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ABANDONED CHILDREN

MAJOR CATEGORIES: Abandonment; Emotional Abuse

DESCRIPTION

Abandonment is a legal term that refers to the willful desertion of a child by a parent or guardian. Desertion may include the acts of leaving a child unattended without regard or care for his or her health, safety, or welfare and/or otherwise severing all care and support for the child. Abandonment of a child may also be presumed if a parent, having left a child with an appropriate person or agency (such as a hospital), does not contact or provide support for the child for a period of time specified by law. To meet the legal definition of child abandonment, the child must be under 18 years old and the parent must have legal custody and leave the child with the purpose of abandonment.

The main causes of child abandonment in the United States are poverty, parental mental illness and/or parental substance abuse, and inadequate social welfare support for families. Communities with weak social welfare systems experience higher rates of child abandonment because of the lack of financial and other support for families. In developing countries, the contributing issues for child abandonment include high levels of poverty, high levels of HIV/AIDS, diminishing support from immediate and extended family, inadequate numbers of orphanages, and restrictive adoption policies.

An extreme form of child neglect, child abandonment is a crime in the United States. In 1999, Texas was the first U.S. state to implement a safe-haven law, which enables a parent to leave an unharmed newborn baby at any site or location permitted by law (such as a hospital or fire station) without fear of prosecution. Safe-haven laws, which now exist in all 50 U.S. states, were implemented in an effort to prevent the unsafe abandonment or death of newborns.

A social worker may become involved with the care of an abandoned child through a hospital or child welfare agency where the social worker's role is to provide essential intervention and treatment

that are essential for the abandoned child's well-being. Effective treatment may include crisis intervention, individual and family therapy, formal and informal support programs, financial assistance, and medical care.

Children who are abandoned, particularly in countries without well-developed foster-care systems, are often placed in institutional settings in which they experience social and emotional deprivation. The impact of abandonment and institutionalization on children's development has been measured by the Bucharest Early Intervention Project, which conducted randomized controlled studies of the development of abandoned children in Romania starting in 2000 by comparing subjects of standard intervention (institutional rearing) to subjects placed in high-quality foster care and to a control group of children reared by their families. Among the findings was the existence of sensitivity periods during which children can "catch up" from delayed development but after which catching up is unlikely. In the children who remained institutionalized the study found lower IQs, deficient attachment skills, delays in language development, higher rates of psychiatric illness by age 4 1/2, delayed brain maturation and smaller brain volume, and shorter telomeres (areas on chromosomes that provide protection from the stress of cell division).

FACTS AND FIGURES

Child abandonment occurs in every type of community, on every social level. Countries with thriving social structures and liberal adoption laws usually have lower rates of abandonment. An estimated 7,000 children are abandoned annually in the United States. Child abandonment that occurs as a result of disease, poverty, and civil war is a pressing issue in many countries. By some estimates, for example, thousands of children are abandoned each year in Venezuela and Colombia. In China, the one-child policy in effect since 1979 has resulted in the abandonment of as

many as 1.7 million female babies annually. In South Africa approximately 3,500 babies were abandoned in 2010.

RISK FACTORS

There are several factors a social worker should identify when assessing a child or family for risk of abandonment: the mental health and physical health issues in the parent or the child; previous social service involvement; history of child maltreatment; lack of medical insurance; poverty; unwanted pregnancy; intimate partner violence; parental criminality; death of one or both parents; and parental or child substance abuse.

SIGNS AND SYMPTOMS

Psychological signs and symptoms abandoned children may have include feelings of low self-esteem/self-worth, feelings of shame and guilt, few or no coping skills, inability to experience empathy or sympathy, anxiety or depression; flat affect, and cognitive or learning disabilities.

Behavioral signs and symptoms experienced by abandoned children may include acting out violently, a history of delinquent behavior, poor school attendance, committing crimes, becoming involved with gangs, sexual promiscuity, and using drugs and/or alcohol.

Physical signs and symptoms of child abandonment may include their general appearance being affected as a result of the child living on the streets/alone, including poor hygiene or signs of malnourishment. The child's clothing may be torn, soiled, ill-fitting, or inappropriate for the weather. The child may be hungry and may beg or steal food or money. The child may have medical issues, poor dental hygiene, vision difficulties, insufficient immunizations, inadequate nutrition, or obesity.

Social signs and symptoms of abandoned children may include the child withdrawing from social relationships, being unable to trust others, showing signs of isolation, having difficulty connecting with others, and having trouble expressing emotions.

ASSESSMENT

The social worker should conduct a biological, psychological, social, and spiritual assessment to include information on any physical, mental, environmental, social, spiritual, or medical factors relating to the child's care.



Children who have been abandoned should be referred for comprehensive medical examination to identify any health conditions or health-related needs. The social worker should initiate efforts to identify/locate the child's parents/family members. The social worker may obtain relevant school records to supplement available history. The social worker should attempt to obtain as much family history as possible to aid in the treatment of the abandoned child. Depending on the age of the child, family history may be unattainable.

ASSESSMENTS AND SCREENING TOOLS

A challenge of using screening and assessment tools with abandoned children is that many tools require input from parents, teachers, or other adults with knowledge of the child, and yet by definition of abandonment, responsible adults are not available for abandoned children. However, the social worker may utilize the Achenbach System of Empirically Based Assessments (ASEBA) which includes a range of assessments that could be used depending on the social worker's initial impression of area(s) that require further information.

TREATMENT

When a child is abandoned, early intervention and treatment are essential for its well-being. The social worker should first attempt to locate and contact a parent or guardian. If contact with a parent is made, services should be offered to help the parent reunite with the child, if deemed appropriate. These services include mental health and substance abuse treatment for the parent or child, family or individual counseling for the parent or child, respite care to

allow the parent time to reconsider the abandonment, financial assistance, and referrals for medical insurance. Child protective service agencies often intervene if a parent or guardian cannot be located. It is important for the child to be placed in a permanent, safe environment in which he or she can develop normally.

Trauma-informed care models are often used for children who have been exposed to trauma (such as child maltreatment, unstable home environment, exposure to violence, abandonment). This child-focused collaborative approach utilizes individualized assessment and recognizes the profound impact trauma can have on the child and the family. Treatment goals include establishing a therapeutic relationship, improving immediate safety (e.g., health, relationships, environment), identifying how the trauma impacts the child's current functioning, and helping the child develop adaptive ways of coping (such as relaxation, meditation, exercise).

INTERVENTION

If a child is at risk for abandonment, the social worker should provide any necessary crisis interventions and assess for any other needs such as mental health counseling and substance abuse services. The social worker should assist the parent/guardian with these needed services in order to prevent abandonment of the child.

If a child is abandoned, the social worker should assess the child's family history for any possible placement options, and make referrals for individual therapy, mental health evaluations, medical needs, emotional support needs, and services with the school system if child is of school age.

