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Research Article

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Culturally Sensitive Approaches to Identification and Treatment of Depression among HIV Infected African American Adults: A Qualitative Study of Primary Care Providers' Perspectives

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Abstract

Background: Major depressive disorder (MDD) is highly prevalent among HIV-infected (HIV+) individuals, and is associated with non-adherence to antiretroviral therapy (ART), and accelerated disease progression. MDD is underdiagnosed and undertreated among low-income African Americans, who are disproportionately impacted by the HIV epidemic. To improve detection and treatment of depression among African Americans living with HIV/AIDS, it is important to understand culturally and contextually relevant aspects of MDD and attitudes about mental health treatment.

Methods: A focus group session was conducted with seven providers and staff at a primary care center that serves a largely African-American community heavily impacted by the HIV epidemic in Washington, DC. Data were analyzed using an inductive approach to distill prominent themes, perspectives, and experiences among participating providers.

Results: Five themes emerged to characterize the lived experiences of HIV+ African-American patients: (a) Changes in perceptions of HIV over time; (b) HIV is comorbid with mental illness, particularly depression and substance abuse; (c) Stigma is associated with both HIV and depression; (d) Existing mental health services vary and are insufficient and (e) Suggestions for optimal treatment for comorbid HIV and depression.

Limitation: This study reflects the views of providers from one clinic in this community.

Conclusion: Substantial economic disadvantage, pervasive childhood adversity, limited education and limited resources jointly put members of this community at risk for acquisition of HIV and for development of depression and addictions. These contextual factors provide an important reminder that any patient-level depression identification or intervention in this community will have to be mindful of such circumstances.

Keywords: HIV, Depression, African-Americans, Cross-cultural psychiatry

Introduction

Major depressive disorder (MDD) is a significant public health problem among individuals living with HIV. MDD is 2-7 times as prevalent among HIV-infected (HIV+) individuals as in the general population [1], and is associated with poor HIV viral suppression [2], a five-fold increased risk of HIV-Associated dementia [3], increased mortality and accelerated disease progression [4], antiretroviral therapy (ART) non-adherence [5,6] and substance abuse and ART non-adherence during pregnancy in HIV+ women [7]. The compounding effect of depression and HIV is particularly acute among urban-dwelling, low-income African Americans, not only because they are disproportionately affected by HIV/AIDS [8], but also because they are less likely to be accurately diagnosed with depression, to seek or access mental health treatment, or to receive adequate treatment when they do access care, compared to other ethnic groups in North America. There is, therefore, a critical need for novel approaches to identifying HIV+ African Americans struggling with depression and engaging them in appropriate care.

When applied to members of a specific minority group, evidence-based psychosocial interventions are significantly more effective if these interventions are adapted to incorporate cultural values and beliefs, and to recognize salient community-specific and socio-economic factors [9-13]. Yet, exactly which cultural factors need to be included and which specific components of an evidence-based intervention need to be adapted varies from one specific minority community to another [10]. With regards to depression specifically in African Americans, two recent literature reviews identified the following unmet needs: 1) the need for culturally appropriate diagnostic instruments to identify depressed individuals, 2) the need for proper training and cultural competencies of those who administer the instruments, and 3) the need for greater input from black communities into the questions being asked and the interpretation of results [14,15].

With a long-term objective to identify culturally and contextually relevant aspects of depression and acceptable help-seeking patterns in low-income African American communities, we sought input from a group of providers who serve one such community in Washington DC. With 2.5% of the population known to be HIV+, the DC epidemic

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exceeds the World Health Organization's definition of 1% as a severe epidemic [16]. In addition, although African Americans account for 48% of DC residents, they constitute 75% of all HIV cases, have the highest incidence of HIV infections, and account for the majority of new AIDS cases and AIDS-related deaths in the District [17]. Here, we describe the results of a focus group discussion, which aimed to understand the experiences of African Americans living with HIV and comorbid depression from the perspective of clinic providers and staff.

Methods

Design

This article draws upon a focus group data collected in the context of a 36-month study titled, "Adaptation of Effective Depression Screening Tool for HIV+ Low-Income African-American Urban DC Residents." The aim of this National Institutes of Health-funded study was to develop a culturally valid tool for detection of depression and develop a culturally adapted intervention for the community served by the Family and Medical Counseling Service, Inc. (FMCS) in Southeast Washington DC, with the overarching goal of improving depression outcomes and adherence to HIV treatment.

