, a wonderful supportive family and good friends; how could I even



consider suicide? It is not a logical reasonable thought – that is why! Depression is caused by a chemical imbalance in the brain. I know this, so why do I still feel so damn guilty?

I am stuck in a dark, barren, soulless place. What can I do with the rest of my life? I have really screwed up big time so far. Is it too late for me to turn my life around and make something of myself with my limited energy and poor health? I am quite awful to be around some days, in fact more days than I care to admit. I am not a very pleasant person a lot of the time. I often hate myself. I know I am behaving in a beastly manner and still cannot stop doing what I am doing. I am a stranger who I do not like at all.

Living with me must be akin to living on the edge of a rumbling volcano – never knowing when I will explode for no obvious reason. I have become so volatile and moody and I was over-sensitive before this latest depression set in!

I have been told I have osteopenia. I had a bone scan earlier this year after two falls and two broken bones, I am not surprised: my periods stopped eighteen years ago and when it was investigated I was told my body wasn't producing enough oestrogen, which wasn't a problem unless I wished to conceive. I didn't. So nothing was done to correct my hormonal imbalance so now I have thinning of the bones and worse, for me, I have thinning hair! No woman expects to lose her hair. It is not just about baldness or vanity; it strikes at the very heart of my femininity. I am by nature a tall, large-framed woman, and have always suffered extremely low self-esteem. Ironically, the thing people used to compliment me on was my hair and my eyes. How cruel then, of fate, to give me shingles in my eyes, and now my hair is falling out! Someone up there is having a huge laugh at my expense! (It certainly seems that way!) Not only that, but I have a lump on my head the size of a snooker ball, from my brain operation when I had a shunt inserted for hydrocephalus and I am so self-conscious of my bump! I live in fear that my bump will be exposed!

I have just managed to tell my GP of my sadness and mood swings. Unfortunately, he is a man. I don't believe he understands how bad I am feeling about my hair loss. I have been asking for his help for three months now and still he has done nothing. I saw him last week and sat in his office, the tears came, and they wouldn't stop. I felt a fool, and all he did was confirm that yes! I do have 'male-pattern baldness', well thanks mate! Thanks for nothing! I left his surgery with an appointment to see him again in two weeks and a possible referral to a counsellor to help deal with my grief for the loss of my dear brother! I miss him so much. It's almost three years since he died and I still can't quite believe he has left me. He was always there for me, my big bro.

# is a Better Day

I didn't realise how grounded he kept me till he was gone. He was calm, logical, laid back and had a knack of helping me to see where I was going wrong (or right) and if I had a problem, he could always make it better or teach me to accept things. He was cool, my brother. I thought we would always have each other for company. How wrong could I be?

This year seems to be worse than last year as we approach June (Mark died on 15 June 2006) I have now lived longer on this earth than Mark did. He was 45 when he died. I am now 46. I cannot imagine the years stretching out ahead of me without someone to share the highs and lows with but meeting someone is another minefield fraught with anxieties, which I'm not sure I can cope with?

How can I expect someone to take me on with all my problems? I just can't see anyone accepting me, even taking HIV out of the picture, I still have a lot of health problems.

Friends tell me any man worth having would accept me with all my problems if they loved me, but how can I expect anyone to love me when I don't love myself?

I wish the medical establishment would be a little more caring when it comes to mental illness. I may have been unlucky, as I have had very little help with my troubles. It took such a huge effort to trust my new GP with my admission of suicidal

thoughts, yet I feel let down, I realise he isn't a miracle worker and there is no magic wand he can wave to make my hair grow – if there was, he would be a very wealthy man!

To anyone in the health profession, if you see any people with mental illness, please afford them a little time and consideration.

We are hurting. The only difference is you cannot see mental wounds. No blood or gore, but the scars are there. It is a very real, very serious life-threatening condition. I hope I can beat it. Writing about it here is, I hope, the first step on my road to recovery.

I have survived hydrocephalus and sleep apnoea. I have beaten anorexia and drug addiction, coped with low self-esteem, insecurity, OCD, self-hatred, and body dysmorphia. I have lived with HIV longer than I have lived without it. I have realised the answers I seek are not to be found at the bottom of a bottle. I refuse to give in to my depression. I am a survivor.

I keep telling myself things can only get better. I have yet to see why I have been spared. I have to believe there is a greater purpose for my continued existence. To date, I have not found it, but I will keep trying, and hope tomorrow is a better day.

Today is the first day of the rest of my life...

Tina

## Women

Women are more likely to have been treated for a mental health problem than men (29% compared to 17%). This could be because, when asked, women are more likely to report symptoms of common mental health problems.

*Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain, National Statistics (2003)*

Depression is more common in women than men. 1 in 4 women will require treatment for depression at some time, compared to 1 in 10 men. The reasons for this are unclear, but are thought to be due to both social and biological factors. It has also been suggested that depression in men may have been under diagnosed because they present to their GP with different symptoms.

*National Institute For Clinical Excellence (2003)*

Women are twice as likely to experience anxiety as men. Of people with phobias or OCD, about 60% are female.

*The Office for National Statistics Psychiatric Morbidity report (2001)*

Men are more likely than women to have an alcohol or drug problem. 67% of British people who consume alcohol at 'hazardous' levels, and 80% of those dependent on alcohol are male. Almost three quarters of people dependent on cannabis and 69% of those dependent on other illegal drugs are male.

*The Office for National Statistics Psychiatric Morbidity report (2001)*

# Prison and Mental Health

A young woman is sitting in front of me in the health adviser's office in a UK prison. The office would look like any consultation room at your GP's, if it wasn't for the bars on the windows, the recurrent sound of keys, and doors being locked in the background. I will call this woman 'Y'. I have to be very careful about what I disclose about her, even in the pages of this magazine. If accidentally other inmates or prison officers knew her identity and HIV status, she could risk bullying, insults, ignorant remarks, a refusal to sharing everyday objects such as cutlery and cups, and isolation. Inside prison, HIV is a secret that needs to be kept at any cost.

'Y' is in prison for a violent crime she has committed to help her boyfriend when she was a teenager. She is still only 21 years old and pregnant. 'Y' tells me her story, without searching for pity, just recounting the events that have happened in her life. Born in an African country at war, she became a refugee when still a small child. 'Y' and her family – her mother and other siblings – escaped the war, first to refugee camps in neighbouring countries and later on to northern Europe, the safest option. She moved through several countries before settling in the UK.



If the horrors of war and exile weren't enough, 'Y' was raped when she was eight, by a family member. That's how she contracted HIV. It is not a surprise that her mental health is an issue. The prison is very concerned about her. There will be meetings among psychologists, social workers, doctors and prison staff to decide if 'Y' is mentally and emotionally fit enough to have her baby.

While I talk to her, I get the impression that in spite of all she has been through there is force, clarity, and strength in this young woman. But her life and the life of her baby are – for now – in the hands of the 'experts', the ones with power.

When I leave prison and I go back to my home, it is difficult to leave 'Y' behind. I keep thinking about her. I feel sad, angry, and powerless. I can't help asking myself: Is prison really the best place for 'Y'? Will she get any better in such an environment? Will she really have the possibility of moving away from her past life and growing to her full potential? What will happen to her baby?

This story is dramatic, but it is not that unusual. So many of the women I see in prison have tragic pasts; addiction, abuse – including sexual abuse – neglect, and poverty are recurrent themes. I believe many of them suffer from mental health problems. This is just my observation as an outreach worker who has visited HIV positive women in a UK prison for the past eight years.

## What do the experts say?

Well not much. One of the biggest problems about the situation of women in prison is that it is severely under-researched. For 'security reasons', everything about prison is very guarded. Prison is very difficult for anybody, but the added burden and terrible anxiety of having to guard the secret of HIV makes it a lot harder.

What is known about women in prison in the UK, at present, is that they are a fast-growing population. According to the Prison Reform Trust Report of 2006 in England and Wales, the number of women has increased by more than 200% in the past 10 years compared to a 50% increase in the number of men in prison during the same period. At present, there are more than 4,200 women in prison in the UK.

This increase in the UK follows global trends towards a greater use and popularity of imprisonment and a lack of interest in constructive alternatives such as non-custodial sentences. Those would be particularly relevant to drug offences and non-violent theft. Drug offenders in particular, would be better dealt with by therapeutically addressing their addiction.

Prison has a tremendously harsh effect on women, for several reasons. Firstly, women offenders are often the sole carer of their children, (more often than male prisoners). Their imprisonment and separation from the children can cause major psychological traumas, which are very difficult for both the mother and the children. This has grave repercussions for all of us in the communities where those children live. If women are the head of their household, their incarceration could result in the loss of their home, and serious disruptions in the lives of the children.

Since there are fewer women's prisons, women are more likely to spend time in a prison which is far away from where they live, so that visits from family and friends are extremely difficult. Women in prison can experience profound isolation, which has an effect on their often already compromised mental health. Additionally, because there are few women's prisons, women convicted from a wide range of offences are often imprisoned together. This means that the overall regime will be determined by the maximum-security requirements of a very few high-risk prisoners. Overall, the prison system was designed to deal with male prisoners, because of this it actually often discriminates against women.

The Prison Reform Trust provides more chilling statistics on the circumstances of women in prison.

- More than half of women in UK prisons say that they have suffered domestic violence and one in three has experienced sexual abuse.
- The educational achievement of women prisoners is lower than for male prisoners. 74% left school at 16 or before. Only 39% have any qualifications at all, compared to 82% of the general population. 41% of women prisoners have not worked in the past five years.
- 70% of women prisoners have two or more diagnosed mental health issues.
- 66% of women prisoners are mothers, and each year it is estimated that more than 17,700 children are separated from their mothers by imprisonment.
- Of all women who are sent to prison, 37% say that they have attempted suicide at some time during their life.
- Rates of self-harm or injury in women's prisons rose 48% in recorded incidents between 2003 and 2007. In 2006, women accounted of 11, 503 or 49% of total recorded incidents of self-harm, even though they form only around 6% of the prison population.
- 66% of sentenced women in prison say they were either drug dependent or drinking to hazardous levels before custody. A University of Oxford report on the health of 500 women prisoners found that 58% of women had used drugs daily in the six months before prison and 75% of women prisoners had used illegal drugs during that six month period.

- One in four women in prison has spent time in local authority care as a child.
- The majority of sentenced female prisoners are held for non-violent offences. At the end of March 2008, the largest group (28%) was held for drug offences.
- More women were sent to prison in 2006 for theft and handling stolen goods than any other crime. They account for almost a third (31%) of all women sentenced to immediate custody.

If you add to this bleak picture the hurdle of living with HIV, and often of being diagnosed while in prison, it is clear that there is an extreme urgency for a radical prison reform that takes into account gender equity and the right to health of women prisoners.

Meanwhile, women like 'Y' have to carry on the best they can with the support available. Fortunately, 'Y' was allowed to have her baby in prison. In spite of the misery of being a first-time mother behind bars, she has bonded with the baby and she seems as happy as she can be. Maybe also thanks to the fact that she wasn't totally isolated, but she had the chance to talk about her feelings around HIV during Positively Women's visits. Soon, 'Y' and her baby will come out of prison, there is still so much uncertainty about her future, and she is particularly worried that it will be hard for her to get a job because of her criminal record and her HIV status. However, Positively Women will continue to support her and hopefully this will be a happy ending story. This is quite rare when you come out of prison.

