NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS

Position Statement

HIV/AIDS

HIV/AIDS has become a serious global health and psychosocial crisis, with at least 40 million infected individuals worldwide. It not only strikes adults, but also children and adolescents. In some developing countries, more than 40% of all live births involve HIV-infected children. Epidemiological data from the U. S. Centers for Disease Control and Prevention (CDC) indicate that approximately 950,000 U.S. citizens are infected with HIV, and 280,000 (30%) do not know they are infected (CDC, 2004a).

The CDC also estimates that there are 9,300 cases of pediatric HIV/AIDS (i.e., patients < 13 years) in this country, with 82% from African American and Latino communities (CDC, 2004a). The rate of pediatric AIDS has dropped dramatically, and most HIV-infected children now live through their school-age years and beyond. Public schools must prepare for their enrollment. Almost all current cases of pediatric AIDS involve infants born to mothers with HIV infection. Mother-to-child HIV transmission can occur during pregnancy, during delivery, or postpartum through breast-feeding. However, aggressive use of highly active antiretroviral treatments (i.e., HAART) during and after pregnancy has dramatically reduced the number of infected infants. The National Association of School Psychologists (NASP) supports HIV screening during the pregnancy of women.

In contrast to pediatric cases, adolescent HIV infection most often results from risk-taking behaviors at a time when teens are in school. Current CDC data indicate that almost one-half of all 9th through 12th graders are sexually active, with a steady decline in the age of sexual debut (CDC, 2004b). NASP strongly believes that prevention of adolescent HIV infection will depend, in part, on the school-based use of empirically supportable prevention curricula in the broader context of health or sex education.

EPIDEMIOLOGY OF HIV/AIDS

NASP recognizes that HIV/AIDS must be considered in the context of gender, ethnicity, and social class. A woman's elevated risk of HIV infection results from her greater physiological vulnerability to viral infection, vulnerability arising from the social exploitation of women, and violence against women. This risk is exacerbated in situations of social upheaval and economic hardship. African American women are 25 times more likely than European American women to have AIDS. NASP also recognizes that conditions of poverty are related to the incidence of HIV/AIDS. Financial and psychiatric stress, compromised health status, limited access to community services, and drug and alcohol abuse are more prevalent among family members of children with HIV. Homeless and runaway teens represent the greatest HIV risk profile in the United States. Among runaways, unsafe sex in exchange for drugs or money is common.

CONSEQUENCES OF PEDIATRIC HIV

Medical consequences. The HIV virus enters the central nervous system (CNS) shortly after infection. (See Llorente et al., 2003, for details). In the absence of treatment, consequences of infant HIV infection can be devastating because immune and neurological systems are still developing. Unlike adults who experience neurological symptoms later in the course of their illness, a disordered neurological system (i.e., progressive encephalopathy) occurs early, and serves as a marker of HIV infection in young children. Impaired brain growth, motor dysfunction, and developmental delays or regressions are among neurological sequelæ of HIV infection. These effects impact the child's cognitive, motor, language, and social–emotional development.

In the case of adolescent infection, HIV affects a fully developed, intact nervous system. Thus, the neurological deficits associated with pediatric HIV are not as apparent in adolescents and the illness progresses less rapidly. Indicators of neurological involvement in adolescents include general mental slowness, impaired concentration, mild memory loss, and motor skills impairment.

Psychoeducational consequences. Children with HIV present complex, individual differences. Because the disease advances more rapidly in children, the child's performance across various domains of functioning may change regularly (Wachsler-Felder & Golden, 2002). Ongoing progress monitoring should track the course of these changes. For preschool-age children, assessment should occur every 6 months, and for those 5 years or older it should occur once per year. The foci of progress monitoring should include all concomitants of HIV (i.e., cognitive, language, motor, and psychosocial functioning). The longitudinal perspective from this assessment will inform changes in intervention planning for the student with HIV. Instrument selection for progress monitoring must correspond with potential language delays and executive function (e.g., attentional) deficits. NASP believes the student with HIV will benefit from interdisciplinary assessment and services, including disciplines of school psychology, special education, physical therapy, occupational therapy, speech and language pathology, social work, and school nursing. Although the child with HIV in school may have serious academic problems, these psychoeducational impairments are not unique to the disease, and these children can benefit from existing early intervention and special education services for those with other developmental disabilities.