Setting and Participant Recruitment

FMCS provides co-located primary medical care and behavioral health case management services to a largely impoverished, medically underserved group of communities in DC. The center offers comprehensive medical care for HIV-positive persons through all stages of illness. Persons who test positive to HIV are given immediate access to care. Various types of support groups are available based on the needs and interests of the clients such as spirituality, decision-making, anger management, and substance abuse recovery.

The focus group included the FMCS providers and staff with training in medicine and social work. Providers and staff were made aware of the focus group by the chief executive officer via email. All providers and staff were invited to participate in the focus group. The 90-minute focus group took place at the FMCS and was recorded. Following the focus group, the audio recordings were transcribed. The two facilitators are clinical psychologists, one African American and one Asian American, who are part of this collaborative research team.

Focus Group Procedures

The focus group questions were semi-structured and inquired into the experiences of African American patients who were HIV+ who received services in this primary care community center and the interventions that are specific to their client population. Questions were open-ended and facilitators probed, as appropriate, to obtain more detailed and elaborate responses. Questions asked focused on several areas intended to better understand the current mental health of the population of interest, their existing mental health services, and obtaining perspectives of future services to address the comorbidity of HIV and depression. The facilitators further probed for any individual and community-level cultural, social, behavioral and attitudinal factors that are related to the concept of MDD and its associated comorbidities, in order to develop an adaptation of an evidence-based intervention for African Americans with co-occurring HIV/AIDS and MDD.

Study procedures were approved by the Howard University Institutional Review Board for the ethical conduct of research involving human subjects in accordance with the Declaration of Helsinki. Participants provided written informed consent to participate following a complete discussion of the study. Participants were provided buffet lunch and received $20 as compensation for their time.

Analysis

Using an inductive approach, four authors (HL, MH, SK, EN) reviewed the focus group transcripts to understand the experiences of providers and staff that could inform development of interventions for HIV+ African American patients with comorbid depression. We open-coded transcripts for narrative passages related to psychological issues that are affecting low-income African American HIV+ patients. Open coding is a process of labeling portions of text to identify and formulate ideas, themes, and issues suggested by the data [18]. Analytic codes constructed in the context of open coding are tentative and grounded strongly in the data [19]. Through ongoing immersion in the data set, two authors (HL, MH) proceeded to "focused coding," which utilized the provisional themes identified during open coding as the basis for more fine-grained analyses [18]. Through an iterative process of discussing emergent codes and re-reviewing transcripts to compare instances of particular codes, we reached consensus on the main themes presented herein.

Results

Focus Group Participants

The focus group included 7 providers with training in medicine and social work. All participating providers were African American (100%), the majority of whom were female (80%). Table 1 presents demographic characteristics of the study sample.

Qualitative data

We identified five key themes from the interviews: (a) Changes in perceptions of HIV over time; (b) HIV is comorbid with mental illness, including depression and substance abuse; (c) Stigma is associated with both HIV and depression; (d) Existing mental health services vary and are not enough; and (e) Suggestions for optimal treatment for comorbid HIV and depression. The principal themes from the focus group are outlined in Table 2. We discuss each theme and provide illustrative narrative examples below.

Changes in perceptions of HIV over time

The perception of HIV has changed over time: in the 1990s, HIV was a 'death sentence,' but one could get resources. Back then, the primary care center was viewed as source of stability by many patients. The following excerpts illustrate the participating providers' views: "(…) I was here back in '93 when HIV was out – 1994 – where, by far, the thing that depressed the most was they got HIV and that's changed a lot. At that time, (the patients) still had issues of trying to live with it, but they actually used to call the disease 'the gift or the golden ticket', because once they got it back then they got – the door opened. They got food, they got housing, they got all kinds of stuff (…)".

Characteristics	N=7
Female	5
African American	7
Occupation	2 - clinical social worker
	1- intake specialist
	2 - behavioral health counselor
	1- referral specialist
	1- clinical operations manager
Years of Service to FMCS	2: >20 years
	2: >10 years
	3: >3 years

Table 1: Demographic characteristics of focus group participants.