Silvia

For more information: [www.womeninprison.org.uk](http://www.womeninprison.org.uk)

## Mental Health in Prison

More than 70% of the prison population has two or more mental health disorders. Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners 35 times more likely than women in general

*Social Exclusion Unit (2004) quoting, Psychiatric Morbidity Among Prisoners In England And Wales, (1998)*

The suicide rate in prisons is almost 15 times higher than in the general population. In 2002 the rate was 143 per 100,000<sup>1</sup> compared to 9 per 100,000 in the general population.<sup>2</sup>

- 1 *The National Service Framework For Mental Health: Five Years On, Department of Health (2004)*
- 2 *Samaritans (2004) Information Resource Pack (2004)*

Only one in 10 prisoners has no mental disorder  
[www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

# HIV and Mental Health – An Obvious Partnership?

Allan Anderson and Beulah Gordon

The problem with mental health is that it is so misunderstood and stigmatised; the last thing anyone wants is to be labelled with a mental health sticker. Someone who has an angry outburst is often referred to as 'going mental' or 'mad'. Yet, most people at some point in their life would have experienced some mental health difficulties. The root cause, how it's managed and the support given is what makes the difference between short and long term needs or worst, having a crisis.

Working with HIV positive women with mental health issues is a part of the daily work life at Positively Women. How is it recognised? Over the years, the case workers have become skilled through training and case by case experience. Workers know that asking the right questions, careful listening and exploring emotional difficulties are key to recognising and supporting women with mental health difficulties, along with focusing on solutions rather than difficulties, setting goals and knowing where to sign-post.

Are mental health difficulties and an HIV diagnosis synonymous? Positively Women have found that women present a varying range of mental health issues; short-term, long-term and presenting with crisis situations that require clinical and psychological interventions. However, there is not

necessarily a direct correlation between severity of mental health and stage of someone's HIV diagnosis in terms of newly diagnosed, long term diagnosed or somewhere in between. This is borne out from years of supporting women living with HIV through a whole range of emotion. There are undoubtedly some who are more predisposed to mental health difficulties and an HIV diagnosis may be the catalyst for setting it in motion; and some who are not predisposed to mental health difficulties can find themselves unable to manage emotionally and psychologically after a diagnosis.

Some women often cite fear of dying, disclosure and isolation (I have no one to talk to). Immigration and all its accompanying problems such as homelessness, poverty and deportation are a major worry and concern, especially as people in this situation feel powerless to change their circumstances. For longer term diagnosed, it may be treatment issues such as changing combinations, isolation, changing body image, getting older and other health conditions that are their major concerns. Some of those who presented late for testing may already have cognitive, mobility and other physical impairment added to all their other concerns.

Of course mental health is not an issue only for women; the same issues affect men as well. In addition, studies show that gay men are prone to mental health difficulties; these can be exacerbated by an HIV diagnosis.

At the 2007 British HIV Association Autumn conference, during the Children's HIV Association parallel session, it was recognised that HIV infected children often experience cognitive impairment and developmental delay. This can present as difficulties in expressing themselves, short concentration spans and aggressive behaviour.

Mental health is a key issue for the HIV sector and the challenge is how the voluntary sector and health care professionals respond and find ways of supporting women, men and their children now and in the future.

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**“We were a little apprehensive about it at first – I felt a little embarrassed and clumsy inserting it, although, once it was in, it felt fine and we forgot about it, for the rest of what was, a highly pleasurable afternoon, thank you!”**

**“I like the female condom as I often have issues with negotiating safe sex with my partner. With the female condom I can take control and I feel more confident.”**

**“My experience has been a good one. Me and my husband can feel more sensation when we use the female condom. My husband is not positive and he feels more comfortable if I use a female condom...”**

# The Female Condom



[www.femalehealth.com](http://www.femalehealth.com) [www.postalcondoms.co.uk](http://www.postalcondoms.co.uk)

**Depression**

depression  
[di prэш'n]  
n

1. sadness:  
a state of  
unhappiness and  
hopelessness

2. psychiatric  
disorder: a  
psychiatric  
disorder showing  
symptoms such  
as persistent  
feelings of  
hopelessness,  
dejection, poor  
concentration,  
lack of energy,  
inability to sleep,  
and, sometimes,  
suicidal  
tendencies

3. economic  
slump: a period  
in which an  
economy  
is greatly  
affected by  
unemployment,  
low output, and  
poverty

4. reduced  
activity: a  
lowering of  
activity, quality,  
vitality, or force

5. hollow: an  
area on the  
surface of  
something that  
is lower than  
the surface  
surrounding it

# Postnatal Depression

– Susan Cole

Gwyneth Paltrow, Brooke Shields, Jordan – what do these women all have in common? No, not just fame and lots of money, they've all suffered from postnatal depression. Anyone can get postnatal depression, regardless of income or background. Over 1,000 women are diagnosed each week in the UK alone.

## What is postnatal depression?

**Baby Blues** – This is so common it can be considered normal. Most mothers feel weepy and irritable around three days after having a baby, however it normally only lasts a few days and does not require any specific treatment.

Julia\*, 38, spoke about her experiences; 'The day I got back from the hospital I just burst into tears over the slightest thing. My husband walked on eggshells for about a week until I was back to normal!'

**Postnatal depression (PND)** – This usually develops within the first four to six weeks after childbirth, although it can start several months later. About one in 10 mothers develop PND, although this figure may be higher as many women don't seek help and often pretend to cope.

**Puerperal psychosis** – This is a serious mental illness that affects about one in 500 mothers. Symptoms include hallucinations with paranoia, delusions, and bizarre behaviour. Treatment is needed in hospital but most women make a full recovery.

## What are the symptoms of PND?

Most women usually experience some, but by no means all of the following:

- Feeling unhappy or wretched much of the time for a week or more and frequently tearful without any apparent reason.
- Not really enjoying anything and feeling guilty or inadequate.
- Finding it hard to concentrate and to sleep.
- Feeling irritable and lacking in energy, taking little interest in the outside world.

- Feeling frequently anxious with the possibility of experiencing panic attacks.
- Feeling hostile or indifferent to your partner.
- Thoughts of harming yourself or the baby.

Many women don't recognise what they're experiencing is PND. First time mother Sandra\* talked about this:

'My baby wouldn't feed properly and just seemed to cry all the time. Nothing I did seemed to calm him down. I felt that I was an awful mother and spent hours crying every day. I had such high expectations of motherhood and what I was going through was the complete opposite of how I thought I would feel. It was months later after I'd spoken to another mother who had suffered with postnatal depression that I realised I'd had it too.'

## What causes PND?

There doesn't seem to be any particular single reason why some women develop PND and others don't. Sometimes it can start without any particular cause. Hormonal factors may play some role, but a number of different stresses may add up to cause it. Not having a supportive partner, having a sick baby or health concerns, and experiencing depression during pregnancy or in the past can all contribute to developing PND. Recent life stressors, such as bereavement, money, housing worries and unemployment are also significant contributing factors. Women living with HIV frequently face many of these stressors and may therefore be at increased risk of developing PND.

## What can be done to help with PND?

**Support and advice:** Understanding and support from family and friends can help significantly. Talking about how you are feeling to a sympathetic and non-judgemental listener is much better than bottling up your emotions. Talking to a health visitor can also be of great help and they should be able to offer you advice on getting further support if you feel you need it.

**Counselling and psychotherapy:** Talking treatments can give you the opportunity to understand the factors that have contributed to PND and help you with practical strategies to deal with the problem. Many GPs have a counsellor who can help you with PND or can refer you to a psychologist, counsellor, or psychiatrist.

**Anti-depressants:** An antidepressant can help, especially for moderate or severe PND, easing symptoms such as low mood, poor sleep and irritability, helping you to cope better with your new baby.

**Helping yourself:** Other strategies that may prove useful include finding time to have fun with your partner and not blaming each other, eating well and taking every opportunity to rest.

Sandra\* gave this advice 'Remember you are not alone, so may other mothers go through what's happening to you. Try to talk to other mothers if you can and never forget you will get through this. I did and now love spending time with my wonderful son.'

## For further help and advice:

### Association for Post-Natal Illness

145 Dawes Road, Fulham, London SW6 7EB, UK  
Tel: 020 7386 0868 Web: [www.apni.org](http://www.apni.org)  
Aims to help women who suffer from postnatal depression.

### CRY-SIS

Helpline: 020 7404 5011 (line open 9.00 am to 10.00 pm, 365 days a year)  
Provides self-help and support for families with excessively crying and sleepless babies.

### Meet-A-Mum-Association (MAMA)

Helpline: 0845 120 3746 (7.00 pm to 10.00 pm weekdays)  
Self-help groups for mothers with small children and specific help and support to women suffering from postnatal depression.

### The Samaritans

Tel: 08457 909090 (UK) or 1850 609090 (Eire);  
Email: [jo@samaritans.org](mailto:jo@samaritans.org)  
Provides confidential emotional support to any person who is suicidal or despairing.

\*Names have been changed

# Postnatal depression – Personal account – Sarah\*

It's been a year since I had my baby. She's delightful and I'm happy, so it's hard to find the inspiration to write about postnatal depression. It's easy now to shrug it off as a bout of the baby blues. Like recollecting childbirth itself, my memories are muddled and vague, the past seems distant and surreal. But when I force myself to look back, the old tentacles of despair worm their way back into my consciousness.

It wasn't an easy pregnancy. Anaemia sapped me of energy and I hobbled around swollen and uncomfortable, but I was brightly optimistic. I envisaged life would snap back into place once my baby was born. Even after a traumatic c-section and complications after the birth, I remained upbeat; no expected baby blues sullied my emotions, on day three and my baby was considered 'good' – sleeping frequently and rarely crying. Yet, still it came, stealthily, silently depression began to choke my happiness. I found myself crying, almost all the time when I got the chance to be alone or just with my baby. I loved her fiercely, but still my tears would splash down on her face as I held her in my lap. I felt desolate, empty, and useless.

I pretended everything was OK to most people. I felt guilty and stupid and ungrateful for allowing myself to wallow in despair. I went through the motions of social interaction, but I felt dead inside. My husband noticed I was down, but finding himself unable to initially help and I expect feeling frozen out, he turned irritable and distant. This tipped me into a new realm of misery. I was unable to put things into perspective and felt my marriage was doomed, little things were blown alarmingly out of proportion. I began to think about dying and at my darkest moments almost began to believe my children would be better off without me.

I'm not sure what the catalyst that helped me back on track was. My health visitor asked me one day how I was feeling, even though I didn't particularly elaborate, just saying, 'I think I might be a bit depressed' seemed to help a little. I think it was actually talking to my cleaner about how I was feeling that helped the most. Just being held by someone as I cried, who listened and didn't judge was enormously helpful. My best friend came to stay for a week. I didn't have time to be depressed, I was laughing and enjoying life again. Humour was the biggest healer in the end.

So here I am a year later, still with my husband and happy with life. I can barely recognise the angst filled tormented creature I was back then. So ladies, if you too are going through this, hold on, it is going to be OK.

