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Human Immunodeficiency Virus

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Introduction

Within the past 10 years, there has been a groundswell of interest in the vocational rehabilitation of individuals with HIV/AIDS. Like many emergent disabilities that are relatively new and/or rapidly increasing in geographic range or incidence, an important characteristic of HIV/AIDS is its constant evolution and the need for ongoing adjustment in vocational services as medical advancements are made. When HIV first appeared, little, if anything, was known about this disease except that many people were dying. At that time, people often were not aware of their illness until they had significant medical problems and were not able to work. As such, in the early years of the HIV pandemic, there was minimal reference to HIV in the field of vocational rehabilitation. It was not until 1988 that the Journal of Applied Rehabilitation Counseling published one of the first manuscripts providing an overview of AIDS for rehabilitation professionals, that addressed vocational implications and counseling interventions for this population (Reichert et al. 1988).

Because the rates and prevalence of HIV and AIDS varies from country to country the impact of this illness on the overall workforce of each country can vary. In some countries, the extent of the HIV pandemic poses significant threats to the workforce and overall economic development whereas in other countries, the relatively limited number of people with HIV has less of an impact on the overall workforce and economy. As such, different countries place different emphasis on the role of government and social policies to address the employment and health care needs of its citizens with HIV/AIDS. Similarly, different attitudes, policies and resources regarding health care can also impact on the availability and access to quality health care for individuals with HIV, which can impact their overall health and ability to contribute to the workforce. Nonetheless, as the world has gained a better understanding of HIV and medical advances have improved health outcomes for many, issues related to the vocational development and employment needs of people with HIV have gained increasing prominence.

What is HIV/AIDS?

Before considering the vocational rehabilitation issues of people with HIV, it is important to have a basis understanding of this illness. The acronym HIV is short form for the human immunodeficiency virus. HIV is a particularly serious virus because it attacks the immune system, which protects the body from major illnesses and infections. In particular, HIV destroys T cells or CD4 cells, which are white blood cells that the immune system relies on to fight off illness. Without the proper functioning of these T cells, individuals with HIV become much more vulnerable to serious illness that can

seriously compromise their health. HIV is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). Each aspect of this definition reveals important characteristics of this disease. Acquired highlights that a person can become infected with this virus. Immune deficiency reflects the weakness in the body's immune system that fights diseases. Syndrome indicates that this illness typically leads to a number of health problems that make up this disease. AIDS is considered to be the final stage of HIV infection where the virus has significantly weakened the immune system so that the individual has a very low number of T cells or has certain types of cancer or one or more specific infections.

HIV is an infectious disease that is primarily transmitted through direct contact with bodily fluids such as blood, semen or vaginal fluids. As such, people can only become infected with HIV if they get infected blood or sexual fluids into their system. There have been no documented incidents caused by saliva, tears or sweat. HIV is primarily transmitted through having sex or sharing needles and syringes with someone who is infected with HIV. Without proper medical attention, HIV can also be transmitted to a fetus or infant before or during birth or through breast-feeding. Finally, HIV can be transmitted through blood transfusions if the blood is infected with HIV. Given the improvements in neonatal care, fewer cases of HIV are transmitted at birth but these rates can vary from country to country depending upon access to critical medications. Likewise, many countries carefully monitor and test their blood supply to ensure that the blood supply is safe and free of HIV infection, which has significantly reduced HIV transmission through blood transfusions. All donated blood in the United States has been tested for HIV since 1985 (CDC). Despite being an infectious disease, it is critically important to understand that the HIV virus is fragile and cannot survive for long outside of the body. This means that HIV **cannot** be transmitted through day-to-day interactions such as hugging, shaking hands, using a toilet or water fountain, sharing food or clothing, or touching doorknobs or dishes used by a person with HIV/AIDS. Therefore, there is no reason to discriminate against individuals with HIV in a work setting.