Principal themes and their descriptive codes
Changing in perceptions of HIV over time
• HIV was a 'death sentence' back in the '90s but one could get resources.
• Improved understanding of HIV led to health stability and longevity.
• Life stressors on how to live with the illness are experienced.
HIV is comorbid with mental illness, including depression and substance abuse
• HIV is highly comorbid with psychiatric conditions, including substance abuse and depression.
• Depression is very high and is contributed to and by HIV diagnosis, and lack of knowledge about HIV.
• Maladaptive coping is widespread, including substance use as form of dealing with stress and a form of avoidance of dealing with issues/being reminded of their HIV status.
• Childhood trauma is a source of avoidance, mistrust, and helplessness as well as a source of remarkable resilience.
Stigma is associated with both HIV and depression
• Significant stigma associated with having HIV+ status and comorbid mental illness in the African American community exists.
• Depression is used to refer to someone as "crazy" hence they keep mental health problems within the family in an attempt to hide from the outside world.
• Reverse stigma in undetectable individuals.
• Spirituality serves as an integral aspect of their dealing with the depression.
• Spirituality is less stigmatizing, and more acceptable way to talk about their mental concerns.
Existing mental health services vary and are not enough
• Changed over time due to different regulations and funding resources.
• Getting mental health services for individuals with HIV entail coordination among providers and staff as it requires multiple steps for referrals and wait times.
• Having access to an in-house psychiatrist is optimal and results in quicker care.
• Severe cases are often referred out, but there are some services in-house such as social work.
Suggestions for optimal treatment for comorbid HIV and depression
• Interventions for depressed HIV clients should be comprehensive and address the multiple stressors associated with trauma, depression, and substance abuse.
• Depression screening questions should probe for life stressors experienced by their client population.
• Group or individual therapy depending on the client need is vital to include psychoeducation about the illness.
• There is a need for creative individualized intervention approaches tailored to a specific client's circumstances.

Table 2: Outline of the principal themes from the focus group.

However, over time, improved understanding of the HIV disease and increased access to effective treatment have resulted in improved health stability and longevity among people living with HIV. Now there are different issues of how to live with this illness. Many patients have limited resources as the economy worsened over the years. Clients now experience more life stressors. "(…) before, they [patients] would come here and they'd say 'okay, I need tokens' or whatever and we'd say, 'oh, sure'. Now, we can't give you – a number of them get angry and they go 'you're not helping me. You're trying to hold something back.' (…) 'I know the government gives you money to give me' – or whatever. And so in a way, I see them seeing failure – a lot more failures. 'I'm going to fail. I'm going to try to get this, but it's going to be a failure.' "And after you've been told 'no' a number of times it really eats into what you feel about yourself and self-perception."

"And the other thing, too, is that a number of them [patients] are frustrated because they don't have what's necessary that's being requested of them (while) we [providers] are actually being asked more and more to make our patients more independent. They have to come here more frequently to fill out paperwork to get their Social Security benefits. They have to understand this to go get that – understand that – do that. And many of them (are) in the situation they're in because they don't have the educability that – the education level, the understanding to do that. So now, we're actually telling them you have to do more, (…) but the concept of – they just don't want to do a thing – they just want things for free."

HIV is comorbid with mental illness

All participants opined that HIV was highly comorbid with depression, as well as substance abuse and other psychiatric conditions, in this predominantly African American patient population. The high prevalence rates of depression and substance abuse are associated with the presence of an HIV diagnosis, and lack of knowledge about HIV. Depression is often a trigger for substance abuse as a way to self-medicate.

"(…) I go so far to say 100 percent of people say they're probably depressed on any given day. And the reason that they're depressed is because the first – when they first (find out about their HIV diagnosis) they probably don't have any information. So in their minds it's a death sentence and then even when they do get some information then they got to deal with the stigma – the people that don't have any information got to deal with. And because they're depressed they do get 'high.' They do use drugs. They do involve their self with a lot of negative behaviors because they don't have a sense of the future. They're living for right now. So when you're living for right now that's what you do. You get high [inaudible]. You try to feel good. So it's an uphill battle. It really is."

"And because of this stigma and the everyday stressors with the housing and the economic issues that everyone else has already brought up I'm seeing more substance abuse as a result of not being able to openly disclose or get treatment, not being able to talk to their family members, or having an outlet to discuss their issues. They're using substances to self-medicate."