\*Name has been changed

# Treatment and

People with HIV have high rates of the more common mental health problems like depression and anxiety, surveys show. The figures vary according to how these conditions are measured; if you ask patients whether they have recently experienced depression or anxiety, both UK and US surveys have shown rates of 60-70%. If you get people to answer a more objective set of questionnaires designed to measure current depression or anxiety, about 30-50% report anxiety and/or depression and about one in five has major depression.

In addition, about one in five people with HIV (averaged over the patient population, and not taking into account variations between men and women, black and white, and gay and straight) reports heavy drinking and about one in six problematic drug use. And another UK survey found that 31% of patients at a particular HIV clinic in London reported suicidal thinking – ‘Is it all worth it?’ in the previous week.

However you measure it, the rate of mental ill-health is roughly two to three times greater in people living with HIV than with comparable HIV negative people. That’s a big burden of unhappiness. But it is one that can be successfully treated.

## Cause and effect

Some of these emotional problems are undoubtedly due to the stigma of having HIV infection. Other studies have found particularly high rates of depression on groups of patients that feel particularly stigmatised. One example is the suicidal-thoughts study referred to above. Heterosexual men were more likely to feel suicidal than other groups and the researchers commented that ‘the burden of secrecy and lack of community and social support’ may hit them specially hard.

Some mental health problems may be a cause rather than effect of having HIV. Having had traumatic experiences in your life may make you more vulnerable to contracting HIV because of consequent problems with drink, drugs and relationships or poor risk management. For instance, a US study found that 30% of people with HIV had experienced child sexual abuse and a UK study found that 45% had been sexually, physically or emotionally abused as kids.

Finally, a lot of people wonder if HIV treatment itself might be partly to blame for the high rates of depression and anxiety in people with HIV, having heard that some HIV medications can have psychological side effects.

## The Benefits of HIV Treatment

It’s true that some do have such effects, and we’ll look into these later, but there’s a lot of evidence that also shows that HIV treatment in general improves mental as well as physical health. Back in the late 1990s, for instance, when combination HIV therapy was new, a survey found that rates of psychiatric disorder among people with HIV fell from about 50% to about 38% in one clinic once HIV combination therapy started to be offered – whether or not people were actually taking it. More recently, in the large SMART study of continuous versus intermittent HIV treatment, patients who took HIV therapy all the time reported improvements in their mental health, social functioning, and general quality of life, whereas patients who came off therapy when their CD4 counts were over 350 and resumed therapy at 250 reported significant declines. In general, being on HIV therapy seems to improve mental health.

## Psychiatric side effects of HIV drugs

There are exceptions to this of course. One of the drugs most associated with psychological problems also happens to be one of the most effective: the drug Efavirenz (Sustiva, also in Atripla). It is acknowledged by the drug’s manufacturers that people often experience psychological side effects during their first month on the drug: dizziness, depression and odd moods, poor concentration, vivid dreams and sleepiness.

Whether these persist beyond the first month is more contentious, but a 2005 study of 120 patients who had been taking HIV therapy for at least a year, 60 on Efavirenz and 60 not, found that just over half of patients on Efavirenz reported at least one of the side effects listed above compared with just over a quarter on other drugs.

These did not impact on quality of life or adherence levels, so must have in the main been mild. A minority that already have mental health issues may react much worse, however. For instance, another study of HIV patients in San Francisco found that 18% of patients with previously-diagnosed depression had to stop taking Efavirenz because of side effects compared with only 2% who had not had a depression diagnosis.

Efavirenz is not the only HIV drug associated with psychological side-effects, though with other drugs reports are more scattered and tend to involve acute reactions just after people start therapy. In the case of Efavirenz it is usually possible to switch to the similar drug Nevirapine (Viramune), probably with an overlap period to allow the body to get used to Nevirapine, which has its own set of acute side effects.

# Mental Health

## The effects of poor mental health on HIV treatment

Considerably more dangerous to overall health is the fact that bad mental health is strongly associated with poor HIV drug adherence and treatment failure. A 2007 study, for instance, looked at 198 patients attending a clinic in North Carolina, USA. It asked them a couple of different questionnaires that predicted the likelihood of their developing a mental health disorder of any kind over the next year. It found that patients assessed as having a high risk of poor mental health were nearly twice as likely to fail their HIV treatment as patients with a low risk.

Another study of HIV positive women attending HIV clinics in four US cities found that women with CD4 counts under 200 and symptoms of depression were more than twice as likely to die within a year as patients without depression. If they had chronic depression they were twice as likely to die even if their CD4 cells were in the 200-350 range.

So clearly addressing and trying to improve poor emotional health can be a lifesaver and can have a dramatic effect not just on quality of life but on whether people have a life at all.

## Drugs for mental health problems

There are a variety of drugs targeting different mental health problems. These include the SSRI anti-depressants such as Citalopram and Fluoxetine (Prozac) and the beta-blockers such as Propranolol, which control anxiety symptoms. Other drugs are used for more serious mental health problems such as antipsychotics for schizophrenia and the highly addictive Benzodiazepine sedatives such as Diazepam (Valium) which are still sometimes prescribed in short courses for severe anxiety and insomnia.

Because the mind is such a complex thing, prescribing medication for mental health problems is a very imprecise art and results are very variable; it's not like using HIV drugs to suppress your virus. *Positively Women* readers may be surprised to find out how relatively weak the effects of anti-depressants are. A UK review, for instance, found that if you give a group of patients with various severities of depression an SSRI anti-depressant, about half of them improve. However, if you give people placebo pills about a third of them improve too.

A US review of studies has similarly found that giving patients SSRI anti-depressants is about a third more effective than giving people sugar pills and that about 58% of patients given anti-depressants experience an improvement in their symptoms compared with 45% given a placebo. Anti-depressants are

relatively more effective for patients with moderate-to-severe depression. But for those with mild depression, placebos work just as well as anti-depressants.

In terms specifically of patients with HIV, a review of seven studies of anti-depressants versus placebo found that 43% of patients in general got better but that more than half of this improvement could be explained by the placebo effect.

This is not to deride the use of psychiatric medications altogether. Anti-depressants, tranquillisers and antipsychotics may be lifesavers for people who are severely depressed, suicidal, deluded or physically sick with anxiety. But it does suggest they are widely over-prescribed. As a result the recently revised guidelines on depression for the National Institute for Health and Clinical Excellence (NICE) now recommend that anti-depressants are not offered for mild depression and patients should be offered, if anything, short-term counselling.

Very few psychiatric drugs have really significant interactions with HIV medications, though some people may need their dose adjusted. A few of the more uncommon anti-psychotics and sedatives are ruled out and the class of migraine drugs called ergot derivatives cannot be used with HIV therapy at all. The biggest exception is the herbal supplement St John's Wort, which is often used as a 'natural' anti-depressant. It works, but it substantially reduces the levels of the majority of HIV drugs in the body, so cannot be used with HIV medication.

Even without drug interactions, some psychiatric drugs have side effects of their own or can make HIV drug side effects worse. A notorious example is sexual dysfunction where anti-depressants can cause or worsen difficulties in achieving erection and orgasm.

## Counselling and psychotherapy

The other sort of treatment for mental distress involves talking through your problems with a trained professional. 'Talking Therapy' is a huge growth profession in itself and some people doubt its efficacy. But in fact counselling (which is usually short-term and focuses on specific problems) and psychotherapy (which is usually long-term and aims to change more engrained personality quirks) are effective, and generally more effective than anti-depressants used by themselves.

Research shows that approximately 80% of people will do better after therapy than the average person who has not had therapy, while 20% will do worse. That's an average 60% improvement rate: about 10% better than anti-depressants. We also know that the positive effects of psychotherapy

are generally maintained for one to two years after therapy has ended and that psychotherapy has a lower drop-out rate than taking medication and because of this is cost-effective.

There are a vast number of different therapies on offer in the private sphere ranging from the standard to the wacky. If you get counselling on the NHS, however, you are likely only to be offered the ones for which there is solid scientific evidence, namely Cognitive Behavioural Therapy (CBT), which tackles negative thinking, and possibly Interpersonal Therapy (IPT), which tackles isolation and difficulty with relationships.

This doesn't mean that anti-depressants and other psychotherapeutic drugs should be abandoned altogether. A course of anti-depressants or anti-anxiety drugs can serve as a life-boat. Once you've got into relatively calmer waters then counselling and psychotherapy can help you avoid the emotional depths in the future. One study from New York took 101 people with HIV and divided them into four groups who received counselling, CBT or IPT, and counselling plus anti-depressants. Counselling-plus-anti-depressants worked best and IPT came a close second, with significantly worse results for CBT and for counselling by itself.

Which kind of therapy you get is, in fact, probably the least important predictor of success. Researcher Mick Cooper found that the choice of therapy was responsible for only about one to two per cent of the variation in the success rate of psychotherapy.

The therapist's skills are more important in the long run. One study for instance of a student therapy service found that the clients of the most effective therapist showed a rate of improvement 10 times the average, while the clients of the least effective therapist showed an average worsening of problems (so you wouldn't want to see them!)

What are the skills most associated with success? The research shows that the most important three factors are:

- A therapist who collaborates with you on having a clear aim for the therapy and clear success criteria.
- A therapist who is empathetic, in other words can accurately hear what is going on in your mind and can articulate it in a meaningful way.
- A therapist who asks for and responds to feedback from you as to how you think it's going.

Even so, however, it is estimated that only 10-30% of success in therapy is due to individual therapist qualities.

So what's the magic factor that is responsible for at least 70% of the difference in whether counselling or psychotherapy works for you? You, the client, that's who. One 50-year-old study found that two-thirds of clients who saw themselves as having an active part to play in the success of the therapy continued with psychotherapy, compared with just a quarter of clients who placed responsibility completely in the hands of their therapists. Therapy tends to help people capitalise on their strengths, as opposed to compensating for their deficiencies. In the words of the old joke, 'How many therapists does it take to change a lightbulb? One, but the lightbulb has to want to change'.

## How did you do?

### 1. Mental health problems are rare.

**This is a myth.** Mental health problems affect one in four people in any one year. So, even if you don't have a mental health problem, it's likely your best friend, a family member or work colleague will be affected.

### 2. People with mental health problems are violent.

**This is a myth.** People with mental health problems are much more likely to be the victim of violence. The violence myth makes it harder for people to talk openly about mental health problems. It can also make friends reluctant to stay in touch.

### 3. People can recover completely from a mental illness.

**This is a fact.** Many people can and do recover completely from mental health problems. Alongside professional help, the support of friends, family and getting back to work are all important in helping people recover.

### 4. On average, people with severe mental illnesses die ten years younger.

**This is a fact.** But it's not the mental illness that kills – it's the discrimination. The physical health needs of people with mental health problems are often dismissed, causing higher rates of death from heart attacks, diabetes and cancer for people with severe mental illness.

### 5. You can be open about mental health problems without fearing you'll be treated differently.

**This is a myth.** People fear telling friends, family and work colleagues if they have a mental health problem because of stigma. In fact, 87% of people with a mental health problem have experienced discrimination.

### 6. There's not much you can do to help a friend experiencing a mental health problem.

**This is a myth.** If someone you know is experiencing a mental health problem, just staying in touch can really help. For many people, it is the small things that friends do that can make a difference like visiting or phoning.