Psychosocial consequences. The psychological and social issues associated with HIV are compelling. Children with HIV may evidence higher rates of social withdrawal, flat affect, as well as depression and anxiety. HIV forces the child to confront chronic illness and the possibility of their own death, with concomitant fear of loss of abilities, social stigma, and the likelihood that family members may have the same disease. Many infected children did not receive sufficient prenatal and postnatal care, and many had in utero exposure to heroin, cocaine, alcohol, and/or nicotine. Death of a parent from AIDS, and the resulting instability in family living arrangements, should be anticipated. HIV is most prevalent in economically and socially oppressed communities. This fact serves to exacerbate the personal crises caused by HIV/AIDS.

The stigma associated with AIDS presents a major problem for families of children with HIV. The dread of ostracism can delay detection and efforts to access needed services. In addition, extended

family members may fear catching the virus and remain distant, leading to social isolation. (See Battles & Weiner, 2002, for a discussion of "safe people" who can provide social support.) The resulting loss of a family support network exacerbates the vulnerability of the child. A child's exposure to psychosocial stressors may worsen the medical course of pediatric HIV. In addition, some parents are reluctant to have their children in the same classroom with a student with HIV, leading to intense emotional reactions in some communities. In response, AIDS-related stigma and contamination concerns from school staff and members of the community must be confronted.

PREVENTION

NASP recognizes that implementation of effective strategies to prevent HIV transmission represents a global imperative. To reduce mother-to-child transmission of HIV, NASP believes it is essential that all women have access to high quality, confidential medical care that includes early detection of HIV infection, family planning services, comprehensive prenatal care, and antiretroviral therapy. In addition, NASP concurs with the World Health Organization (WHO) position that prevention of the sexual transmission of HIV is accomplished through a combination of strategies including abstinence or delay of sexual initiation, being faithful to one's partner, and correct and consistent use of condoms. Prevention efforts also occur within families, where protection against HIV transmission can be provided by the health beliefs and healthy behaviors taught in the home, and in the way families discuss sexual matters (Tinsley, Lees, & Sumartojo, 2004). Further, NASP believes school psychologists must be at the forefront of prevention efforts to reduce the risk of HIV transmission, as well as intervention efforts to address psychosocial needs of children with HIV, and to foster their full inclusion in the community. Finally, NASP strongly believes that services to prevent adolescent HIV must be broadly designed to address all aspects of healthy adolescent development, and include efforts to keep teens in school (Goodenow, Netherland, & Szalacha, 2002).

School-based prevention efforts should include:

Safety precautions in the school. NASP recommends that all members of the school community, including school psychologists, receive training in the CDC's Universal Precautions concerning exposure to blood and other bodily fluids. This training should occur regardless of the known presence of a student with HIV (see National Association of State Boards of Education, 2001). NASP believes instruction in these Universal Precautions should begin at the preservice level of professional training.

HIV/AIDS education for students. Schools must address all social and health problems relevant to a student's learning. NASP supports the CDC recommendation that age-appropriate AIDS education be provided at all grade levels to increase the likelihood that high-risk behaviors will be prevented before they become firmly established and resistant to change. NASP believes an AIDS prevention curriculum should:

- be jointly developed by school psychologists, parents, teachers, school administrators, health educators, and appropriate community representatives

- be designed to fit with the specific prevention needs and cultural norms of the group to which it is delivered
- be infused into a more general health education program
- provide scientifically accurate information about the various modes of HIV transmission and effective methods for reducing the risk of transmission
- be taught by general education teachers in the elementary grades and qualified health educators in secondary grades
- describe the benefits of sexual abstinence for young people and, for teenagers approaching the potential age of sexual debut, address ways to reduce the risk of HIV infection and other sexually transmitted disease. This should include discussion of the correct and consistent use of condoms
- be guided by empirical demonstrations of program efficacy, monitored periodically to determine effectiveness, and modified as necessary
- include guidelines to address the epidemic of HIV/AIDS stigma. School-based curricular efforts typically stress virus prevention, but often overlook social reactions to those already infected. NASP believes the stigma surrounding HIV can be a formidable obstacle in the design and implementation of prevention education at school. NASP recommends the infusion of psychological and social constructs throughout school-based AIDS programming