Although HIV affects men and women of all races, ethnicities, sexual orientations, and socioeconomic levels across the world, there tends to be a disproportionate representation of HIV among people living in poverty. In the United States ethnic and sexual minorities are at higher risk for HIV/AIDS transmission and have higher rates of HIV than the majority population. While there is no cure for HIV/AIDS, medications are available to slow the growth of the virus and the damage that it can do to the immune system. These medications are referred to as antiretroviral therapy (ART or ARV). There are a number of different types or "classes" of ARV drugs (e.g., nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors and integrase inhibitor), each of which attacks HIV in different ways. To increase effectiveness and reduce drug resistance, ARV drugs are usually prescribed in combinations of three or more drugs from more than one class. Some manufacturers have combined some of these drugs into a single pill to make the drugs easier to manage. In addition to ARV, other drugs are also available to prevent or treat opportunistic infections. Depending upon one's circumstances the number and combination of drugs that one may need to take can vary greatly among those infected with HIV. Medication

management and side effects can also play an important role in the vocational rehabilitation process of individuals with HIV.

Employment Challenges and the Need for Vocational Rehabilitation

HIV/AIDS can have a pervasive impact on the vocational development of individuals living with this disease. Many studies have found a high incidence of unemployment among people with HIV, with some reporting rates of unemployment at 50% or higher (Blalock et al. 2002) (Burns et al. 2006 and 2007); (Dray-Spira et al. 2006); (Ezzy et al. 1999); (Fleishman 1998). Although initial studies related to HIV and employment tended to focus on employer needs and co-worker responses, there has been an increasing focus on the actual vocational development and work-related experiences of people with HIV/AIDS (Allen et al. 2003); Brooks RA, Klosinski LE 1999; (Fesko, 2001b); (Braveman 2001a and 2001b); (Conyers, 2004a and 2004b); (Fesko, 2001a); (Glen et al. 2003); Hergenrather, Rhodes, & Clark, G., 2004; 2005); (Hergenrather et al. 2008; Hergenrather et al. 2006; Hergenrather et al. 2005; Hergenrather et al. 2005; Hergenrather et al. 2004) (Hunt et al. 2003); (Kielhofner et al. 2003); (Kohlenberg et al. 2003); (Lightfoot et al. 2001); (Martin et al. 2003); (McReynolds 2001); (Miceli et al. 2001); (Timmons et al. 2004). Research indicates that many people with HIV/AIDS are able to achieve vocational goals with vocational rehabilitations services (Conyers,2004a); (Escovitz et al. 2005); (Martin 1999). Despite these findings, many people with HIV/AIDS face significant barriers to achieving their vocational goals and need the skills and services that rehabilitation professionals have to offer. This section will review some of the main barriers that individuals encounter within the context of vocational rehabilitation needs and services.

HIV Stigma and Employment Discrimination

The high level of social stigma associated with HIV/AIDS has been widely recognized ever since the outbreak of this disease. Consequently people with HIV/AIDS often must contend with widespread discrimination across all aspects of their lives, including employment (Lange 2004) (Conyers 2004a and 2004b). Some suggest that the nature of employment discrimination against individuals with HIV/AIDS may be more profound that that encountered by other disability groups (Conyers et al. 2005).

One theory that has been proposed to explain the unique nature of HIV/AIDS discrimination focuses on the fact that HIV/AIDS is a potentially fatal infectious disease with no cure (Pranschke et al. 1995).. Unfortunately, many people around the world continue to believe unfounded myths about their risk of HIV infection despite strenuous public health guidelines and research, which indicates the risk of transmission through casual contact is minute (Herek et al. 2002). Throughout history public fear and misapprehension about contagious diseases have frequently led to isolation and malicious myths about those disorders, and HIV/AIDS is no exception (Sontag, 1978, 1989). Furthermore, in some parts of the world, HIV/AIDS is more prevalent among already devalued and marginalized groups (e.g. intravenous drug users, gay men, people with a history of incarceration or living in poverty). Consequently, many contend that