### 7. People can't work if they have a mental health problem.

**This is a myth.** With one in four people affected by mental health problems, you probably work with someone with a mental health problem.

### 8. If you use a mental health service, there's a one in three chance you'll lose contact with friends.

**This is a fact.** Sometimes friends feel like they don't know enough to be able to help or feel uncomfortable. But you don't need to be an expert on mental health to be a friend. It's often the everyday things, like a phone call or text, that make a difference.

### If you got more than four right...

Great! You know the mental health myths from the facts.

### If you got fewer than four right...

It looks like it's time to find out the facts about mental health problems. But just doing this quiz will have helped.

## Get involved today

There's lots you can do to support friends and family experiencing mental health problems and help end mental health discrimination.

Go to [www.time-to-change.org.uk](http://www.time-to-change.org.uk) and get involved today.

# Putting <sup>1st</sup> Patients



*Real faces, real stories, real lives*

Gilead believes in supporting people living with HIV. That is why we have created a series of booklets to help patients make the most appropriate choices to maintain their health. If you would like to receive copies of these booklets, **please contact your healthcare professional.**

# Mind Gardener's World

**Depression and dark moods go back much further than my HIV diagnosis.**

They did not start with being raped and the hideous head full of shame, self-blame, and confusion that came with that, nor even the destructive and damaging first relationship that I had, or with the complexities of a hidden and perhaps somewhat inappropriate friendship with a vicar in early adolescence. Indeed, I can remember them even further back than the evidence of the onset of raging adolescent hormones zooming about my body.

I played alone a lot as a child the four-year age gap between my sister and myself and a culture of playing out and going off for the day meant that I developed a keen imagination. I seem to have spent a fair amount of my childhood in trees being a phantom, hanging upside down from the crossbar of the swings being a bat; I was queen of the wasps, caterpillar-racing champion, saver of worms, lighter of fires, finder of dens. I liked making things – old woman's skin out of toilet paper or facemasks and tents.

I was I think a sensitive child, with a liking for nature; although I had dolls I preferred poking about in the garden. Earwigs, wood lice, caterpillars and insects, frog spawn, toads and sticklebacks. I fell into park lakes more times than I care to remember, trying to reach (usually with a stick) something that was just outside my grasp. This is something that I have metaphorically continued to do thorough out my life.

I leapt from childhood into an adult world of pubs and clubs by the age of 12-13. I got a lot of attention, sometimes from men with sticky lips congealed with spittle, trousers that were a bit too short and their hand thrust twitching through the hole in their trouser pocket. Some men wanted to protect and I guess others thought if I was playing out with the big boys and girls I was fair game.

Perhaps adolescence came too quickly, breasted and menstruating before I was 11. Teased and seemingly loathed by girls and grabbed and ogled by men and boys; Slag and Jailbait where my nick names and purely based on what I looked like. Perhaps the realisation that I was no longer a child, or perceived as one was one, which I was both grateful for and repelled by.

I feel like I was aware even as a child that I was striking an uneasy balance between what I wanted for myself, and what those closest to me, expected of me. I wanted to be a vet, a nun, an adventurer, or someone who created things. However, I was indecisive and a daydreamer and my parents, grandparent and teachers, thought that I was not academically inclined.

I don't know at what point I felt that following my dreams was not possible, or at what time I became distracted, but I remember my grandmother once suggested that if I worked really hard I might be able to get a job on the till at Marks and Spencers . I remember thinking that I would not fit in there and that I just was not clever enough.

I do not blame my parents or family members for my lack of direction and focus, if you insist on taking the wheel the responsibility for driving is then with you. I wanted to lead my life and make my own decisions and even when I have made almighty blunders, they have always been there. Despite life throwing a few curved balls I seem to have managed OK. I do, however, wonder if I will ever achieve what I know I am capable of, I fear not of failures, but of failing to be. Failing to be who I believe I should be.

There have been points where hope has felt whisker thin and the darkness of depression has descended all spiteful and squawking like a murder of crows, screeching, skipping and jumping, dancing a tormentor's jig.

Depression breeds fear and stress as the self-doubt turns to loathing and shame; it means a thousand humiliations and hardships and endless sleepless nights raking over failings. Depression is not romantic, it holds you back and leaves your imagination suffocated and gasping for life. Most of us are not equipped to deal with the darkness of depression and rather than knowing how to reject it, we end up well acquainted with the sense of helplessness that is depression's companion.

I am wise enough to know that many of you have experienced depression, heartache, hardship, fear, loss, and heartbreak. Even the most privileged and content of us will not have enjoyed a life that has been led without being ruffled or anguished at some point or another. Climbing out of depression is indeed something to be proud of, whether this is alone or with help. I have had



much help not just from family and friends but also from a variety of professionals.

Each one has offered me a chance to look at myself from a different angle, to learn to live with the tension of uncertainty and not let the fear overwhelm me. I now ask for help well before I feel overwhelmed. The seeds of depressive thinking may have been planted long ago, but weeding the growth of negativity out before they reap destruction, is like mind gardening. There may be lots of weeding to be done, but if I keep on top of it, then I'll be able to grow the things that I want to.

Being able to imagine myself in a better place helped me to work my way out, but it took more than imagination, imagination is just the start, it is the action of consciously (and physically) doing something about it that is the difficult step; and then maintain it.

Some things we have little or no control over, the external world that can be imposed on us, but your internal world is something that only you inhabit and there are ways of learning to control that.

The knowledge that I have emerged wiser and stronger from setbacks means that I am secure in my ability to survive difficult times. We will never truly know ourselves, or the strength of our spirit and relationships, until both have been tested by adversity. Whilst this may be a painfully earned reward, it is one worth having.

Ultimately, we all have to decide for ourselves what constitutes success and failure, and what we value, but the

world will be quite eager to give you a set of criteria if you let it. Money, material belongings, youth, physical beauty, strength, health the absence of all these can leave us feeling inadequate and without a place in the world.

Life and the things that have happened in it can feel both a privilege, and a burden. I have chosen to use my HIV status and voice hoping that somehow I will say the words of those who have no voice. I have also stepped back and left the talking to those whose voices need to be heard, feeling that supporting to, rather than doing for, can be more effective. I have made a decision to identify with those who are powerless and do not have my advantages, even when I am at my most powerful. I still want to make a difference in the world and not just for myself. Finding the best way to do this remains a challenge.

At 43, I would have hoped that contentment might have started to settle in and that I would be pleased with the things that I have achieved. Unfortunately this is not always so. I sometimes peer at my internal self and see someone sad, scared, and caged.

Although I have learnt to trust my instincts more and I am trying to change my thinking and make my own reality, finding the power and courage to change the way I see things and then in turn how to act sometimes remains a struggle. Setting boundaries for myself whilst also striving to push myself to do what I think I am capable of remains difficult.

My internal script often has the voice of a disappointed parent talking to a talented child who refuses to learn. Trying to change that to a supportive and encouraging voice can sometimes feel too difficult and contrived. I have to work hard not to spend hours inside my own head. It's as if I am constantly looking for things to connect and other things to disconnect, perhaps all the while knowing that a total re-wiring is a mission impossible.

Over the years many layers have been stripped away in order to seek the things that are important and essential. I am more content with myself than I have been in many years and I have begun to direct my energy into the things that matter to me. I wish I could say I have the answers, that I never feel remotely down and that my life is exactly as I want it to be. I can't.

What I can say I am getting better at making the choices that are good for me; and two steps forward and one back is still a step forward and one in the right direction. I have a good life and it will get better because I still have plenty of things that I want to achieve. I spend more time than I ever have in a place of positive reflection and self-belief. Even if I do sometimes have a wobble I know that the garden of my mind will continue to bloom and grow not with a tangle of weeds but with all the efforts of my considered planting and ongoing care.

Julie

# Sexuality

I was born in February 1975 in Hackney; I was eighteen months old when, at my grandmother's urging, my mum put my sister and I on a plane to Lesotho to live with my maternal grandparents. We reunited in February 1978, when my mum came to Lesotho to live. My mum and dad had long been having marital problems; they divorced when I was five; so my mum, and my grandparents raised me. I spent my childhood in the fresh air, I was happiest riding my bike, playing with toy cars, playing football, playing with dolls, drawing and painting, roller-skating, catching ants, grasshoppers and tadpoles, picking fruits and nuts, and just running around. My grandmother was a wise woman; I doubt my childhood would have been as happy or as free had I grown up in East London. Ever since I was young, my grandparents constantly urged my sister, my cousins and I to aim for university degrees; my grandmother was a senior lecturer and my grandfather a professor. My grandfather had a saying, which became the soundtrack to my childhood; 'sweet are the rewards of labour'. I was well behaved and was rarely in any trouble growing up. At eight, I knew that like my mum and grandmother I was going to be a professional woman. When I was 12, I strongly protested against my mum's efforts at getting our then helper/cleaner to teach me how to do the housework, my reasoning was that I'd have my own cleaner when I grew up. Over my teenage years, the 'financial power' that I had up till then linked with being a professional began to encompass the freedom to live without cultural impositions or restrictions, which I defined as 'happiness'. So my aspirations to become a professional grew stronger in line with my efforts through high school and university, and I could hide away from myself and from others behind these books, they were a comfort.

I had my first crush at eight, her name was Bontle, she was in her 20s, on seeing her I told my cousin that I loved her more than I loved God, which was very significant as I was brought up in the Anglican church. At 12, I had many more crushes on girls; this was to be the beginning of the rest of my life. By 16, in boarding school, I had come to the realisation that my community frowned at gay people, I didn't know anyone else

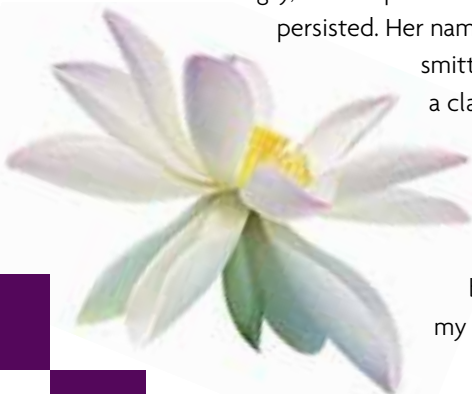
who was gay, and despite this my feelings for women persisted. Her name was Lorraine, I was

smitten she was 17 and in a class up, one weekend she was helping me with my maths, my heart skipped a beat, my breathing became laboured and my head swam every

time she got too close and every time we inadvertently made contact. I couldn't concentrate, she noticed this but didn't verbalise it, just avoided physical contact for the duration of the tutoring; it was a minor setback compared to what would follow in my later years. At 17, braved it again and made a subtle move on Margaret, I let her listen to a romantic song on headphones and told her it was dedicated to her. She was horrified, and ran off, not before asking (in an accusatory tone) whether I was a lesbian; it was a blow that absolutely winded me, I was ashamed. It was around the same time that I started seeing a counsellor because I felt inadequate; this followed a failed suicide attempt. At 18, I wrote a love poem to my best friend from the age of five, we were both doing our first year in university; she didn't talk to me for a year after this. To facilitate conciliation a year later she wrote me a letter in which she blamed me for the rift, said that she missed me as a friend, and asked that I never ask her out again. In the letter she also mentioned that she'd sought advice from a friend who told her that I was not a lesbian, but that I was getting myself to believe that I was one; and that being a lesbian is encouraged by the behaviour of the people surrounding one, and that the people surrounding me responded VERY negatively towards it. We are still good friends.