HIV/AIDS education for school personnel and parents. NASP believes all school personnel should be educated about physical, psychosocial, and developmental aspects of HIV. School personnel and parents must recognize and address their own feelings and personal concerns regarding AIDS. HIV/AIDS education can alleviate fears and, thus, promote acceptance of children with HIV. Furthermore, school personnel and parents who are knowledgeable about HIV/AIDS are better prepared to educate children and model appropriate behavior and attitudes. Given their training in psychological and educational principles, NASP believes school psychologists should advocate the use of empirically supportable HIV/AIDS training programs that promote prevention education and address psychosocial issues surrounding AIDS. (See Kirby, 2002, for details regarding empirically supportable prevention curricula.)

INTERVENTION

Confidentiality/disclosure/legal issues. At the federal level, civil rights law protects HIV-infected students and school staff from discrimination. Often, state law determines whether professionals at school (e.g., a superintendent, school nurse) should/must be informed of a student's HIV status. NASP strongly recommends that school psychologists and administrators become familiar with relevant laws in their state. As a general rule, NASP believes only those who have a legitimate need to know should be informed of a child's HIV status. In some cases, this may mean classroom teachers and school psychologists will not have access to this information unless it can be documented that such disclosure will benefit the child, and a parent has consented to its release. Regardless of individual decisions regarding disclosure, school personnel must be formally prepared to handle the spread of HIV-related rumors among students and staff.

Psychoeducational interventions. NASP believes multidisciplinary teams should be involved in the assessment, intervention planning, and outcome evaluation of children with HIV. NASP

advocates a repeated, comprehensive, developmental assessment to describe the child's changes over time. This assessment should focus on current cognitive functioning, psychosocial status, the nature of physical impairments, receptive and expressive language, attention, memory, perceptual–motor skills, academic skills, and adaptive behavior. NASP affirms the rights of children with HIV to a free and appropriate education in the least restrictive environment. If special education services are needed, preschool children with HIV will qualify under IDEA because of the likelihood of developmental delay, and school-age children will qualify under IDEA if the disease adversely affects educational performance. Students with HIV can be considered "handicapped" according to Section 504 if they experience HIV-related cognitive and physical impairments, as well as discrimination and ostracism related to perceived contagiousness.

Psychosocial interventions. NASP recommends that issues of social contamination and stigma be considered in all decisions regarding children with HIV and their families. Negative reactions from classmates and school staff must be addressed through proper education. School psychologists can reduce children's social isolation by gaining greater knowledge of HIV/AIDS and by training others through inservice presentations that reduce the fear of contagion. NASP believes schools must work to protect children with HIV from the ostracism that frequently accompanies HIV/AIDS. Pediatric HIV may indicate the presence of AIDS in other family members, and these individuals will experience intense emotional strain, social stigma, and bereavement. NASP strongly believes schools must address family issues from a culturally relevant perspective, and should lead the community in a reasoned response to HIV/AIDS.

Bereavement issues. The health of school-age children with HIV tends to decline over time, and can lead to departure from school, and hospital-based care. NASP believes school psychologists must assist children with bereavement issues at school. These issues may include students' bereavement due to the death of a classmate, AIDS-related deaths of teachers and other school staff, as well as deaths of family members of the infected child. School psychologists should be knowledgeable about children's developmental differences in understanding death and specific helping behaviors to use in school. In addition, school psychologists must recognize the child with HIV may experience family disintegration. AIDS not only creates orphans, it causes other major stressors for children, such as witnessing the medical deterioration of a loved one, moving to live with an extended family member or foster parent, and/or legal battles regarding custody.

Research and training. NASP believes school psychology should contribute to the limited research base regarding psychoeducational and psychosocial consequences of HIV/AIDS among children and adolescents. This research is essential to better serve children with HIV, and to meet the needs of others indirectly affected by the illness and its stigma. School psychologists should also accept this mission by sensitizing colleagues and training graduate students about the complex issues surrounding HIV disease. NASP also believes school psychologists must become actively involved in systematic program evaluation of school-based AIDS curricula to refine the knowledge base of empirically supportable interventions.