The providers report that many patients have very limited options for healthy coping. As a result, maladaptive coping is widespread, including substance use. Providers view missed medical appointments as a form of avoidance of dealing with issues and being reminded of their HIV status. "(…) a lot of it has to do with everyday living and they actually – that affects how they do their medicines, it affects how they approach us, it affects whether they come back." Furthermore, acting out is a normative reaction to stress/frustration that has been modeled to many while growing up. Most patients have history of recurrent childhood trauma, which is viewed by respondents as another source of mistrust, avoidance and helplessness, as well as a source of acting out and substance use.

"(…) the process that they are in has resulted from a lot of unresolved childhood trauma that they have experienced and by the time they do become clients here they're really – they are adults, but they're really functioning (at) adolescent levels because of the trauma that has been in their lives. I find that probably 85 percent of the clients – males and females – have been subjected to childhood trauma, whether it was sexual (or) physical abuse that they experienced (growing up) – some as young as three years of age and on into adolescence and so forth. And as a result (the behavior) they have developed in their lives has been destructive behavior. And by the time they come here it takes extensive work (…) to help them to want to become empowered to live a more quality life."

"(Trauma) is real with many of the clients here – it's just so much has been suppressed and the pain of what they've had to live with (…) one of the clients shared with me where he was constantly – when he acted out he was beaten – and when he got old enough – which was about – I think he said he must've been about 12 – he started running away from home. And then by the time he turned 15 he left home completely and then got involved in the drug lifestyle and that's how he basically maintained his life."

Stigma is associated with both HIV and depression

There is a significant stigma associated with having a mental illness in this African American community. The term "depression", in particular, is only used to refer to someone as "crazy". As a result, there is often denial of the issue and/or an attempt to hide this from the outside world by keeping mental health problems within the family.

"What is evolving from our clients here is because the community that they have grown up in – there's always been a huge stigma in regards to mental health and mental illness and even getting help because in the community, the thought is always 'keep it within the family' so it's not a need to go to a therapist, not a need to go be seen by a psychiatrist. This is something that can be hammered within the family."

"I know in the intakes, when I do the screening tools – for mental health and substance abuse the clients – most of them are adamant. They'll say 'I'm not crazy.' 'I don't need to talk to a therapist.' 'I don't have those kinds of problems.' But some of the things that we discuss during the intake – sounds like depression, looks like depression, and the screening tool shows some depression, some anxiety. So in order to get them to buy in to seeing (the social worker), I say one of the best gifts you can give yourself is just to be able to talk things out with somebody."

With regards to HIV, there is what one staff member referred to as "reverse stigma", which ultimately contributes to distress. "I think we have gone backwards with the stigma a little. (…) People (have undetectable HIV viral loads) now, so they're taking that as 'I don't have to talk about my HIV anymore – whatever. So now I don't disclose at all'. And so it's creating a reverse stigma (…) – they don't talk about it anymore and they're still having unprotected sex or having sex – even in long-term relationships – people living with them who don't know their status. (…) So there's the stress of that: 'I'm carrying all this weight of my diagnosis that I really can't share with people or don't share." Spirituality is an element that cuts across the dimensions of depression in this population. The way the client population addresses their depression often involves utilizing some form of spirituality or philosophy that gives hope and meaning to life. Therefore, spirituality appears to serve as a valuable source of hope and an integral aspect of their dealing with the depression. In addition, many clients view spirituality as less stigmatizing, and thus a more culturally acceptable way to talk about their depression or other mental health problems.

"… if they do the self-screening and they say 'I've had depressive symptoms for the past two weeks' and you try to expand upon it – 'oh, no. I checked that? Oh, no, no, no. Change it.' And it's not true now that you want to have a discussion about it. And trying to use certain words like depression or anxiety – or [inaudible] sad – 'oh, no. I don't worry. I don't get sad. God's got it. I'm good. I don't need to. I have my people.' Normally, the people that they talk to – it's very few and they have to be loyal. 'Oh, no. That's not a snitch."

Existing mental health services vary and are not enough

The participants noted that available mental health services have changed over time – in part due to changing regulations and funding sources. Currently, the process of getting mental health services entails coordination among providers and staff, and requires multiple steps for referrals, resulting in protracted waiting periods to receive needed care. Having access to an in-house psychiatrist is optimal and results in more efficient care. Severe cases are often referred out, but there are some in-house services such as social work.

"We had two different psychiatrists that were consultants or part-time and it did make a tremendous difference during that period – the psychiatrist was on staff for the clients to be able to access immediately – being able to see the psychiatrist, get evaluated for medication."