Again, I was winded with the following feelings: humiliation, pain, rejection, loneliness, sadness, insecurity, unhappiness, scared, failure, lowest ebb, distant, depressed, no one understands me, I want to die, confused, difficult existence, feeling sorry for myself, useless, inferior, negative, low self-esteem etc. These feelings got worse with the subsequent rejections from the long list of girls, whose names I do not remember anymore. Two examples that stand out were a public humiliation at a party in front of all my friends and everyone else there; another time it was more of a private rejection; I was torn by the aftermath laughter that I could hear from outside her room, she didn't know I was listening, it tore me, like a knife being twisted in my guts. Of course these girls weren't gay, so in hindsight, I shouldn't have taken it so hard, but I did; on both occasions I was drunk, but on both occasions the alcohol failed to dull the pain at the moment of execution and at subsequent moments when I revived these memories. I never told anyone for the fear of further pain and rejection.

Before then, at 15, I weaved a cocoon around myself and pledged not to share my feelings with anyone, I also became stoic to protect myself; I did this by standing in front of my wardrobe mirror and banging my head against the wooden wardrobe frame, I felt the excruciating pain, and worked at not converting it into a facial expression in the mirror. By my late teens, I was so good at



concealing all emotions, that when my mum died my aunt decided that I was to be the one to hold things together and comfort my older sister, I was 20 and my sister was 26. So although I was devastated with grief when my mum died I didn't cry; it was when my grandfather died three years later that the floodgates opened, it was the final straw, my grandmother had passed away when I was 17, and my grandfather had become my sole guardian following my mum's death. He was like a father to me, I was already doing my Masters degree in Wales, his last letter to me was signed off 'my fondest love, always yours affectionate'.

Drinking alcohol till I passed out was the only way I knew how to 'handle' and take a break from my emotions, when I wasn't doing that I was hiding behind my studies and dreaming of a better future. Alcohol placed me in many dangerous situations, one defining example was when I drank so much potent alcohol with two people I had just met on the day that I passed out for 24 hours straight, and thus narrowly missed witnessing one of these persons shooting the other one dead, I only found out about the tragedy on waking.

I abused alcohol until I was 29, then I weaned myself off the alcohol with marijuana, which was not a good idea because it exacerbated my escapism and worsened my depression and low self-esteem. I stopped taking marijuana in March 2008, and I am no longer dependent on alcohol. I am a professional, out gay woman with a cleaner (only once a month) and the freedom to live without cultural impositions or restrictions, just as I aspired to growing up. As for 'happiness', although the emotional baggage didn't feature in my daydreams, it is a reality and so I continue seeing my counsellor to try and undo the negatives, so far I have come to divorce myself from the shame and guilt, but I still struggle with trusting people, trusting my instincts and acknowledging my true feelings.

**Ntsundux**

## Useful organisations

### London Lesbian and Gay Switchboard (LLGS)

PO Box 7324, London N1 9QS  
tel : 020 7837 6768 (office)  
helpline: 020 7837 7324  
email: admin@llgs.org.uk  
web: www.llgs.org.uk

### Mind Out Cymru

PO Box 79, Carmarthen SA31 3XB  
email: contactwales@mind.org.uk

### PACE

34 Hartham Road, London N7 9LJ  
tel: 020 7700 1323  
helpline: 0808 1807 223 (for family and relationship support; Monday 9.30-12.30 and Thursday 3.30-6.30)  
email: info@pace.dircon.co.uk  
email helpline: pacehelpline@pace.dircon.co.uk  
web: www.pacehealth.org.uk

### Pink Therapy

Archer Street, London W1D 7AP  
tel: 020 7434 0367  
email: info@pinktherapy.com  
web: www.pinktherapy.com

### Stonewall

Tower Building, York Road, London SE1 7NX  
tel: 020 7593 1860 (office)  
free phone: 08000 50 20 20  
fax: 020 7593 1877  
email: info@stonewall.org.uk  
web: www.stonewall.org.uk

### Positively Women

LBT Support Group – monthly  
helpline: 020 7713 0222  
email: lbt@positivelywomen.org.uk

# HIV and Dementia

Simon Collins from HIV i-Base looks at the difficult issue of HIV, dementia and changes in brain function. The information is interesting, but we don't want people to panic – worry itself can make you think you have problems. But these issues will be important for some people now, and perhaps for all of us in the future.

## Introduction

One of the main worries most people have about getting older, is that we might lose the ability to think clearly and start to forget things. In many ways this is a natural part of aging that, for many people, is never connected to any specific illness. Sometimes though there is a diagnosed cause such as Alzheimer's disease.

When symptoms are mild, they are often easy to manage, but more severe neurological problems can change your whole life, making normal conversation and daily activities confusing or impossible.

So what does this introduction about aging have to do with HIV?

Partly, this is because as we get older, health issues that affect the general population, are just as important for us, perhaps more so. It is important to look at diet, exercise and smoking to reduce the risk of heart disease, for example. Partly though, it is because just like aging, HIV itself may also affect how well your brain functions. This is very rarely a factor in the short- or medium-term, but there is a concern that it might become an issue in the long-term.

Because we know that HIV gets into the brain, and can cause nerve cells there (called neurons) to die prematurely, HIV might be the additional factor that puts us at a higher risk of any of other complications.

In fact, prior to 1997 when effective treatment became available, HIV-related dementia was very common in people with late-stage illness.

Luckily, combination therapy (HAART) has dramatically reduced the incidence of HIV-related dementia. It has done this in two main ways. Firstly, the higher CD4 counts after treatment prevented many of the infections that are more common at a low CD4 count. Opportunistic infections (OIs) and other illnesses that can affect brain function (including toxoplasmosis, CMV, cerebral TB, some lymphoma), are all now much rarer.

Secondly, by reducing viral load levels in the brain and the fluid that surrounds it (cerebral spinal fluid, often abbreviated to CSF) this reduces the chance of HIV directly causing damage. As the level of HIV activation in the brain is related to viral load, being on treatment and getting an undetectable viral load, may protect against any direct brain damage by the virus.

The brain is our most complicated organ. But is it difficult to study because it is both physically difficult to get to, and because the symptoms of reduced brain function, can be affected by non-medical factors. For example, if you are stressed or worried about something, it is more common to forget other things.

Because the brain is closely related to feelings and thoughts, it can be difficult to link mild changes or symptoms to a particular cause, which, even if real, might not be a medical problem at all.

## Symptoms of dementia

A broad definition of dementia is related to a wide range of symptoms. These include:

- Changes in thinking, memory, concentration, decision making and solving problems (commonly called 'cognitive' changes);
- Personality ('behavioural') changes; and
- Changes in speech, balance, or becoming 'more clumsy' ('motor' changes).

While all these symptoms could be caused by common opportunistic infections or illnesses directly from HIV itself, many can be caused by non-medical factors including worry and stress. If you have noticed any changes over time, this is something to talk about with your doctor.

## ARV activity in the brain

The brain is difficult to study because it is both physically protected by the bone of your skull and protected within the body by a fine filter called the 'blood-brain barrier'. This barrier is good at keeping some infections out, but it also stops some drugs from getting in.

Studies of the brain often do not directly look at brain tissue, but they can still be invasive, even when looking in the fluid that surrounds the brain (the CSF). This is much more tricky to sample than blood, needing a lumbar puncture ('spinal tap') performed by an expert.

While we have a good idea about whether some HIV drugs get into the brain (see Table 1), we are not sure about whether this is at the right dose and how important this is clinically. We also know which drugs are not good at getting in to the brain, but in practice, HAART that uses these drugs produces similar responses to combinations with better CSF penetration.



In someone diagnosed with brain-related disease, using combinations that penetrate the brain are generally an important way to manage their HIV care. We don't know how important CSF penetration is though for people who currently have no symptoms. This is important to know, because although all combinations seem similar in the short-term, over a long period of treatment, perhaps 10 or 20 years, it may be that CSF penetration becomes essential.

As an area of research there are still so many outstanding questions:

- How effectively do individual HIV-drugs cross the blood-brain barrier?
- How important is this?
- How many drugs in a combination need to cross to the brain?
- Should we be worried about side effects from drugs that cross into the brain? (This is a subject that is rarely discussed).
- What is the effect of HIV itself on brain function?
- Are there different concerns in the long-term?
- Are HIV positive people at higher risk of traditional brain-related illness i.e. Parkinson's Disease and Alzheimer's?

Table 1: Which HIV drugs get into the brain (based on Charter Study)

Score = 0 (no active drug levels)
Tenofovir, ddI, Nelfinavir, PIs with or without Ritonavir: Saquinavir, Tipranavir
Score = 0.5 (some active levels)
d4T, 3TC*, FTC*, Efavirenz*, PIs not boosted by Ritonavir: Fosamprenavir, Indinavir and Atazanavir
Score = 1.0 (good levels cross to the brain)
AZT, Abacavir, Nevirapine; PIs boosted by Ritonavir: Fosamprenavir, Indinavir, Atazanavir, Lopinavir

\* recent data may change 3TC, FTC and Efavirenz to 1.0

## Latest research

Until recently, although we knew that these questions about HIV and the brain were important, there were very few convincing studies that could say what is going on in the context of HAART treatment.

This year at the retrovirus conference, several research groups suggested that this is an important area that's not going to go away. Indeed, the fact that the HIV population is aging, means this is going to become increasingly important.

A summary of these new studies included:

- Several studies showed higher rates of cognitive impairment in people with HIV compared to the general population. Some of these studies suggested that a quarter to one-third of HIV positive patients have a lower level of brain function.
- Generally, while HAART reduces CSF viral load in nearly everyone who had an undetectable viral load in blood, low levels of viral load in the CSF could still be detected by using a more sensitive test.
- Lower levels of viral load in the CSF were generally related to using HIV drugs that crossed the blood-brain barrier.

- An autopsy study showed that 75% of cases had evidence of brain damage, even though less than 20% had a history of possible brain-related complications prior to their death.
- A study of brain scans from 300 HIV positive people without symptoms found widespread evidence of inflammation and changes in chemical markers that are associated with nerve damage in the brain.
- Another study using scans found that blood flow to the brain was markedly reduced in people who had been HIV positive for longer than four years. The impact of HIV on blood flow was described as similar to aging by 15-20 years.

Luckily, for most people, the brain is a sanctuary site in the body where HIV is present in much lower levels and if it is causing any damage, it may be doing this very slowly, and in ways that do not affect day-to-day activity in the short-term.

The range and consistency of the above studies shows the need for more research, in order to predict whether CSF-related problems could become a major limiting factor to the otherwise successful responses to HAART.

## Conclusion

One of the comments from a colleague at i-Base, when I asked for suggestions for this article, was that if people think seriously about dementia, it is so worrying that they have to use humour to laugh about it.

While a degree of resignation to some level of reduced brain function is probably healthy – certainly in preference to obsessively worrying about something that may never happen – this will not be so helpful if you have early stages of an illness that is causing real symptoms.