HIV/AIDS-related discrimination is often related to preexisting stigma, which makes individuals with HIV/AIDS particularly vulnerable to discrimination (Herek et al. 2002; Herek et al. 1988; Leonard 1985; Studdert 2002). Employers who inaccurately perceive people with HIV/AIDS as direct threat to the work environment are likely to experience heightened anxiety and be at greater risk of making rash decisions without fully considering the legal and social consequences of those decisions. This fear and ignorance associated with HIV and those most affected by this illness can undermine an objective employment decisions and result in overt or covert discrimination CONYERS (Leonard, 1985). One key role that vocational rehabilitation professionals can play is to counter HIV related stigma and to provide more accurate information about this illness whenever possible.

Health

Poor health, which can lead to significant cognitive and functional limitations, is a primary barrier to employment for many with HIV/AIDS (Razzano et al. 2005). Despite advancements in the medical management of HIV that have lead to vast improvements in health outcomes for many of those who have access to ongoing medical treatment, many people throughout the world do not have access to these vital treatments and some do not respond to the treatments that they can access. Access to high quality medical treatment, preferably by a well-trained infectious disease specialist who has experience working with people with HIV and is aware of the many different strains of HIV virus and medication resistance goes a long way to help individuals with HIV to be able to function and engage in daily activities, including work. For medical treatment to be most effective, it is important that individuals with HIV get diagnosed as early as possible once they become infected so that their health status can be carefully monitored and early intervention can be applied when medically determined. Early intervention can help to prevent serious illness and gaps in one's vocational development or work history.

In addition to health challenges associated with HIV management many individuals with HIV/AIDS often contend with a range of other health issues, including mental health issues, that also need to be treated as part of the overall vocational rehabilitation process. Preliminary data from the National Working Positive Coalition's Vocational Development and Employment Needs Survey, which surveyed over 1,800 HIV positive people in the United States, indicates that only 9% of the respondents reported having no other disabilities or health concerns (Conyers, 2009). Over 20% of the respondents who responded to this item (N=1,582) indicated one or more of the following health challenges (22% Hepatitis C, 28% High Blood Pressure, 37% Mental Health/Psychiatirc, 42% Fatigue, 31% Neuropathy, 29% Night Sweats/Neuropathy). According to Citron, Brioullette, & Beckett (2005) anxiety, grief, and depression tend to be the most common mental health issues presented, however, mania, psychosis and suicide also occur among individuals with HIV and individuals who have a serious mental illness (e.g., schizophrenia and bipolar disorder) are at risk for infection with HIV, leading to an increasing number of individuals with a dual diagnosis. In particular, women with HIV/AIDS experience significant levels of depression and anxiety (Siegel et al. 2006). Any of the above mentioned health concerns may compromise one's ability to work. In some cases these health barriers can also help some individuals to quality for

governmental assistance with vocational training and employment services (e.g., State Federal Vocational Rehabilitation Services in the United States).

Unfortunately the medications and treatments used to manage HIV and associated health concerns can include potential side effects that can impede vocational development. These may include fatigue, nausea, diarrhea, anxiety, abnormal fat gain or loss and disruptions of sleep patterns (Max et al. 2000; Panther and Libman 2005). At times, it can be difficult to differentiate medication side effects from actual medical symptoms, which underscores the need for appropriate medication management to minimize any negative consequences of treatment as an essential aspect of the overall vocational rehabilitation process.

While it is crucial to emphasize self-determination and vocational services for people with HIV/AIDS so that they can plan for a productive life with economic stability, it is equally important to ensure that fundamental health and prevention services are available to individuals most at risk for HIV infection or poor health outcomes. Given the potential role that vocational planning and employment can have on motivating individuals to take care of themselves to achieve their goals it would be prudent to integrate vocational rehabilitation into public health and policy initiatives worldwide.