If a child is exhibiting maladaptive and/or disruptive behaviors as a result of being abandoned, the social worker may provide or make referrals for services to reduce the problem behaviors and teach and reinforce prosocial behavior skills. Individualized behavioral strategies focused on reinforcing positive behaviors and/or individual and group skills coaching for the child may be appropriate interventions.

If a child has suffered multiple traumas (such as unstable living situations, maltreatment, and abandonment) and exhibits increased levels of emotional distress, the social worker should provide services

and referrals to ensure the child's physical, mental, and emotional well-being. Possible referrals and interventions may include trauma-focused cognitive behavioral therapy to reduce symptoms of distress, dynamic play therapy, game-based cognitive-behavioral therapy, and group therapy.

LAWS AND REGULATIONS

Safe-haven laws allow parents to leave an infant or newborn child at designated sites (such as fire stations, hospitals, police stations) without being prosecuted, so that the child becomes a ward of the state. Safe-haven laws have been enacted in all 50 U.S. states. The U.S. Child Abuse Prevention and Treatment Act—Public Law 93-247 provides funding to states in support of prevention, assessment, investigation, prosecution, and treatment of child maltreatment.

Local laws and requirements for reporting neglect and abuse should be known and observed by all professionals assisting children and families.

In South Africa, the Children's Act 38 of 2005 provides general regulations regarding children and includes legislation that governs abandonment of children. The main objectives of the act are to make provision for structures, services, and means for promoting and monitoring the sound physical, psychological, intellectual, emotional, and social development of children; to provide care and protection for children in need; to promote the protection, development, and well-being of children; to recognize the special needs that children with disabilities may have; and to give effect to the constitutional rights of children.

The Children and Young Persons Act 1933 was enacted in the United Kingdom to punish cruelty to children, which includes abandonment of a child. Article 27 of the United Nations Convention on the Rights of the Child (CRC) acknowledges the right of every child to a standard of living adequate for his or her mental, physical, moral, spiritual, and social development. Abandonment denies children this right.

SERVICES AND RESOURCES

- National Safe Haven Alliance: <http://www.nationalsafehavenalliance.org>, 1-888-510-BABY
- Childhelp National Child Abuse Hotline: <https://www.childhelp.org/hotline/>, 1-800-4-A-CHILD

FOOD FOR THOUGHT

Some desperate families seeking care solutions for youth with medical or behavioral health challenges have utilized safe-haven laws to abandon children. In July 2008, Nebraska adopted a safe-haven law intended to allow parents to leave newborns safely at designated sites without fear of prosecution. The state did not specify an age limit and by November of the same year 35 children over 5 years of age had been left at safe-haven sites. Nebraska has since limited its safe-haven law to infants up to 30 days old.

RED FLAGS

Child abandonment can create conditions for negative patterns of social behavior in children and thus affect personality development. Children who have been abandoned are more likely to engage in delinquent and criminal behaviors. For younger children, failure to establish a parent/child bond has a negative impact on self-esteem, emotional attachment, and confidence later in life. Poverty, mental health issues, domestic and community violence, parental substance abuse, and lack of healthcare all contribute to child abandonment. Studies indicate that children in foster care and foster care alumni are at a higher risk for one or more behavioral health disorders.

NEXT STEPS

The social worker should contact the local office of children and family services to report the child abandonment and seek services and ensure that the child has suitable placement and that his or her basic needs are met. Linkage to community resources such as developmental screening; medical, financial, and educational assistance programs; and counseling services should be provided as appropriate. The social worker should follow up with available family members for any additional resource or support needs.

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REFERENCES

Blackie, D. (2014). Fact Sheet on child abandonment research in South Africa. National

Adoption Coalition. Retrieved March 25, 2015, from http://www.adoptioncoalitionsa.org/wp-content/uploads/2014/05/Fact-Sheet-Research-on-Child-Abandonment-in-South-Africa_Final2.pdf

British Association of Social Workers. (2012). The Code of Ethics for Social Work: Statement of principles. Retrieved March 25, 2015, from http://cdn.basw.co.uk/upload/basw_112315-7.pdf

Encyclopedia of Children's Health. (n.d.). Abandonment. Retrieved April 22, 2015, from <http://www.healthofchildren.com/A/Abandonment.html>

Gustavsson, N. S., & MacEachron, A. E. (2011). Lessons from Nebraska. *Social Work*, 56(2), 181-184.

International Federation of Social Workers. (2012, March 3). Statement of Ethical Principles. Retrieved March 25, 2015, from <http://ifsw.org/policies/statement-of-ethical-principles/>

Kuo, C., & Operario, D. (2009). Caring for AIDS-orphaned children: A systematic review of studies on caregivers. *Vulnerable Children and Youth Studies*, 4(1), 1-12.

Mizrahi, T., & Mayden, R. W. (2001). NASW Standards for Cultural Competence in Social Work Practice. Retrieved March 25, 2015, from <http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>

National Safe Haven Alliance. (n.d.). Baby Safe Haven—Abandoned Infant Protection Laws. Retrieved March 25, 2015, from <http://www.nationalsafehavenalliance.org/law.php>

Nelson, C. A., III, Fox, N. A., & Zeanah, C. H. (2013). Anguish of the abandoned child. *Scientific American*, 308(4), 62-67.

Philpot, T. (2004). Found and lost. *Community Care*, (1505), 32.

Schimmel, N. (2006). Freedom and autonomy of street children. *International Journal of Children's Rights*, 14(3), 211-233.

The criminal law and child neglect: An independent analysis and proposal for reform. (2013). Action for Children. Retrieved March 25, 2015, from http://www.actionforchildren.org.uk/media/5178586/criminal_law_and_child_neglect.pdf

Fact sheet: A summary of the rights under the Convention on the Rights of the Child. (n.d.). UNICEF. Retrieved March 25, 2015, from http://www.unicef.org/crc/files/Rights_overview.pdf

ABUSED PARENTS

MAJOR CATEGORIES: Emotional Abuse; Parent/Child Relationships

DESCRIPTION

Abuse of a parent by a child is defined as an act or behavior by a child under age 18 that is intended to cause physical, psychological, emotional, or financial harm in an effort to get attention from, manipulate, or gain control over a parent or caretaker. Parental abuse by a child is a rarely discussed form of abuse that has been insufficiently researched and is underreported. Many abused parents view their child's actions as normal behavior and do not recognize themselves as victims.