If you think you have symptoms and they are getting worse, then speaking to your doctor is important. Some simple tests are easy to perform and can show if there is evidence to access more complicated testing such as CT or MRI scans.

It would also help in the management of this aspect of our health if BHIVA, the UK's leading organisation for doctors who treat HIV positive people, could take a lead in recommending which tests might be appropriate in different settings, and produced guidelines for how to address neurological disease in HIV.

## Further information

The i-Base phonenumber is a free confidential information service on 0808 800 6013. It is run by HIV positive people. Opening hours are 12.00 noon – 4 pm, Monday, Tuesday and Wednesday.

The lectures and presentations from the retrovirus conference are available online.

'Emerging patterns of neuropathogenesis on current ART'.  
Webcast Feb 11, 2009 10:00 AM

<http://www.retroconference.org/2009/data/files/webcast.htm>

# Lighter Shades of Blue

It is a truism that it often takes crisis to precipitate the necessary changes and so it was for me. In 2007, my life felt as though it was coming apart at the seams. I had to do something to help myself, I chose to enter psychotherapy sessions at the Helios Centre, it became the first of several therapies I engaged with: life-coaching and Shiatsu followed, that allowed the healing process to take root and for me to begin to feel as though I was getting my life back on track.

It was in psychotherapy that I came to acknowledge the influence and extent that depression had played in my life. It was a challenge to my self-image, certainly not how I would choose to describe myself. However, it didn't take much examination to realise there was a pattern to the low moods, the tendency to withdraw from the world. These were themes that had been playing out since childhood; unacknowledged feelings, negative thinking habits. My upbringing though loving was very stoical; it was understood we keep to ourselves that which is uncomfortable and challenges the status quo of the family, we wear smiles to please others, often disguising how we truly feel. We struggle through in silence until what is uncomfortable dissipates, is banished, or made to fit the mould. Such values were the crucible where my character was forged and my ability to be patient and endure honed.

In psychotherapy, I had found a safe space to look at the backlog of some of the most significant events of my life, most with unfortunate outcomes, that had influenced me from within my family circle. There were a substantial amount of issues from bereavement, suicide, drug and alcohol abuse, elderly abuse not to mention my own diagnosis and spending years fighting my own child custody case.

I had tried to do my best to deal with the issues rationally, shed my tears and find a place within to store the pain and carry on, but it kept spilling over unexpectedly, arresting me from my ability to communicate, be at peace, focus on my own and my children's future with a lightness of being that accompanies a joy of living. Everything was a struggle, my mind and spirit divided, contradicting itself. There were so many unspoken, barely acknowledged truths and something had to give. My mental health was shattering under the strain – I had to reach for that point of transformation – I knew it poignantly from my diagnosis years earlier. Instinctively I had rejected the medication I was offered and the vision of myself as an ill and helpless person. Though shocked and somewhat fearful, I fundamentally believed in my own healthiness and inner strength. I was very fortunate in the following years (mid '90s) that I came across Barbera Joseph's Yoga class for positive people. That has been a mainstay of maintaining this positive view of myself.

Barbera is a very experienced and special Yoga teacher who knows well how to apply the therapeutic and healing value of Yoga. Her classes are organised around the principle of each week focusing on a different chakra: These are energy centres of the body, particularly affiliated with the emotions, situated upon and connected by the meridians, the bodies' energy pathways. Illnesses can generally be viewed as imbalances or blockages of the energy system. Yoga assists in freeing these blockages thereby inviting the intelligence of the energy system to restore health and heal.

The postures or asanas are practiced in an exacting way; physical movement is correlated with the movement of the breath consciously. We are made aware of the postures and sequences that are extrovert in nature such as warrior pose and 'sun salute' respectively, these can be used to raise energies and the introverted postures such as forward bends conversely are used to quieten heightened energies. The aim is to seek balance for all the bodily systems and so the one and a half hour class progresses from relaxed warm up postures to more challenging asanas and their counter poses through to extended meditations focusing on breath work and visualisation, moving on to chanting and the class always ends on a resounding expression of AUM.



There is a sense of sanctuary and personal development for me in these classes. Friday mornings are the one time of the week I dedicate to myself, when all other considerations are set aside. I am stilled, my mind focused on the discipline before me... Invariably, I come away with my spirits lifted, fortified and feeling more orientated in the world. To reap the full benefit of yoga practice Barbera urges us to build a daily practice. That level of discipline is still for me a quest, yet increasingly within my sight. In addition to my efforts in Yoga, having acknowledged my tendencies to lapse into depressive episodes, I enrolled on a course at the Buddhist Centre entitled 'Meditation for Depression'. It is an eight-week course grounded in Mindfulness – based cognitive therapy.

Communally, you learn to acknowledge depression as a manageable state. It is demystified by examining its characteristics; much of the coursework is making very detailed observations of the self, starting at the foundational level: Awareness of the breath. There are many different exercises given to encourage awareness. For example eating a raisin mindfully, really noticing; Being with that experience. As your familiarity increases with observing the self in a kindly interested way, as opposed to the harsh voice of criticism and judgement with which we often diminish and hurt ourselves, we can approach Being with our unpleasant experiences without rejecting them, using the breath to manage our reactions even pain can be minimised in this way. If we are able to accept our experiences Choices naturally emerge, the implicit awareness means we are more likely to be able to make intelligent responses to a situation and avoid the old mental ruts, well worn pathways, where thoughts seem to 'pop into mind' and have a trajectory that relies on assumptions. This is being in autopilot and a definitive indicator to return to a simple awareness – of the breath: it is grounding, bringing you back to the moment.

One of the exercises that I found most helpful was to make a list of my top 10 habitual, automatic unhelpful thinking habits, including the issues that often triggered them. There were practical steps I took to challenge some of them and I made a decision to focus more on what nourished and supported me, things I enjoyed, that made me feel truly present and alive. In contrast, I determined to give less energy to that which depleted me.

A degree of mindfulness, being in the moment, has become a habit with me. I never fail to take pleasure in the scent of Jasmine, leaning across a garden fence and overhanging the pavement along my street; I sometimes stop to put my nose to it, I'm mindful that it is also a spot where invariably some dog mess is awaiting the less vigilant shoe.

The final sessions of the course are concerning recommendations of how to best take care of yourself, and prevent relapse into depression; there are often early warning signs that you might be heading for a downward spiral such as becoming irritable, not wanting to see friends, not wanting to deal with business – not opening mail, and changes in sleep patterns. We were

encouraged to develop an action plan to put in place in difficult times and enable as much control of the situation.

I found the course to be quite demanding, especially in terms of time commitments, completing detailed record sheets and listening to the instructional meditational CD's provided but ultimately it provided a template to re-train your mind from some potentially very damaging habits and reconnect oneself with their life's purpose.

A prevention tool for depression that I have taken to heart is: to do that which gives you pleasure and a feeling of satisfaction or mastery. I find my release and regular exercise in taking to my bike and pedalling at a pace through the Lea Valley park.

Specifically in relation to HIV, I've found that my mental health has been much more profoundly affected than my physical. I have been fortunate that my adherence to combination therapy has proved straightforward. The stigma, however, that's associated with HIV, directly relates to one's mental health. It is a persistent manifold struggle for acceptance without and within the self.

I feel that much more attention to mental health service provision for positive people could be given. There is so little that is readily accessible, unless a person is seriously ill. We are all aware of the wisdom of the adage 'prevention is better than cure'. I believe Yoga and meditation are particularly appropriate as potentially they can provide one with the knowledge and means to combat their condition, create their own healing and personal growth.

I think it is particularly revealing, that Barbera's Yoga class, so long established and who's membership is majorly comprised of long term survivors of HIV, is no longer deemed worthy of funding. Regardless of the politics of funding the class thrives, as we know what we have is far too precious to let economics dictate its existence.

Janine

### Therapy

therapy [thérrɒpi]  
n

1. treatment to cure: treatment of physical, mental, or behavioural disorders that is meant to cure or rehabilitate somebody (often used in combination)  
radiation therapy
2. North America psychotherapy: psychoanalysis or techniques from another school of psychotherapy, intended to treat mental and emotional problems with psychological methods

[Mid-19th century, Via modern Latin < Greek  
therapeia < therapeuein 'treat medically' <  
theraps 'attendant']

# Cate's Column

Recently as I was sorting through some boxes, which had been stored away in my mother's attic for the past two years, I came across this photograph of me looking like a film star!

It was taken at 'Altered Image' in Manchester, several months after I had been diagnosed positive, in the days when I thought that I would have died of AIDS by now. Dying of AIDS is not pretty and I wanted some beautiful photographs to leave my children to remember me by.

And it is a beautiful photograph but there is something wistful and sad about the eyes, that look beyond the lens, the photographer, the studio – trying desperately to reach into the future, with a message to convey to my children.

I love you. I miss you. I'm sorry. Forgive me – there are so many things to be forgiven for, a castigating litany of wrongs and mistakes. When you think that your life is limited, it is all too easy to reflect harshly upon yourself. That was certainly true of me. I didn't want to have any unresolved business when I died and that led to some severe navel dwelling and reflection, which often resulted in unnecessarily harsh self criticism.