However, with funding cuts, these psychiatrists were no longer available. As a result, there is now a more complex referral process that may lead to delayed treatment.

"The referrals – the clients that I get who are in need for a psychiatric evaluation – I have to utilize either Department of Mental Health for emergency ones and then for the other ones who need I have to go through Mental Health Access… And sometimes that can be,… maybe about a week to two weeks before they can be seen if the client is referred through Mental Health Access now, whereas (when) I give it to Department of Mental Health – if a client receives a referral to go there for an emergency evaluation they see them on the same day."

Suggestions for optimal management of comorbid HIV and depression

The focus group participants opined that ongoing life stressors and related distress had high relevance to manifestations of depression in this population.

"Stress is going to debilitate them. It's going to let everything else work negatively for them (…) I want them to deal with their mental health and because of low self-esteem and all that – they're not looking at their (mental health) – the only thing they can see is the (stressor) – 'I need housing'"

The participants' narratives also highlight the need for creative, individualized intervention approaches, often tailored to a specific client's life circumstances.

"I try to meet the client where the client is, (not where the) client should be, could be, we'd like them to be. (…) I (get) my best results when I meet the client where they are."

"I want them to deal with their mental health situation so what I say is the best way you get housing is through mental health. They're not giving it to you so if you want an apartment what you need to do is you need to get (a mental health) evaluation and then you probably can get some housing."

Recognizing the limited resources of the patients' lives, including incentives is important to increase intervention participation.

"We get more participation when we give out incentives because, quite frankly, they want incentives."

"So two staples (for any group intervention should be) transportation and food and you got an audience. The incentive is plus, but some will come just for food."

According to all participants, interventions for HIV+ clients who are depressed should be comprehensive and address not only the symptoms of depression, but also the multiple correlates of their depression, including trauma and substance abuse. Psychoeducation should be a significant component of such intervention.

"… not just getting some insight into what's going on with them – some insight and understanding of the disease (…) and behaviors that are attached to it, which – they might've thought that 'it's just me'. This is what I do – just connecting those dots and normalizing it – just giving them insight is so empowering, I think, to be able to see things differently and go on to do something else. So I think that would be my first approach."

"I find that (…) the more information you give to them to understand what depression is then the more they're able to utilize the information and take the steps that they need to take. And I find that that really makes a difference with our clients that we have here – is that although their educational level may not be (high) –they seem to always be open to information. And any information that you can provide to them that's going to help them to understand their condition, whether it's medical, whether it's mental health, or whatever information – they're open to it."

In terms of intervention modalities, the participants indicated this could be in the form of a group or individual, depending on the client need. The facilitators may vary depending on the content of the group - if dealing with depression, having a mental health provider as part of the team would help.

"I like the groups because there's always somebody in the group who is – at least one or two who is – acknowledges their depression and the treatment and can encourage other people that – it's okay. You can get through it and this is what I do and this (is) what I don't do. So the group always normalizes it or at least gets rid of some of the stigma that they may have going on inside of them and not able to articulate. So the group, to me, is a powerful tool in working through some of that."

"It's such a complex issue to try to have just one group of individuals – in some groups you're going to need three or four departments and people experiencing three or four ways – and some groups may be less, but overall, I truly find that it has to be a village of individuals who are going to care – treat. It has to be a village."

Discussion

The focus group participants, most of them working in this community clinic for over two decades, provided their perspectives on the determinants of depression and associated behaviors among HIV+ African Americans. The focus group yielded five themes: (a) Changes in perceptions of HIV over time; (b) HIV is comorbid with mental illness, including depression and substance abuse; (c) Stigma is associated with both HIV and depression; (d) Existing mental health services vary and are not enough; and (e) Suggestions for optimal treatment for comorbid HIV and depression. We discuss these themes below.

The perception of HIV has changed over years, as this once fatal, rapidly progressing illness has evolved into a manageable, chronic infection. The relative shrinkage of available resources has laid bare some individual patient-level barriers, including prevalent mental illness and maladaptive coping. This trend, combined with the providers' reports of insufficient mental health services, is very concerning not only because the most vulnerable patients are not getting the needed care and resources, but also because of the well-known relationship between untreated mental illness and antiretroviral therapy non-adherence, accelerated HIV progression, viral resistance, and transmission of HIV in the community. Stigma and unfavorable community-level attitudes towards both depression and HIV only help sustain the maladaptive coping that continues to impact the course and transmission of HIV infection.