The abuse that parents experience from their children can be physical, emotional, or financial. Physical abuse is the act of using force that results in physical pain (such as hitting, punching, slapping, kicking, pushing, hair pulling). Emotional abuse is the infliction of emotional distress through verbal and non-verbal acts such as intimidation, threats of suicide, threats to harm others, mind games (such as hiding car keys from parents, making unrealistic demands), truancy, lying, and staying out all night. Adolescent children may also engage in self-harming behaviors (such as cutting, suicide attempts, eating disorders) to instill fear in a parent. Financial abuse is when a child or adolescent uses money or possessions as a means of manipulation and control. Financial abuse includes such acts as stealing; misusing, selling, or destroying a parent's belongings; and demanding money.

These behaviors tend to become more severe and chronic as the child ages. The most noticeable change in a child's behavior towards the parent or caregiver typically occurs at the onset of adolescence, when the adolescent is attempting to individuate and is undergoing hormonal changes. This is a time when typical behaviors such as defiance, aggression, and resistance to authority can escalate into combative and threatening behaviors towards the parent or caregiver.

Many abused parents struggle to admit or fail to recognize that their child's behavior is abusive. Abused parents often fail to report the abuse for fear that they will be labeled bad parents or judged based on the behavior that is out of their control. Typically, ongoing conflict in the home is accepted as an issue that the family must deal with as an everyday part of life. For this reason, it is important for social workers

to determine when typical teenage behavior has crossed over into abusive behavior by assessing the intent of the action or behavior (the motive behind an act or statement), the intensity of the action or behavior (extreme degrees of anger, violence, destruction), and the form of the action or behavior (physical, emotional, psychological, financial). Treatment for abused parents may include cognitive behavioral therapy and psychologically educational therapy that is family-focused. If the offending teen remains in the home, it is crucial that the therapist or social worker attempts to involve the teen in family sessions because the primary goal of the therapy is to stop the abuse and assist the parent(s) in regaining leadership of the family.

FACTS AND FIGURES

Parental abuse affects families of all socioeconomic levels (e.g. a family's income level and profession), education levels, and structures (such as single-parent versus two-parent households). Typically, mothers are the primary targets of abuse. Fathers and stepfathers can also be victims, but such abuse usually is less frequent and less severe. The findings on whether boys or girls are more likely to perpetrate the abuse in child-to-parent aggression are limited and mixed.

RISK FACTORS

Parents who spend little or no time with their children, are often away from home, or leave their children unsupervised for long periods may be creating an environment for the development of unacceptable behaviors. Parents increase their risk of being abused by their children when they fail to set limits and boundaries out of fear that their child will stop loving them. Lack of parental warmth towards the child may also increase the risk of child-to-parent abuse. Older adult parents of adolescents who had their children later in life are especially vulnerable to abuse. Single mothers, especially those under intense stress, are more likely to experience abuse by their teenage children.

Women who have been victims of intimate partner violence are also at higher risk of being abused

parents. Parents who engage in conflict with one another in the presence of their children may increase their chances of becoming targets of abuse by their children. Children with a history of physical violence in the home, substance abuse, maltreatment, or mental health disorders (such as oppositional defiant disorder, attention-deficit/hyperactivity disorder, conduct disorder), are at increased risk of becoming abusive teens. Children who are disconnected and feel rejected by a parent are also at increased risk of becoming abusive teens towards their parents.

SIGNS AND SYMPTOMS

Abuse towards parents may have psychological effects on both the abused parent and the abusive teen. The abused parent may express helplessness, fear, frustration, shame, sadness, or embarrassment, and may report feeling overwhelmed or assume blame for the abuse. The abusive teen may express feeling powerful, angry, or uncaring; may struggle internally with self-worth and demonstrate low self-esteem; may disassociate from feelings of pain and remorse; may be unable to control and manage feelings or anger; may have limited ability to solve problems and deal with stress; may harbor resentment toward parents; and may have a grandiose view of him- or herself or a sense of entitlement.

Abuse towards parents may also have behavioral effects on both the abused parent and the abusive teen. The abused parent may be resistant to disclosing abuse for fear of being blamed or judged and may be neglectful of his or her own needs or the needs of other family members. The abusive teen may demonstrate an unwillingness to take responsibility for his or her actions; may be defiant and disrespectful to authority figures; may refuse participation in services; may lie or attempt to manipulate the social worker or use treatment sessions to blame parents and maintain control; may be quick to become angry; may demonstrate poor impulse control and a lack of conflict-management skills; and may engage in delinquent behaviors (such as truancy, substance use, petty crimes).

Abuse towards parents may also have social effects on both the abused parent and the abusive teen. The abused parent may avoid talking with family and friends out of fear of being criticized and may spend more time away from home. The abusive teen may experience academic difficulties

or refuse to attend school; or may run away from home, engage in delinquent behavior, or withdraw from family and peers.

ASSESSMENT

The social worker working with the parent, adolescent, or family should complete an interview to address feelings of powerlessness, fear, and self-blame and educate the parent, adolescent, or family on the prevalence and dynamics of parent abuse by children.

A biological, psychological, social, and spiritual assessment of the abused parent and the abusive child should be conducted. The assessment should include any history of childhood abuse of the parent, child abuse by the parent, and any history of intimate partner violence between parents.

Information about the history of mental health disorders in the family, the parent or child's current mental health symptoms (such as anxiety, depression), and the history of current or previous substance abuse in both the parent and the offending child or teen should be included in the social worker's assessment.

It should be determined if the abusive teen is still in the home, and a safety plan for the abused parent(s) should be created. Possible out-of-home placement of the abusive child or notification of law enforcement about the abusive child may be needed. A person-centered approach should be used by a social worker when determining the goals of treatment for the parent, child, and family. The importance of joint counseling with other family members should be explained.

It is important to note that parents who have been physically abused may have physical injuries. Abused parents may also have somatic complaints, including gastrointestinal disturbances, headaches, and sleep disturbances.

ASSESSMENT AND SCREENING TOOLS

Assessment and screening tools to assist in gathering information may include the Conflict Tactics Scales-Revised (CTS-R), which is a clinician-administered 62-item tool used to assess the type and frequency of violent interactions between family members; and the Conners' Parent Rating Scale-Revised (CPRS-R), which is a 28-item clinical tool used to measure parental reports of behavioral problems in children ages 3-17 years.

There are no laboratory/diagnostic tests to assist in the diagnosis/treatment of parent abuse. Tests for the presence of alcohol or other substances at levels that would indicate abuse may be useful.

TREATMENT

The failure to have an intervention on behalf of an abused parent may have a devastating impact on the family's long-term sustainability. Participating in individual therapy is essential to helping a parent re-establish the role of leader in the home and develop confidence in his or her ability to parent. The psychologically educational approach involves a social worker or therapist teaching the family to recognize that violent/aggressive behavior is a learned response and providing the family with tools to change their patterns of interaction. The identification of a family's strengths rather than the focus on blaming and judging will help to put family members at ease and foster faith in their ability to resolve future conflicts.