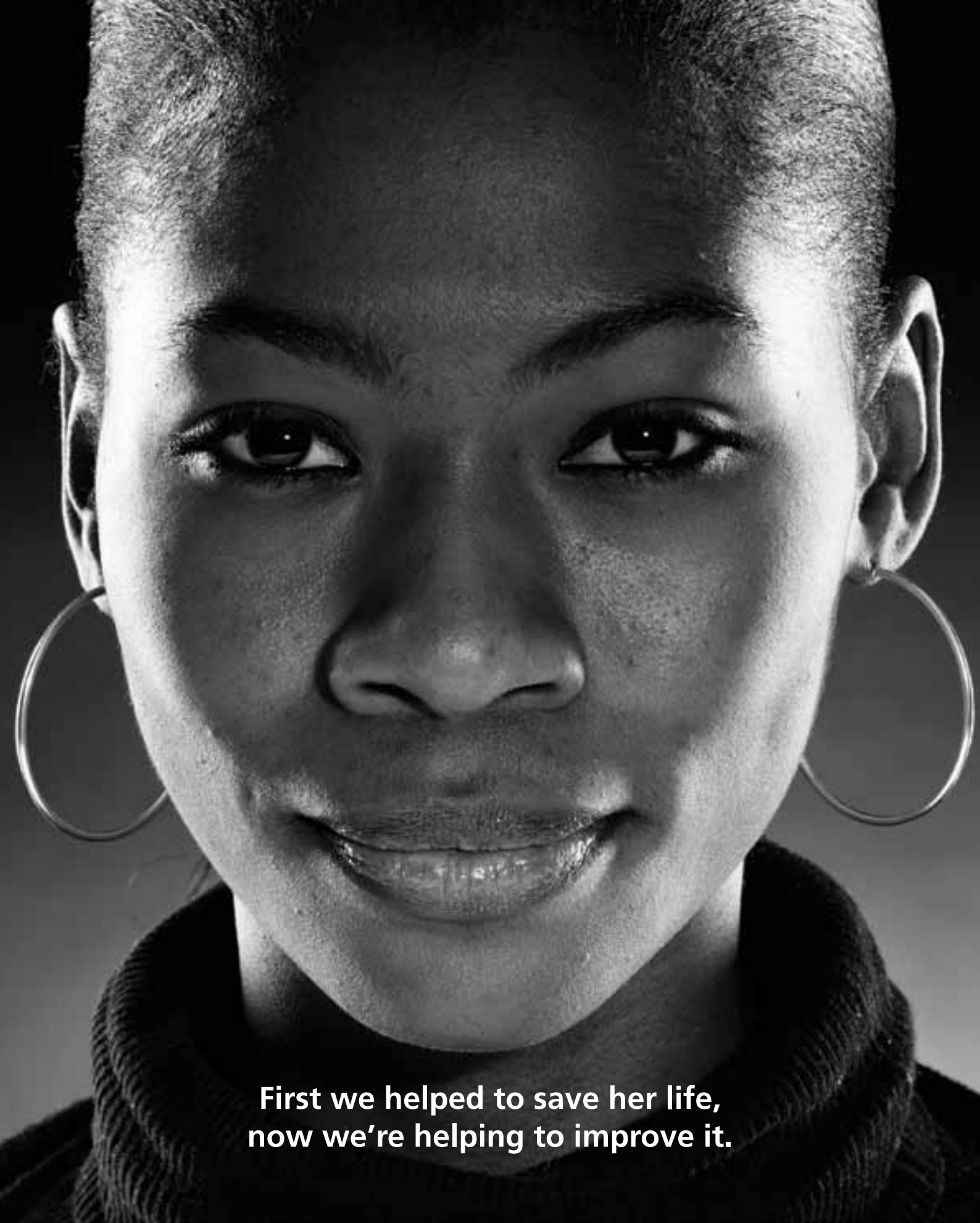
Fourteen years later I realise that actually what the woman in the photograph needs most, is my forgiveness. She wasn't a bad person. She made mistakes and has her regrets, but there are things about her that I loved. She was wild and passionate, crazy, playful and loving. She could sing like a siren

and laughter was never more than a smile away. She was resilient and resourceful – could make three lentils and a baked bean into the most amazing feast! All this and she still needs my forgiveness.

I suppose the problem lies in what we believe forgiveness to mean - that somehow to forgive means that you can erase or forget a wrongdoing; and what is a wrongdoing anyway - it's just a choice. Choices have consequences. The difficult bit arises when our choices have consequences for others. I can live with the choices I have made; it is not always easy to live with the consequences those choices have had for others; and that is what I was struggling with on the day that photograph was taken. No matter what I did, my diagnosis would resonate in the lives of my children for as long as they lived. It has been a heavy enough burden for me to carry, without knowing that they shoulder it too. Perhaps forgiveness does not mean excusing what has been done to us or by us; perhaps it means, no longer being willing to carry the pain of it.

Yesterday morning I was looking after my granddaughter, I held her in my arms and wondered what it would be like for her growing up with a positive granny and I realised she would never have known me any other way. It would be normal to her and suddenly the burden felt lighter. A tear rolled down my cheek. She touched it with her finger looked me in the eyes and asked: 'You alright?' and I replied: 'Yes, little moon. I'm alright.'





**First we helped to save her life,  
now we're helping to improve it.**



**Bristol-Myers Squibb**

**A future for people living with HIV**

# Mental Health and Well-Being

## Recognising the signs

Positively Women have been providing peer support to women living with HIV for over 20 years. The team of staff and volunteer case workers have witnessed an increase of the number of women presenting with mental health issues ranging from stress and anxiety to acute symptoms such as depression and schizophrenia. Identifying mental health problems and interventions at an early stage are vital to support people get help and prevent those problems escalating. Some of the signs the case workers look out for are obvious, other less so.

### Mental health – a holistic approach at the Mortimer Market Centre

A visit to the Bloomsbury Clinic at the Mortimer Market Centre demonstrates how one clinic manages the mental health and well-being of their patients, which they believe to be as important as physical health. 'After all, our patients are with us for life.'

The Bloomsbury Clinic takes a holistic approach to their patients' care offering a wide range of emotional, psychological and practical support and advice. There are four main areas in which they do this: a large team of Health Advisers, a Psychology Department, Patient Representatives and the Bloomsbury Patient Network.

The clinic also recognises that seeking help and support when needed, can often take a huge amount of courage and strength.

Mortimer Market Centre – Bloomsbury Clinic  
020 7530 5050

### Isolation

These days HIV is often described as a long-term and chronic medical condition, however unlike other conditions, HIV carries with it stigma. With stigma comes fear of prejudice and a reticence to disclose an HIV status for concerns of the repercussions for friends, family and community. This fear of disclosure, leads to isolation, with no one to talk to about problems, inability to seek help without explaining why help is sought, and the constant worrying of others finding out. The latter is often as a result of a bad experience around disclosure and Positively Women case workers have often heard women speak of partners who threatened to tell others of her status, preventing her from accessing services.

For some women this fear of isolation manifests itself in holding on to a problem. Women will return to discuss a single issue but will not want to move forward to seek resolution. The concern is that once that problem has been solved they will have no reason to seek support, and will be left alone again and isolated. In issues of isolation the importance of peer group and networks; providing a space where people living with HIV can talk in a confidential space on a regular basis, are paramount in tackling this issue that remains unique and dominant with an HIV diagnosis.

### Behaving in an irrational way

However, persuading people to come to a peer group is not always straightforward. For some there is what can be perceived of as an irrational fear around disclosure; women are happy to talk to a person on the phone or in person, but do not want to come into the building or meet other women living with HIV. The fear is that someone in the group will recognise her and tell others about her HIV status; despite the fact that those women are in the same position as her. In another case one woman who comes to groups every week sits apart and will not participate with other group members nor talk about problems, although it is known she is homeless and has immigration issues. On the occasion when she does talk, she is angry, her contribution random and out of topic. The reason for irrational behaviour could be that there is an underlying problem or problems that the person does not want to talk about, or perhaps cannot articulate. We are not always rational beings and sometimes understanding what

lies behind a problem, and what causes us to behave in a certain way, is difficult to grasp. This is where professional help such as counselling can help, giving a structured approach to tackling issues of mental health and well-being.

## Denial

Another key indicator is denial. This is a sign that people are not addressing the issues that are confronting them; not wanting to face the truth. Case workers have witnessed one client stating they were not on medications, despite presenting with signs of lipodystrophy, a side-effect of, and clear indication that they were taking prescription HIV medications. For some this denial comes in light of failing health and in some cases has led to women refusing to take medications, as they believe, contrary to their clinician, that they are in better physical health than they are. In another case a woman was convinced she had the wrong diagnosis, reiterating that the doctors have got it wrong; and returning for HIV tests until the day she would get a negative result.

As anyone who is HIV positive will know, receiving an HIV diagnosis can be devastating bringing issues of mortality, long-term health, reactions of friends and family to the fore. This has a huge effect on someone's mental health, and is one of the reasons counselling is so vital both pre and post testing. For people living with HIV and not on medications the issue of starting treatments can have a similar effect, requiring a change in regime to cope with the medications and forcing the person to confront many of those issues around health and mortality again. Many clients have compared commencing treatments to be diagnosed HIV positive all over again.

## Intention to commit suicide

Often people are left shocked when a friend or loved one commits suicide as there was no obvious indication or sign that they could pick up on. If someone is still talking about committing suicide, in some ways it's a positive sign and that person can still be helped. Giving the person time, engaging them in conversation and exploring their reasons for and against taking such action is the best support you can offer. Don't make a judgement and tell the person what they should or shouldn't do, support them in making their own decision and affirming why they should continue.

Hold on to those people, discuss their reasoning, not agree with this person as that will reinforce their belief; but not denying and saying they are wrong, then they will walk away, but supporting them to seek resolution and reach the conclusion that they are HIV positive in their own time.

## Support

Identifying mental health issues is one thing, but persuading people to recognise this and access support can be difficult. One way forward is to continue encouraging people to come and access services where support around stress, isolation and

overall well-being can be addressed. The role of peer support services in achieving this should not be under-valued: a secure space that enables people living with HIV to meet other positive people; identify common problems; put problems into perspective and draw on the experiences and strategies of others for engaging with and addressing problems is a major contribution in tackling mental health, and tackling it at an early stage. Likewise the role of counselling is hugely important for people who do not have access to peer services, cannot articulate concerns or just need that extra help. We are all likely to suffer from some form of mental health problem at some point in our life – recognising the signs and seeking the right help is nothing to be ashamed of.

To speak to the Positively Women Case Work Team call 020 7713 0222.

Sponsored by



### Positive East offers a range of mental health and well-being services for people living with HIV:

- Counselling and Psychotherapy
- Sexual Health Outreach Project
- Gay men's Interactions
- Re:Assure  
A newer addition to the service provides an opportunity for African women to work therapeutically with an experienced female psychologist around trauma.
- Recently Diagnosed Course

In August, Positive East will be launching a new Mental Health and HIV Toolkit.

The toolkit has been developed from mental health training sessions held at Positive East, and in response to comments from healthcare professionals who have not received specialist training in HIV. Non-specialist workers expressed particular interest in developing a good basic knowledge of the virus, and broadening the skills with which they can better support their HIV positive clients.

You can access Mental Health and Well-being services at Positive East by calling them 020 7791 2855 or emailing [info@positiveeast.org.uk](mailto:info@positiveeast.org.uk). For more information about Positive East visit [www.positiveeast.org.uk](http://www.positiveeast.org.uk)

# HIV and

I have been living with HIV for nearly a decade, and been doing quite well until a couple of years ago when I started undergoing other health problems. As a result, I've been through some really tough situations that have definitely had a huge impact on my emotional well-being.

There were days when I was so depressed I barely got out of the house; it was a psychological roller-coaster. When my stress and anxiety levels reached their highest, I started having horrible panic-attacks, nearly on a daily basis. I also developed phobias, which I never had before; sometimes they were so intense and overwhelming I felt out of control.

I found out about some organisations for HIV positive people and that offered different complementary therapies to help cope with a range of issues (stress and depression in particular). I didn't hesitate in contacting them; it was time to finally get some professional help. At the same time, I started seeing a psychologist at my HIV clinic.

My understanding of hypnotherapy was almost non-existent, and the little I knew was mainly from TV but that was far removed from what the reality. Worries like: Will I be asleep? Will I know what's going on? Will I be made to say silly things? vanished once I learnt more about hypnotherapy and realised that there's nothing to be sceptical about.

So what is hypnosis and what happens during a hypnotherapy session? Hypnotherapy is a therapeutic procedure that utilises hypnosis, which under other names, has been in use since ancient times. However, it is only in the past 50 years it has been introduced to physicians and dentists, and more recently to psychologists and other mental health professionals. Today, hypnotherapy is recognised as a highly effective method of personal development and to help cope with a variety of issues, enhance learning, heal emotional scars, improve performance, change habits and speed the healing process.

On my first hypnotherapy session, process was explained to me and the hypnotherapist began by reviewing my case and identifying my needs.

The strangest thing I learnt about hypnosis is that there is nothing extraordinary about it; it is a perfect natural condition. Hypnosis is a natural state of heightened relaxation and awareness, when you are able to open your mind to positive suggestions, and to use your own imagination to help improve your health and life quality.