The providers find HIV and depression to be inseparable in this population. Citing real interactions with real patients in this clinic, most participants drew connections between repetitive childhood maltreatment and running away from home, masked psychological distress, high-risk behaviors, and use of illicit drugs (either as part of the general risky behaviors or as 'self-medication' for their emotional distress) and acquisition of HIV. These views on the relatedness of maltreatment, psychopathology, and HIV have strong support in published epidemiologic data in the US and third world countries [20-23]. Fittingly, the providers find that social stigma is associated with both conditions, and interferes with the clinical efforts to identify individuals struggling with depression.

Unfavorable attitudes and stigma towards depression and other mental illnesses are well documented in Black communities in the US [24-26], but mostly in the context of their impact on utilization of mental health services. However, the implications of stigma to denial of symptoms, and therefore to biased responses to screening questionnaires for depression, raise very significant public health questions concerning the validity of estimated rates of depression in minority populations that share experiences that are similar to members of these communities. In the present study, some respondents revealed documented experiences where HIV+ patients with perceived behavioral correlates of depression deny those symptoms when completing validated depression screening tools approved for use in HIV+ populations. While expanding on symptoms of depression in screening sessions, clinic patients go as far as requesting that clinicians erase previously affirmed depression items.

Given the high relevance of the life stories and client's stressful daily events to their experience of depressive symptoms, asking depression screening questions without first probing for several stressors may be insufficient to identify depression in this population. One can hypothesize that a depression-screening approach that takes this context into consideration might elicit more valid and reliable responses on items of depression. A context-based approach is one that enquires about depression in the context of the patients' daily experiences, such as how they are handling their HIV disease and treatment or health in general. Indeed, our ongoing pilot (unpublished) survey using context-based adaptation of a validated depression tool in HIV+ clients in this community is revealing higher sensitivity for depression compared to the parent depression tool. The fact that same person who previously denied items of depression in a screening tool now responds affirmative to these items in context-based adaptation, probably suggests that attribution of symptoms to context is more acceptable than acknowledging those symptoms in isolation from the context (as the latter is interpreted as 'being crazy').

In the present study, the providers indicated that interventions for depression in their patient population should be comprehensive and address the ongoing stressors, trauma, depression, and substance abuse experienced by their patients. This proposed treatment could be in the form of groups or individual sessions, with the former modality providing an opportunity to effectively address the stigma. The benefit of such a peer effect in encouraging changes in health behaviors have been widely demonstrated [27]. Regardless of the proposed modality of depression intervention, a great degree of flexibility was encouraged, often with incentives to encourage uptake and consistent participation.

A unifying theme running through each of the five themes was the providers' accounts of the life-long social struggles for members of their catchment population that jointly put them at risk for acquisition of HIV and for development of depression and addictions. While the objective of this study was to identify aspects of depression that would help identify and treat depression in individual patients coming from this community, this powerful undercurrent of contextual factors is a reminder that any individual patient-level depression intervention in this community will have to be mindful of those circumstances, and suggests that additional structural and policy-level interventions may be needed to identify and address the contextual factors which create pretext for and perpetuate symptoms of depression.

This study has some noteworthy limitations. The relatively small number of providers and invitations of providers from just one clinic in the community did not enable us to get wider perspectives on this challenging problem. Nevertheless, the providers represented a diverse group of professionals who provided a consistent picture of the current state of services at this primary center. Also, non-inclusion of patients during this qualitative survey of providers might have limited our ability to validate the providers' view. However, this may not be the case, as a subsequent focus group session we conducted on patients from this community did not yield additional information. In conclusion, our focus group of providers and staff in a community primary health center serving a largely impoverished inner-city minority population in Washington, DC revealed very important themes that illuminated the unique experiences of depression in this population, providing useful guidance for efforts to improve identification and interventions for depression. Future qualitative and quantitative studies are needed to validate these findings and provide firm data to inform appropriate prevention, prompt identification, and comprehensive management of depression in these communities ravaged by HIV/AIDS. In the absence of such adapted approaches, many low-income HIV+ African-Americans will continue to progress to AIDS due to effects of a treatable comorbid condition of major depression, even as the HIV infection itself is becoming a more manageable, chronic condition in the general population.

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