A treatment plan for the family should incorporate individual counseling, couples counseling (for two-parent households), and therapeutic mediation between the abused parent and the offending teen in order to facilitate communication and to address maladaptive behaviors that are occurring within family relationships. Temporary respite for the adolescent may be necessary, as well as behavior contracts and family meetings. Individualized safety planning, including having the phone number of the police available and providing a friend with a secret code to alert him or her that danger is present, is another important aspect of treatment to ensure the safety of the abused parent and others in the home.

INTERVENTION

If abuse of a parent is suspected, a biological, psychological, social, and spiritual assessment should be completed to identify the presence of abuse. The interview should be completed in a safe, private setting in order for the social worker to develop rapport and trust. The social worker may utilize assessment tools such as the CTS-R or the CPRS-R to gather information. If it is determined that the abusive teen is still in the home, a safety plan should be developed in order to reduce the risk of continued abuse.

Physical, social, or psychological signs and symptoms of abuse should be assessed. The social worker should help identify the dynamics and behaviors that

reduce the abused parent's potential to experience abuse and develop effective parenting techniques and practices. Individual counseling sessions can assist the abused parent in identifying maladaptive dynamics and parenting gaps. Journaling and mapping can help with the expression of fears and goal-setting. Parenting education can help to develop effective communication and the ability to set healthy boundaries. Family counseling and mediation can help to facilitate communication and to address enabling behaviors, history of violence/abuse, and establishment of parent in role of authority.

A prevention plan should be developed to help maintain safety and reduce the risk of future acts of abuse. The use of a family system intervention may help to enhance communication and reorganize the rules of engagement between parent and child. The safety plan should include a discussion of out-of-home placement options. The abused parent should be provided with referrals to mentoring programs, support groups, and respite care for additional support. The social worker should also educate the abused parent on the pros/cons of involvement with the legal system.

LAWS AND REGULATIONS

The United States Family Law Act 1996 sets the legal guidelines for cases of domestic violence. Each jurisdiction (nation, state, or province) has its own standards, procedures, and laws for involuntary restraint and detention of persons who may be a danger to themselves or others. Local and professional reporting requirements for neglect and abuse should be known and observed.

SERVICES AND RESOURCES

- ACT – Adults and Children Together Against Violence, a resource for parenting tips on teen violence, anger management, and conflict resolution, <http://actagainstviolence.apa.org/>
- Parenting SA, an initiative of the government of South Australia recognizing the important and demanding role of parenting, <http://www.parenting.sa.gov.au/>
- Kids Helpline, a resource for parents and children, <https://kidshelpline.com.au/parents/>
- Stop Abuse for Everyone, a resource for therapy, mentoring programs, and parent education, <http://www.stopabuseforeveryone.org/>

FOOD FOR THOUGHT

Mothers of children who have witnessed intimate partner violence in the home frequently blame themselves for the abuse they experience at the hands of their teen. Abused parents may hesitate to contact social services or law enforcement out of fear that the abusive teen will be removed from the home, thereby jeopardizing any emotional connection between the teen and the parent.

Abused parents may feel as if the abuse is a result of their poor parenting or that they have failed their child. Abused parents need to be reminded that they are not their child's sole influence and that they need to take action to protect themselves against violence. An abused parent must take action to ensure his or her safety, particularly if there are younger children in the home who may be exposed to the abuse.

RED FLAGS

Abusive teens may also be engaging in abusive behaviors with their peers or dating partners. Teens exhibiting aggression, rage, erratic behaviors, or violent thoughts may have an undiagnosed mental health disorder.

NEXT STEPS

Social workers should teach abused parents that self-care is an important behavior to model to the abusive teen. Self-care can help stabilize the child or parent's own emotional health in order for them to achieve insight into the harmful dynamics in the home. Abused parents should be encouraged to discuss the abuse with supportive friends or family members in order to minimize feelings of isolation. Parents should be encouraged to actively practice action, not reaction to the abusive or maladaptive behavior of their children. Parents should attempt to take preventive measures and set boundaries in order to reduce abusive behaviors. Social workers should assist in teaching parents how to impose consequences that modify a teen's behavior.

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REFERENCES

- British Association of Social Workers. (2012, January). The code of ethics for social work: Statement of principles. Retrieved May 13, 2016, from http://cdn.basw.co.uk/upload/basw_112315-7.pdf
- Calvete, E., Orue, I., Gamez-Guadix, M., & Bushman, B. J. (2015). Predictors of child-to-parent aggression: A 3-year longitudinal study. *Developmental Psychology*, 51(5), 663-676. doi:10.1037/a0039092
- Cottrell, B. (2005). *When teens abuse their parents*. Halifax, Nova Scotia, Canada: Fernwood Publishing Co.
- Home Office. (2015). *Information guide: adolescent to parent violence and abuse (APVA)*. Retrieved May 13, 2016, from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/420963/APVA.pdf
- Horne, A., & Sayger, T. V. (1990). *Treating conduct and oppositional defiant disorder in children*. New York, NY: Pergamon Press.
- Hunter, C., Nixon, J., & Parr, S. (2010). Mother abuse: A matter of youth justice, child welfare, or domestic violence?. *Journal of Law and Society*, 37(2), 264-284.
- International Federation of Social Workers. (2012, March 3). *Statement of ethical principles*. Retrieved May 13, 2016, from <http://ifsw.org/policies/statement-of-ethical-principles/>
- Kennedy, T. D., Edmonds, W. A., Dann, K. T. J., & Burnett, K. F. (2010). The clinical and adaptive features of young offenders with histories of child-parent violence. *Journal of Family Violence*, 25(5), 509-520.
- Martin, B. (2015). *Parent abuse by teen*. Retrieved May 13, 2016, from <http://psychcentral.com/lib/parent-abuse-by-teen/>
- National Association of Social Workers. (2003). *Standards for the practice of social work with adolescents*. Retrieved May 13, 2016, from <https://www.socialworkers.org/practice/standards/Adolescents.asp>
- National Association of Social Workers. (2008). *Code of ethics*. Retrieved April 26, 2016, from <https://www.socialworkers.org/pubs/code/code.asp>
- National Association of Social Workers. (2015). *Standards and indicators for cultural competence in social work practice*. Retrieved March 29, 2016,

from <http://www.socialworkers.org/practice/standards/PRA-BRO-253150-CC-Standards.pdf>
 Parenting SA. (n.d.). Violence toward parents: Parent easy guide 17. Retrieved May 13, 2016, from <http://www.parenting.sa.gov.au/pegs/peg17.pdf>
 Routt, G., & Anderson, L. (2011). Adolescent violence towards parents. *Journal of Aggression,*

Maltreatment & Trauma, 20(1), 1-18. doi:10.1080/10926771.2011.537595
 Townsend, J. (2013). When raising teens hurts: Parent abuse. Retrieved May 14, 2016, from <http://www.cloudtownsend.com/when-raising-teens-hurts-parent-abuse-by-dr-john-townsend/>

ACQUIRED IMMUNE DEFICIENCY SYNDROME: DEMENTIA COMPLEX IN OLDER ADULTS

MAJOR CATEGORIES: Medical & Health, Cultural Competency

DESCRIPTION

Acquired immune deficiency syndrome (AIDS) dementia complex (ADC), also called human immunodeficiency virus (HIV)-associated dementia complex (HAD), is a syndrome resulting from complications of infection by human immunodeficiency virus type 1 (HIV-1), which is the cause of AIDS. Often misdiagnosed as Alzheimer's disease or another type of dementia, ADC usually develops in the later stages of AIDS, when the number of blood cells known as CD4 lymphocytes, which belong to the human immune system and play an important role in destroying infectious viruses, falls below 200 cells per microliter, or millionth of a liter, of blood.