SUMMARY

NASP believes schools can no longer react to exigencies of society by focusing exclusively on children's academic competence. The diverse and changing needs of the community, plus increased political and social pressure for health care reform, require public schools to address the general health of students and their families. This includes provisions for students with HIV/AIDS. NASP strongly urges its members to work with schools and communities to slow the spread of HIV infection and improve the lives of all those affected by it.

NASP advocates the use of safety precautions and empirically supportable school-based curricular interventions as the best-practice defense against the spread of HIV/AIDS. In addition, NASP believes school psychologists must be in a position to support students and families affected by HIV/AIDS. Because of the complexity of issues and concerns, the school psychologist will be one of many professionals who must respond to the needs of children with HIV.

REFERENCES

Battles, H. B., & Weiner, L. S. (2002). From adolescence through young adulthood: Psychosocial adjustment associated with long-term survival of HIV. *Journal of Adolescent Health, 30*, 161–168.

Centers for Disease Control and Prevention. (2004a). HIV/AIDS Surveillance Report, 2003 (Vol. 15). Atlanta: U.S. Department of Health and Human Services, Center for Disease Control and Prevention. Also available at http://www.cdc.gov/hiv/stats/hasrlink.htm

Centers for Disease Control and Prevention. (2004b). Youth risk behavior surveillance: United States – 2003. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention. Also available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5302a1.htm

Goodenow, C., Netherland, J., & Szalacha, L. (2002). AIDS-related risk among adolescent males who have sex with males, females, or both: Evidence from a statewide survey. *American Journal of Public Health, 92*, 203–210.

Kirby, D. (2002). Effective approaches to reducing adolescent unprotected sex, pregnancy, and childbearing. *Journal of Sex Research, 39*, 51–57.

Llorente, A., Brouwers, P., Charurat, M., Magder, L., Malee, K., Mellins, C. et al. (2003). Early neurodevelopmental markers predictive of mortality in infants infected with HIV-1. *Developmental Medicine and Child Neurology, 45*, 76–84.

National Association of State Boards of Education. (2001). Someone at school has AIDS: A complete guide to education policies concerning HIV infection. (Retrieved October 22, 2004 from http://www.nasbe.org/HealthySchools/Safe_Healthy/sasha.html

Tinsley, B. J., Lees, N. B., & Sumartojo, E. (2004). Child and adolescent HIV risk: Familial and cultural perspectives. *Journal of Family Psychology, 18*, 208–224.

Wachsler-Felder, J. L., & Golden, C. J. (2002). Neuropsychological consequences of HIV in children: A review of current literature. *Clinical Psychology Review, 22*, 441–462.

RECOMMENDED RESOURCES

Professionals interested in school-based health education are encouraged to consult the Sexuality Information and Education Council of the United States (SIECUS) website at: http://www.siecus.org

HIV: Issues for teenagers, your legal rights, prepared by the AIDS Legal Council of Chicago, is an excellent resource for adolescents. This booklet can be downloaded as a PDF file at http://www.aidslegal.com/media/pdfs/teens.pdf

For those interested in legal issues, Megalaw.com, at http://megalaw.com/top/aids.php, provides a comprehensive directory of HIV and AIDS case law, as well an exhaustive list of web-based sites about HIV/AIDS law.

The National Association of State Boards of Education offers recommendations to school districts regarding HIV-related education policies. Healthy schools: Someone at school has AIDS can be accessed as a PDF file at: http://www.nasbe.org/HealthySchools/Safe_Healthy/sasha.html

Assistance in responding to these and related crises, and information about dealing with loss, can be found on the NASP crisis resources website at http://www.nasponline.org/NEAT/crisismain.html

Adopted by the NASP Delegate Assembly on July, 2005.

Please cite this document as:
National Association of School Psychologists. (2005). *HIV/AIDS* (Position Statement). Bethesda, MD: Author.

© 2005 National Association of School Psychologists, 4340 East West Highway, Suite 402, Bethesda, MD 20814