Individual and Episodic Nature of HIV

The health status of individuals with HIV can fluctuate considerably over time. As such, it can be helpful to conceptualize HIV an episodic disability that shares many of the vocational challenges as other episodic disabilities such as psychiatric disability, multiple sclerosis and many other chronic health conditions. Episodic disability poses unique challenges in that it can be very difficulty to predict when one may encounter a decline in health or to feel confident in future planning that relies on one's ability to consistently function at a certain level of performance. Episodic disabilities also vary greatly from individual to individual. For example, some have lived with HIV for over 20 years without any decline in health, while others have ongoing health challenges. Some respond well to treatments over extended periods of time and others need ongoing adjustments to their treatment plans and medication management. The need to change medications can be very disruptive to a daily work routine as individuals often have to adjust to new medication side effects and may have to have more frequent visits to the doctor. As such, the implications of health setbacks can be fairly debilitating but can also then lead to periods of relatively good health.

Vocational planning within this uncertain context can be fraught with ambivalence, negative outcome expectations, and lack of motivation associated with significant concerns about the future (Conyers et al. 2005). Additionally, issues related to episodic disability can pose a specific challenge to vocational rehabilitation planning when governmental health and financial supports that are provided to citizens with disabilities are removed upon return to work, with no guarantee or safety net regarding how these individuals would be able to reconnect with these resources in the future should their health decline. Thus those who may experience some degree of improvement in their overall health status may be reluctant to consider employment based upon the fear

associated with an uncertain future and the risk of losing access to financial, housing and medical benefits. In order to lessen this potential barrier to seeking employment vocational rehabilitation counselors will need to address these concerns to ensure that individuals are aware of any policies that would provide such a safety net or to advocate for changes in policies that would help to alleviate some of these concerns.

In countries and corporations/job settings where the employer or economy can not afford the long-term loss of productive employees, it would be equally important to plan for potential disruptions in employee's health to try to address these concerns and to keep the person as connected to their work as possible, even during periods of poor health, to increase the likelihood to eventual return to productivity. These interventions could include the provision of reasonable accommodations (e.g., rest periods, change in job duties, flexible scheduling). In this case, vocational rehabilitation assessment and counseling can play a critical role in maintaining a productive workforce. Unfortunately, although some efforts have been established to provide early intervention and access to health care for employees with HIV/AIDS in some countries, the stigma associated with disclosing one's HIV status prevents many from participating in these efforts and benefiting from the services and supports that are provided. As mentioned above, vocational rehabilitation professionals will need to work with public health and governmental initiatives designed to reduce HIV-related stigma on the societal level as well as work with individuals with HIV to reduce the internalized stigma that can limit one's ability to access needed services.

In light of the common vocational issues shared by many people with episodic disability, the research base and services delivery models that have been developed for other episodic disabilities can provide a rich foundation for the development of vocational rehabilitation programming for people with HIV/AIDS. Two theoretical foundations that show particular efficacy for their application to individuals with HIV/AIDS are the integration of the stages of change theory that had typically been applied to substance abuse rehabilitation and the application of psychiatric rehabilitation principles and practices (Escovitz et al. Donegan 2005; Martin et al. 2005).

National and International Efforts to Promote the Vocational Rehabilitation of People with HIV/AIDS

Vocational Rehabilitation Research and Planning for individuals with HIV/AIDS is still in a relatively early stage. Many of the systems that were established to respond to HIV/AIDS were developed prior to the advancements in medical treatment and therefore do not incorporate vocational or other services that are designed to help individuals plan for a more productive future. Many programs and services that do exist are grounded in a purely medical model with limited funding or resources available for broader psychosocial concerns that may have a significant impact on the well-being of individuals living with HIV/AIDS, including their ability and motivation to take their HIV medications. While preliminary evidence indicates that work may help facilitate positive health and prevention outcomes for many, the integration of vocational rehabilitation services into the HIV/AIDS service system remains a challenge. To help address this challenge and to advocate for the vocational and economic concerns of individuals with

HIV/AIDS, a number of efforts have been organized in the United States, Canada ad Cuba.