ADC is characterized by what is known as impaired psychomotor function, consisting of a slowing of thinking and reduced physical movement; impaired perception, recognition, and memory; and abnormalities in behavior. In its early stages, in which it often appears in the form of changes in behavior, ADC is likely to be accompanied by abnormal results of tests done on cerebrospinal fluid, and is less likely to include the impaired ability to effectively use speech or language known as aphasia. ADC progresses in a stepwise manner, beginning with slight impairments in decision-making and the performance of activities of daily living (ADLs) such as eating, bathing, and dressing, and ultimately progresses to major impairments in decision-making and the performance of ADLs, requiring total care of the affected individual.

The effects of ADC typically occur in four aspects of psychomotor function, consisting of emotion, behavior, cognition, and motor function. In terms of emotion, these effects are depressive symptoms; irritability; mania, or abnormally exuberant

behavior; and loss of contact with reality, or psychosis. Behaviorally, the effects of ADC are slowed speech, slower response times, social isolation and withdrawal, apathy, changes in personality, and organic psychosis, in which abnormalities in behavior result from damage to the structure and physical function of the brain. In terms of cognition, the effects of ADC include impairment of visual and spatial function, such as the misplacement of objects, poor coordination, difficulties in attention and concentration, trouble in finding words for expressing thoughts or feelings, and a slowing of mental function. Common early symptoms of ADC are difficulty in finding words for describing objects and other purposes, general forgetfulness, a slowing of psychomotor abilities, a diminished ability to write, and diminished motor and visual skills. Motor deficits caused by ADC include an unsteady gait, poor balance, leg weakness, frequent dropping of objects, tremors, and a loss of clear handwriting and fine motor skills, such as in the handling of small objects.

The symptoms of ADC may persist despite the treatment of HIV infection with highly active anti-retroviral therapy (HAART), consisting of drugs that eradicate the HIV-1 virus.

Although the use of HAART has led to the longer survival of people living with HIV/AIDS (PLWHA) in the United States and other developed countries, delay in the diagnosis and treatment of HIV/AIDS increases the risk that ADC will develop in an affected individual. Yet unfortunately, the diagnosis and treatment of HIV/AIDS in women and members of various ethnic groups is often delayed because members of these groups fear discrimination and stigma if they are found to have HIV. Furthermore, inaccurate

information, fear of the unknown, religious or moral beliefs, and beliefs about victims' personal irresponsibility can lead to the stigmatization of persons with HIV/AIDS. In particular, Black and Hispanic persons in the United States can face rejection by social and religious groups because of strong cultural beliefs that associate AIDS with behaviors that differ from such groups' social standards and a religious belief that contracting HIV/AIDS results from immoral behavior and constitutes a "punishment from God."

Older adult PLWHA are less likely than young adult PLWHA to seek and obtain healthcare and social services for HIV/AIDS, possibly because of fear of discrimination and bias. Moreover, because of misinformation about the way in which older adults contract HIV/AIDS, members of this older population often fail to request or get appropriate treatment for these conditions from medical and social service professionals in nursing homes and hospitals. Staff members with inaccurate information about pain control may not provide appropriate treatment. Additionally, older PLWHA often have comorbid conditions that exacerbate the effects of HIV/AIDS and impair such older persons' ability to socialize, work, and obtain healthcare services, and such persons may withdraw from their social networks to an even greater degree than younger PLWHA. This is a serious problem because such withdrawal leads to decreased social contact, which has been shown to cause a decline in cognitive function, accelerating the decline initiated by ADC itself. Because of their direct one-on-one interpersonal contact in various settings, such as home visits, outpatient services, and adult services, social workers are in a good position to identify older persons with cognitive deficits as a result of ADC.

Multiple measures are recommended for treating mild to moderate cognitive impairment in ADC. However, although stress management has been shown to improve cognition and ease the severity of depression in persons with ADC, the spaced retrieval method has so far been the only remediation method used successfully in older adult PLWHA. In this technique, which is intended to improve the mental retention of information and reduce deficits in memory and executive functioning, an individual is given a set of information and instructed to rehearse it on repeated occasions, with a longer time being allowed to elapse between each new rehearsal and the previous rehearsal.

WHAT CAN BE DONE

Learn about ADC in older adults, and develop an awareness of your own cultural values, beliefs, and biases and a knowledge of the histories, traditions, and values of the older adults you know who have ADC.

Healthcare practitioners who treat these adults must be sensitive to their cultural, religious, and aging-related issues. They must be able to educate older adults about risky sexual practices and work towards changing stereotyped attitudes that older adults are less sexually active than younger ones. Efforts should also be made to provide educational materials about the prevention of HIV/AIDS in older adults to various assisted-living facilities, community centers, and other locations where such adults live or gather.

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REFERENCES

- British Association of Social Workers. (2012). The code of ethics for social work. Retrieved February 12, 2016, from http://cdn.basw.co.uk/upload/basw_112315-7.pdf
- Emlert, C. A. (2006). An examination of the social networks and social isolation in older and younger adults living with HIV/AIDS. *Health & Social Work, 31*(4), 299-308. doi:10.1093/hsw/31.4.299
- Emlert, C. A. (2004). HIV/AIDS and aging: A diverse population of vulnerable older adults. *Journal of Human Behavior in the Social Environment, 9*(4), 45-63. doi:10.1300/J137v09n04_03
- Fox-Hill, E. J., Gibson, D. V., & Engle, V. F. (2002). Nursing home experiences of older African Americans with HIV/AIDS: Issues for future research. *Journal of Mental Health & Aging, 8*(4), 319-330.
- Hatchett, B., & Duran, D. A. (2002). An approach to community outreach practice in the 21st century. *Journal of Community Practice, 10*(2), 37-52. doi:10.1300/J125v10n02_03
- Jacobs, R. J., & Kane, M. N. (2010). HIV-related stigma in midlife and older women. *Social Work in Health Care, 49*(1), 68-89. doi:10.1080/00981380903018140
- Levy-Dweck, S. (2005). HIV/AIDS fifty and older: A hidden and growing population. *Journal*