It's true that any therapy is a process and a partnership: the patient brings knowledge of themselves and the therapist brings their skills. The key solution to the most beneficial results is a good relationship with the therapist, but of course in order to obtain that, communication, and trust are essential. The hypnotherapist will always co-operate with their patients in the most caring and gentle manner, while either by regressing back in time to find the root of the problem, or by using further progression techniques in order to change future situation.

I remember that every new hypnotherapy session was unique and I always felt in control of the situation, there was nothing that made me feel uncomfortable in any way. I was actually looking forward to my next sessions. My favourite parts were the visualisation and the progressive breathing technique. It was one the most satisfactory therapies I've ever experienced and the results were long-term and extremely beneficial, after only a few sessions both my therapist and I noticed a general improvement. I was energetic, I had a better appetite, my stress levels were going down while my confidence was boosting, I was self-motivated and optimistic again.

Of course this didn't happen over night, like any process it takes time. If you'd like to try hypnotherapy, you should first ask a professional's advice.

Anca

# Hypnotherapy

Whilst working with HIV positive clients, I have noticed a common issue that links many together, and that is stress. Although stress might not play a direct part on their lives in relation to their diagnosis, most of my clients have been living with their diagnosis for well over eight years; it certainly plays a part in their lives over all.

With the high-pressure lives that many of us lead (jobs, financial pressures, social pressures and family responsibilities), it's no wonder that we sometimes feel 'stressed out' or 'out of control' of our lives.

For clients living with HIV, these issues may be exacerbated with the extra health concerns, emotional vulnerabilities or social challenges faced.

Not all stress is bad. In fact, it protects us (initially) in many instances by priming the body to react quickly to adverse situations. This fight-or-flight response, also referred to as the stress response, has helped keep human beings alive when the environment demanded quick physical reactions in response to threats.

The problem in modern times and our everyday lives is that our body's stress response is regularly triggered even though our lives are not in danger. When the stress response is regularly stimulated it produces higher levels of stress hormones, Cortisol, in the blood stream and can contribute directly to the everyday headaches, upset stomach, high blood pressure, skin conditions, hair loss, racing heartbeat, back pain, and muscle aches we may be familiar with or experience.

Chronic and long-term exposure to stress hormones can damage the body as they can lower immunity and make people more susceptible to infections.

This is why stress-reduction strategies, relaxation, breathing and exercise, which have been shown to help reverse this effect (by

increasing the number of infection-fighting T cells and feel-good chemicals called endorphins in the body) and help prevent disease, is so very important for the HIV positive clients I see.

Medical research suggests that up to 90% of all illness and disease is stress-related, according to the Centers for Disease Control and Prevention.

I always work with stress-reduction strategies to help contribute beneficially to whatever client I am seeing and whatever issues the client brings to the session.

## Here are some techniques for you to try:

- Lying or seated comfortably, preferably somewhere where you cannot be disturbed. Take a full deep breath in filling up the lungs and abdomen, hold it for the mental count of four and let the breath out all the way as you close your eyes down. Take another deep and comfortable breath in all the way, hold it again for the mental count of four and let it out really slowly (twice as long and the in breath of possible!). Repeat the second stage five more times.
- On each and every out breath, begin mentally counting each number from one down to 10 and in between each number mentally say deeper relaxed. So it will go like this: Breath in naturally, then on the out breath mentally count one, naturally breath in again and on the out breath mentally say deeper relaxed. Breath in naturally, then on the out breath mentally count two, breath in naturally again, then on the out breath mentally say deeper relaxed... and so on until you have reached the number 10.

The above to can be done in succession or separately on there own.

**Lauren Hassan-Leslie**  
Clinical Hypnotherapist & EFT Practioner

# WHAT'S HAPPENING AROUND THE UK?

## BIRMINGHAM

Universal Women's Group and is on the last Friday of every month.

Contact Alex on 0121 622 6471 or email [alexbergman@abplus.org.uk](mailto:alexbergman@abplus.org.uk)

Terrence Higgins Trust Birmingham provides support or advocacy services for women living with HIV.

For more information contact Michaela on 0121 694 6440.

## BRIGHTON

The Sussex Beacon run a Women's Group and provide one-to-one support in Brighton. The group is run once a month from 10:30am - 3:30pm.

Contact Paula Evenden on 01273 645698 or e-mail [paula.evenden@sussexbeacon.org.uk](mailto:paula.evenden@sussexbeacon.org.uk)

## BRISTOL

Terrence Higgins Trust multicultural women's group. Monthly on Saturdays.

Contact Bonnie on 0117 955 1000, 11.30am-3pm

## CARDIFF

Terrence Higgins Trust. African women last Thursday of every month 1-4pm, women and carers group – 2nd Monday 11am-1pm, parents group.

Contact on 02920 666 465

## CORNWALL

Kernow Positive Support (KPS) has a new peer support group meeting monthly. Tuesday 10am-1pm drop-in for HIV positive women.

Contact KPS on 01208 264866 or visit [www.kpsdirect.com](http://www.kpsdirect.com)

## COVENTRY

Terrence Higgins Trust. Peer support service is available for HIV positive women. Women's social events are also organised.

Contact Kate and the Community Support Team on 02476 229 292

## DUNDEE

Body Positive Tayside – Care and support group offering a range of services for people with a blood borne virus. Women's group meets regularly.

Contact Kim on 01382 461424 [www.sol.co.uk/b/bptayside](http://www.sol.co.uk/b/bptayside)

## EAST ANGLIA

PLP – Support group for HIV positive women.

Contact 01502 537 985 or email [info@plpea.org.uk](mailto:info@plpea.org.uk)

Women Living Positively runs a monthly support group for infected and affected women.

Contact Joe on 01473 692 616 for more details

## EAST SUSSEX

Terrence Higgins Trust. African positive women's groups meet monthly in Eastbourne and Hastings.

Contact Caroline 01323 649927.

## EDINBURGH

Isis Women's Group for HIV positive women and affected women (carers or partners). Every Tuesday from 1-3.30pm at Waverley Care, Solas.

Contact Maro on 0131 661 0982

Waverley Care – Offers a number of services providing practical and emotional support to people living with HIV in Scotland and to their partners and families.

Contact on 0131 661 0982 or visit [www.waverleycare.org](http://www.waverleycare.org)

Positive Voice – Advocacy and support from other people living with HIV.

Contact on 0131 652 0754 or visit [www.positive-voice.org.uk](http://www.positive-voice.org.uk)

Positive Help – Practical support for people affected by HIV and AIDS.

Contact on 0131 558 1122

## ESSEX – SOUTHEND-ON-SEA AND THURROCK

Terrence Higgins Trust Safe Haven African Women's group monthly.

Contact Winnie on 01702 340 791 or 07766 428 355

## GLASGOW

Phace Scotland – Provides a range of services for people who are HIV positive.

Contact on 0141 332 3838 or visit [www.phacescotland.org](http://www.phacescotland.org)

Body Positive Strathclyde women's support group. Weekly, Friday 5-8pm.

Contact on 0141 332 5010

## HAMPSHIRE

Monthly Support group for women infected or affected by HIV/AIDS

For details contact 01252 345 019 or email [info@positiveaction.org.uk](mailto:info@positiveaction.org.uk)

## INVERNESS

Terrence Higgins Trust Scotland Highland Services. Free and confidential HIV, HepB, HepC testing, HepB vaccination. Welfare rights support, one to one support and monthly support group for HIV positive people.

Contact Agnes on 07816 064 752

## LEEDS

One-to-one emotional support. Every 2nd Monday 6-8pm, children welcome.

Contact Becki on 0113 236 4720

# WHAT'S HAPPENING AROUND THE UK?

## LIVERPOOL

Sahir House hold a monthly mentor-led women's peer support group.

Contact Serena on 0151 708 9080 or email [info@sahir.uk.com](mailto:info@sahir.uk.com)

## LONDON

Str8Talk – Islington. A multi-cultural self-help group for heterosexual HIV positive men and women.

Contact Str8Talk on 020 7812 1777

Riverhouse – Hammersmith, Weekly groups for HIV positive women 11am-4pm.

Call 020 8753 5190 for details.

## LUTON/BEDFORDSHIRE

Bbpositive HIV positive women's support group. Wednesdays 4-6pm. Food and refreshments available.

Contact Kirsten or Chrissie on 01582 484 499 or 01582 485 448 or visit [www.bbpositive.com](http://www.bbpositive.com)

## MANCHESTER

George House Trust HIV positive women's support group and African Service. Alternate Tuesdays.

Contact Lynda on 0161 274 4499

Body Positive North West women's support group. Weekly, Friday mornings.

Contact on 0161 873 8100

## SOUTHAMPTON

Ribbons Centre HIV positive women's group. Monthly, Wednesdays.

Contact Ginny on 0238 022 5511

## STOKE ON TRENT

Espirit Women's Group for HIV positive women. Fortnightly on Wednesdays from 11.30am-4pm.

Contact Rosie on 01782 201279

## WOLVERHAMPTON

Terrence Higgins Trust – Support for African women who've been diagnosed HIV positive, monthly on Thursday afternoon.

Contact Jane on 01902 711 818

## SURREY

Monthly Support group for women infected or affected by HIV/AIDS

For details contact 01252 345019 or email [info@positiveaction.org.uk](mailto:info@positiveaction.org.uk)

## SWANSEA

AIDS Trust Cymru. Monthly women's group 11am-3.30pm. Usually the first Wednesday of the month.

Contact Silvia on 01792 461 848 or visit [www.AIDStrustcymru.org.uk](http://www.AIDStrustcymru.org.uk)

**Please get in touch if you know of a group or service that can be included. Call 020 7713 0444 or email [losman@positivelywomen.org.uk](mailto:losman@positivelywomen.org.uk)**

## LONDON – POSITIVELY WOMEN'S SERVICES

### Support Groups:

#### Cara – Ladbroke Grove.

Weekly groups for HIV positive women. 11.30am-3.30pm.

Call 020 7745 7257 for details.

#### Positively Women – Islington

Monthly support groups:

- Tuesdays for Lesbian, bi-sexual and transgender HIV positive women
- Thursdays for HIV positive women
- Parenting groups for HIV positive parents
- Caribbean Group last Saturday of every month

Call 020 7713 0444 for details or crèche booking. Or see [www.positivelywomen.org.uk/supportgroups.html](http://www.positivelywomen.org.uk/supportgroups.html)

#### Riverhouse – Hammersmith

Weekly one-to-one sessions and groups for HIV positive women. Mondays 3-8pm.

Call 020 8753 5190 for details.

#### One-to-one sessions:

- General support
- Newly diagnosed support
- Immigration support
- Evening and daytime sessions

PW – call 020 7713 0444

### Outreach one-to-one sessions:

Homerton – call 020 8510 7996

Royal Free Hospital – call 020 7794 0500

### Complementary therapies:

Weekly appointments for Shiatsu, Cranio-Sacral Therapy and Hypnotherapy.

New Yoga class is drop-in term time, (outside school holidays) 11-12.30 on a Friday.

PW – call 020 7713 0444



Committed to you  
and your family