- of Gerontological Social Work, 46(2), 37-50. doi:10.1300/J083v46n02_04
- Wheeler, D. (2015). NASW standards and indicators for cultural competence in social work practice. Retrieved November 29, 2015, from <http://www.socialworkers.org/practice/standards/PRA-BRO-253150-CC-Standards.pdf>
- Navia, B. A., Jordan, B. D., & Price, R. W. (1986). The AIDS dementia complex: I. Clinical features. *Annals of Neurology*, 19(6), 517-524. doi:10.1002/ana.410190602
- Tangenberg, K. M. (2002). Mental health dimensions of HIV/AIDS in women over 50. *Journal of Mental Health & Aging*, 8(4), 281-293.
- Uthman, O. A., & Abdulmalik, J. O. (2008). Adjunctive therapies for AIDS dementia complex (Review). *Cochrane Database of Systematic Reviews*. Art. No.: CD006946.
- Vance, D. E., & Struzick, T. C. (2007). Addressing Risk Factors of cognitive impairment in adults aging with HIV: A social work model. *Journal of Gerontological Social Work*, 49(4), 51-77. doi:10.1300/J083v49n04_04
- Williams, E., & Donnelly, J. (2002). Older Americans and AIDS: Some guidelines for prevention. *Social Work*, 47(2), 105-110. doi:10.1093/sw/47.2.105
- Cognitive disorders and HIV/AIDS: HIV associated dementia and delirium. HIV Clinical Resource. (2013). New York State Department of Health. Retrieved from <http://www.hivguidelines.org/wp-content/uploads/2013/07/cognitive-disorders-and-hiv-aids.pdf>
- Statement of ethical principles. (2012, March 3). International Federation of Social Workers. Retrieved November 29, 2015, from <http://ifsw.org/policies/statement-of-ethical-principles>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental health disorders*. (5th ed.). Arlington, VA: Author.

ACQUIRED IMMUNODEFICIENCY SYNDROME: CHILDREN & ADOLESCENTS

MAJOR CATEGORIES: Medical & Health

DESCRIPTION

Acquired immunodeficiency syndrome (AIDS) describes a group of symptoms and diseases associated with infection by the human immunodeficiency virus (HIV), resulting in damage to the body's immune system. Acquired immunodeficiency syndrome is the most advanced stage of infection by HIV, at which the number of CD4 lymphocytes, a group of white blood cells that belong to the immune system and play a major role in protecting the body from infection, falls below a level established by the U.S. Centers for Disease Control and Prevention (CDC). AIDS can also occur when an HIV infection has weakened the body's immune defenses to the extent that it develops an opportunistic infection (OI), so-called because it is caused by bacteria, viruses, or fungi that might not infect the body in the presence of a strong immune system. HIV can also cause opportunistic infection by damaging the body's usual physical barriers to infection, or by creating other situations that give infecting organisms a greater-than-usual opportunity to cause infection.

Infection with HIV generally occurs when the virus is carried into the body by white blood cells known as CD4 T-lymphocytes that are present in the blood, semen, vaginal fluid, or breast milk of someone who already has an HIV infection. This can occur during sexual intercourse, breastfeeding, or through the use of a contaminated hypodermic needle, among other circumstances. In the absence of perinatal prevention of HIV infection, it develops in from 13 percent to 40 percent of children born to HIV-infected mothers. In contrast to the infections caused by most viruses that are kept in check by the immune system, HIV typically continues to multiply after entering the body, and infects increasing numbers of cells, and most persons with HIV infections ultimately develop AIDS. Although it is not known precisely how HIV causes AIDS, it does progressively damage and weaken the immune system, raising the risk of infections such as tuberculosis and opportunistic infections, as well as the development of tumors, with these effects being collectively referred to as AIDS. Despite this, HIV does not in every case progress to AIDS. For reasons

that remain unknown, a small percentage of people retain the ability to make antibodies to HIV, and to prevent infection with the virus from progressing to AIDS, and some people who have been exposed to HIV do not become infected with it.

Today, despite progress in understanding the mechanisms by which HIV causes AIDS, and in treating HIV infection and AIDS, the size of the world population with AIDS continues to grow.

FACTS AND FIGURES

The CDC initially recognized AIDS in 1981, soon followed by the identification of HIV as its cause. In 2009, approximately 260,000 children worldwide died of AIDS-related causes.

According to the World Health Organization (WHO), in 2014 nearly 37 million persons globally were living with HIV, of whom 2.6 million were children under the age of 15. Approximately 70 percent of adults and 88 percent of all children infected with HIV live in sub-Saharan Africa, which was the location of 66 percent of the world's total deaths from AIDS in 2014. In the United States, adolescents and young persons ranging from 13 to 24 years of age who have AIDS are a growing population, and in 2010 constituted 26 percent of all new cases of the syndrome. In the United States, 50 percent of young persons with AIDS/HIV do not know that they are infected.

RISK FACTORS

The greatest risk for HIV infection of infants and younger children comes from their exposure to the virus in their mother's body during pregnancy, labor, and delivery, or through breastfeeding. The risk to newborns can be decreased by the avoidance of breastfeeding by women who have HIV infection, and by administering antiretroviral medications to the mother during pregnancy and to the newborn infants of women with HIV infections during the period from 4 to 6 weeks after these infants' birth. Transfusions of infected blood or injections with unsterilized needles can cause HIV infection in children. The United States and Western European countries have medical safeguards to prevent this problem. Children can also be infected with HIV through sexual abuse or rape. In some countries, marriage during childhood is culturally accepted, raising the risk of HIV infection in the marital partners. Risk factors for HIV infection in adolescence

include having multiple sexual partners, intravenous drug use, unprotected anal or vaginal intercourse, tattooing, body piercing with contaminated needles, and lack of education about how HIV is transmitted, as well as limited resources (such as sterile contraceptive devices) for preventing its transmission.

SIGNS AND SYMPTOMS

Psychological symptoms of AIDS can include feelings of loneliness, guilt, anxiety, anger, confusion, denial, depression, and fear. A child or adolescent with AIDS may also experience grief associated with the death of family members from AIDS-related illnesses, and may have suicidal thoughts. Behaviorally, children or adolescents with AIDS may have problems with focusing and maintaining attention, developmental delays, and acting violently, and may have problems with substance abuse. Physically, children and adolescents with AIDS may appear malnourished, have severe diarrhea and other flulike symptoms, have respiratory problems, fail to thrive, and exhibit various signs of opportunistic infections. Socially, children and adolescents with AIDS may withdraw from relationships, be unable to trust others, show signs of isolation, have trouble with expressing emotions, and have excessive absences from school.

TREATMENT

The social worker assisting a child who has or is at risk for HIV infection or AIDS should conduct a complete biological, psychological, social, and spiritual assessment of the child. Assessment of the families of children with or at high risk for HIV infection is also critical. The assessment should include questioning about the onset, duration, and signs and symptoms of any illness; substance abuse and mental-health issues; and stress-management skills and coping mechanisms.

Children and adolescents who carry HIV, and those who have AIDS, may not know this because they may have no symptoms of illness. Furthermore, both infection with HIV and AIDS remain highly stigmatized diseases throughout the world, and some parents and caregivers find it difficult to determine when and how to disclose to a child or adolescent that he or she is infected. The social worker should work with family members to encourage appropriate disclosure practices and treatment plans, and should offer any additional support that is needed.

Because the rapid identification of HIV infection and AIDS is critical to providing early intervention, the social worker, in conjunction with appropriate medical personnel, should ensure complete testing for their presence and status, as well as for possible opportunistic infections, with testing for HIV in newborns done within the first 24 hours after birth. This is essential because fewer than 40 percent of HIV-infected newborns show signs of the virus at birth, although almost all HIV-infected children have detectable HIV in their blood by 4 months of age. Furthermore, in the absence of medical treatment, HIV infection and AIDS progress more rapidly in children than in adults, killing more than half of infected children within the first two years of life. Conversely, with aggressive treatment such as highly active antiretroviral therapy (HAART, which consists of a combination of agents that act to inhibit the proliferation and effects of HIV), most children with AIDS now survive past 5 years of age and live longer and healthier lives. On the other hand, adolescents (ages 15 to 19) may remain free of symptoms for 8 to 12 years after infection, necessitating their continued follow-up and testing, especially for those engaged in activities that pose a high risk for HIV infection.

Medical treatment for HIV infection and/or AIDS can be divided broadly into the categories or treatment of HIV infection with HAART; prophylaxis against opportunistic infections; and treatment of cancers, malignancies, opportunistic infections, and other complications of HIV infection. Healthcare providers planning HAART treatment for HIV-infected children and adolescents should consider the effect of its frequency and dosing on their quality of life, and the ability of a child's parent or caregiver or an adolescent patient to administer or self-administer such treatment, which typically consists of multiple drugs given at different times and intervals. It is crucial that the child and its parent/caregiver, and the adolescent patient, understand the importance of adhering to medication schedules and dosages, and the possible consequences of disruptions of these schedules and dosages.

In addition to HAART and the treatment of opportunistic infections, children and adolescents with AIDS also benefit from individual and family therapy; support groups; nutritional evaluation; physical, occupational, and speech therapy; and case-management services. The social worker should educate

adolescent patients and their families about safe sex practices, since no definitive cures or preventive agents exist for HIV infection or AIDS.

Social workers assisting children with HIV infection and/or AIDS should be aware of the transmissibility of these infections. They should also be aware of their personal cultural values, beliefs, and biases, and should develop specialized knowledge about the histories, traditions, and values of these children and their families. Social workers assisting children with HIV infection and/or AIDS, and their families, should adopt treatment methods that reflect their knowledge of the cultural diversity of the communities in which these children and their families live.

LAWS AND REGULATIONS

Section 504 of the United States Rehabilitation Act of 1973 protects individuals with HIV infection and/or AIDS against discrimination. The United States Health Insurance Portability and Accountability Act of 1996 (HIPAA) ensures the privacy of individuals' health information and their right to review and make corrections to their medical records.

SERVICES AND RESOURCES

The following resources can provide information about HIV infection and AIDS:

- National AIDS Hotline, (800) 342-AIDS
- National Teenage AIDS Hotline, (800) 440-TEEN
- Perinatal HIV Hotline, (888) 448-8765
- Planned Parenthood National Hotline, (800) 230-PLAN
- Centers for Disease Control & Prevention's National STD Hotline, (800) 227-8922
- AIDS Healthcare Foundation, <http://www.aidshealth.org/#/>
- AIDS.gov, <http://www.aids.gov/>
- International HIV/AIDS Alliance, <http://www.aidsalliance.org/>
- HIV InSite, <http://hivinsite.ucsf.edu/InSite?page=li-00-01>
- HIVAids Tribe, <http://www.hivaidstribes.com/>
- Positively UK, <http://positivelyuk.org/>

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REFERENCES

- Aidsmap. (n.d.). The disability discrimination act and the equality act. Retrieved January 20, 2016, from <http://www.aidsmap.com/The-iDisability-Discrimination-Acti-and-the-iEquality-Acti/page/1497533/>
- American Academy of Child & Adolescent Psychiatry. (2012). Facts for Families: Children, Adolescents and HIV/AIDS, No. 30. Retrieved April 18, 2016, from http://www.aacap.org/aacap/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Children_Adolescents_And_HIV_AIDS_30.aspx
- amfAR, the Foundation for AIDS research. (2015). Statistics: Worldwide. Retrieved January 27, 2016, from <http://www.amfar.org/worldwide-aids-stats/>
- Blosser, C.G., Brady, M.A., Royal, R.B. (2013). Infectious diseases and immunizations. In C.E. Burns, A.M. Dunn, M.A. Brady, N.B. Starr, & C.G. Blosser (Eds.), *Pediatric primary care* (5th ed., pp. 457-461). Philadelphia, PA: Elsevier Saunders.
- Branson, B. M., Owen, S. M., Wesolowski, L. G., Bennett, B., Werner, B. G., Wroblewski, K. E., Pentella, M. A. (2014). Laboratory testing for the diagnosis of HIV infection: Updated recommendations. Centers for Disease Control and Prevention and Association of Public Health Laboratories. Retrieved January 22, 2016, from <http://dx.doi.org/10.15620/cdc.23447>
- British Association of Social Workers. (2012, January). The Code of Ethics for Social Workers: Statement of Principles. Retrieved April 18, 2014/2016, from http://cdn.basw.co.uk/upload/basw_112315-7.pdf
- Campbell, C., Skovdal, M., Mupambireyi, Z., Madanhire, C., Robertson, L., Nyamukapa, C. A., Gregson, S. (2012). Can AIDS stigma be reduced to poverty stigma? Exploring Zimbabwean children's representations of poverty and AIDS. *Child: Care, Health Development*, 38(5), 732-742. doi:10.1111/j.1365-2214.2011.01311.x
- Centers for Disease Control and Prevention. (CDC). (2015). HIV among youth. Retrieved January 27, 2016, from <http://www.cdc.gov/hiv/group/age/youth/index.html>
- Committee on Adolescent Health Care. (2013). Reproductive health care for adolescents with human immunodeficiency virus. *Obstetrics and Gynecology*, 122(3), 721-725. doi:10.1097/01.AOG.0000433993.07969.e8
- Domek, G. J. (2006). Social consequences of antiretroviral therapy: Preparing for the unexpected futures of HIV-positive children. *Lancet*, 367(9519), 1367-1369.
- Fair, C., & Walker, S. (2011). Pediatric HIV social workers: Perspectives on disclosure. *Qualitative Social Work*, 10(4), 415-433.
- Fouda, G., Cunningham, C. K., & Permar, S. R. (2015). Infant HIV-1 vaccines: Supplementing strategies to reduce maternal-child transmission. *JAMA*, 313(15), 1513-1514. doi:10.1001/jama.2015.1382
- Guimarães Carvalho, K. E., Oliveira de Freitas, N., Carvalho de Souza, J., Pessôa Santos, C., de Souza Barbosa, E. C., Cavalcante de Araújo, E. (2014). Teen sexual health promotion: Integrative review. *Journal of Nursing UFP/ Revista de Enfermagem UFPE*, 8(9), 3182-3187. doi:10.5205/reuol.5960-55386-1-ED.0809201429
- International Federation of Social Workers. (n.d.). Statement of ethical principles. Retrieved April 18, 2016, from <http://ifsw.org/policies/statement-of-ethical-principles/>
- Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). Report on the global AIDS epidemic. Geneva, Switzerland: UNAIDS.
- Katz, M. H. (2016). HIV infection & AIDS. In M. Papadakis & S. J. McPhee (Eds.), *Current medical diagnosis and treatment* (55th ed., pp. 1310-1341). New York: McGraw-Hill Medical.
- Klitman, R., Marhefka, S., Mellins, C., & Wiener, L. (2008). Ethical issues concerning disclosures of HIV diagnoses to perinatally infected children and adolescents. *Journal of Clinical Ethics*, 19(1), 31-42.
- Kostak, M. A., Unsar, S., Kurt, S., Erol, O. (2012). Attitudes of Turkish midwives and nurses working at hospitals towards people living with human immunodeficiency virus/acquired immune deficiency syndrome. *International Journal of Nursing Practice*, 18(5), 437-444. doi:10.1111/j.1440-172X.2012.02062.x
- Levine, A. B., Aaron, E., Foster, J. (2006). Pregnancy in perinatally HIV-infected adolescents. *Journal of Adolescent Health*, 38(6), 765-768.
- Louw, J. S., Kosciulek, J., Chen, R. (2014). Investigating educators' views of sexuality, HIV and AIDS education in working with students with disabilities in South African schools. *Journal of Applied Rehabilitation Counseling*, 45(2), 9-17.

- Meechaman, C., Fongkaew, W., Chotibang, J., McGrath, B. (2014). Do Thai parents discuss sex and AIDS with young adolescents? A qualitative study. *Nursing and Health Sciences*, 16(1), 97-102. doi:10.1111/nhs.12072
- National Association of Social Workers. (2015). Standards and indicators for cultural competence in social work practice. Retrieved January 22, 2016, from <http://www.socialworkers.org/practice/standards/PRA-BRO-253150-CC-Standards.pdf>
- Qin, J., Yang, T., Kong, F., Wei, J., Shan, X. (2013). Students and their parental attitudes toward the education of children affected by HIV/AIDS: A cross-sectional study in AIDS prevalent rural areas, China. *Australian & New Zealand Journal of Public Health*, 37(1), 52-57. doi:10.1111/1753-6405.12010
- Richter, L. M., Sherr, L. (2012). Countdown to Zero: Only possible with 100 percent support for children and families. *Vulnerable Children & Youth Studies*, 7(1), 1-5.
- Schimmel, N. (2006). Freedom and autonomy of street children. *International Journal of Children's Rights*, 14(3), 211-234. doi:10.1163/157181806778458121
- Thupayagale-Tshweneagae, G., Mokomane, Z. (2014). Evaluation of a peer-based mental health support program for adolescents orphaned by AIDS in South Africa. *Japan Journal of Nursing Science*, 11(1), 44-53. doi:10.1111/j.1742-7924.2012.00231.x
- Wheeler, D. (2015). NASW Standards and Indicators for Cultural Competence in Social Work Practice. Retrieved November 16, 2015, from <http://www.socialworkers.org/practice/standards/PRA-BRO-253150-CC-Standards.pdf>
- World Health Organization (WHO). (2015). Global summary of the AIDS epidemic 2014. Retrieved January 27, 2016, from http://www.who.int/hiv/data/epi_core_july2015.png?ua=1
- Yogev, R., Chadwick, R. G. (2011). Acquired immunodeficiency syndrome (human immunodeficiency virus). In R. M. Kliegman, B. F. Stanton, N. F. Schor, J. W. St Geme, III, R. E. Behrman (Eds.), *Nelson textbook of pediatrics* (19th ed., pp. 1157-1177). Philadelphia, PA: Elsevier Saunders.

ACQUIRED IMMUNODEFICIENCY SYNDROME: OLDER ADULTS

MAJOR CATEGORIES: Cultural Competency, Medical & Health

DESCRIPTION

Acquired immunodeficiency syndrome (AIDS) is diagnosed when infection by human immunodeficiency virus (HIV) has severely compromised the immune system of an individual, either reducing the numbers of the disease-fighting white blood cells known as CD4 lymphocytes below a critical level, or allowing various bacteria, viruses, or fungi to take advantage of the body's weakened immune system by causing infections that it would otherwise have prevented. Such opportunistic infections (OIs) include pneumonia caused by the fungus known as *Pneumocystis jirovecii*, tuberculosis (TB), hepatitis C, hepatitis B, syphilis, and infection by human papillomavirus (HPV). The HIV that is the source of AIDS must pass through the skin or mucous membranes and into the body to cause an infection. It is transmitted from one person to another through exposure to blood, semen, vaginal secretions, breast milk, and penetration of the skin

by HIV-contaminated objects such as hypodermic needles.

The U.S. Centers for Disease Control and Prevention (CDC) identifies older adults with AIDS as persons 50 years of age and older. Once considered universally fatal, AIDS is now considered a chronic disease, manageable through advances in medical treatment. As a result, increasing numbers of older adults are living with HIV infection and/or AIDS (NASW, n.d.). Antiretroviral (ARV) medications, which combat the HIV that is the source of AIDS, have enabled many HIV-infected individuals to live longer and to survive into older adulthood. However, the long-term use of ARV medications has physical consequences, which can be manifested in older adults who are treated with them. Moreover, older adults have a diminished ability to metabolize ARV medications, which can lead to toxicity, and their use can exacerbate preexisting hepatic, cardiac, and metabolic conditions, as well as HIV and AIDS.