Within the United States, the preeminent organization to produce and disseminate knowledge regarding the employment-related needs and concerns of individuals with HIV/AIDS is the National Working Positive Coalition (NWPC, workingpositive.net). The coalition consists of individuals with HIV, services providers and researchers and the mission is to (a) promote research, development, and implementation of effective practices in employment services for individuals with HIV/AIDS, (b) coordinate sharing and dissemination of this information, and (c) advocate for work options and opportunities for people living with HIV/AIDS. In addition to managing a website to serve as an information hub for those interested HIV employment-related issues, services and research, the NWPC sponsors a full-day preconference institute at the United States Conference on AIDS.

As an organization, the NWPC recognizes the importance of integrating our efforts with the many initiatives and organizations currently designed to address the employment issues of individuals with disabilities generally and to continue to welcome new members who share our mission and values to further advance employment opportunities for individuals with HIV/AIDS around the world. For more information about how to join the NWPC please visit our website at workingpositive.net. Cross cultural collaborations in this area would be a great way to expand knowledge in this field and gain new perspectives and insight for all involved. As Chairperson for the NWPC Research Working Group, I would be happy to facilitate any such connections or dialogues on this topic. To date, we have also worked collaboratively with colleagues in Canada and Cuba on research initiatives and conference presentations. The Canadian Working Group on HIV and Rehabilitation (CWGHR, hivandrehab.ca) has a similar mission to the NWPC within the Canadian context and works to bridge the worlds of HIV, disability, and rehabilitation to "address the rehabilitation needs of people with HIV and changing the future of prevention, care treatment, and support." CWGHR recently adapted the 2008 NWPC Vocational Development and Employment Needs Survey to conduct a national study in Canada. For more about CWGHR's research and resources please visit their website: http://hivandrehab.ca/EN/resources/index.php. Finally, our colleagues in Cuba host a special section of the International Conference on Work and Health that is specifically devoted to HIV on a biannual basis. This conference is a great opportunity for individuals interested in this topic to meet and exchange ideas on a regular basis.

Conclusion

Vocational rehabilitation services can play a critical role in the lives of individuals with HIV/AIDS. Despite this fact, vocational rehabilitation services have not been fully integrated into the HIV service delivery system in many countries. In light of the improved medical treatments for people with HIV, it is essential to incorporate a rehabilitation-focused model of HIV/AIDS recovery, rather than to rely exclusively on stabilization and maintenance (Ciasullo et al. 2005). In contrast to a strict medical model, a rehabilitation model focuses on the individual goals of the consumer and uses these goals to provide the necessary resources to promote wellness, growth and full community

integration. Some evidence suggests that loss of employment can lead to increased health risk behaviors and that employment can improve one's outlook on the future (Conyers et al. 2009). At the same time, this study found that some individuals continue to work despite experiencing moderate to severe health-related symptoms. More research is needed to better understand the relationship between vocational rehabilitation and positive health and prevention outcomes for people with HIV/AIDS so that more successful programs can be tailored to meet the unique needs of this population (Conyers, 2008). Cross-national studies and having the opportunity to gain insights and perspectives from those working from different cultural perspectives with different policy and funding contexts could also be a very useful way to expand understanding the vocational rehabilitation in the lives of individuals with HIV/AIDS.

References

Blalock AC, McDaniel JS, Farber EW. 2002. Effect of employment on quality of life and psychological functioning in patients with HIV/AIDS. Psychosomatics 43:400-403.

Braveman BHC. 2001a. Occupational identity: Exploring the narratives of three men living with AIDS. Journal of Occupational Science 8(2):25-31.

Braveman B. 2001b. Development of a community-based return to work program for people living with AIDS. Occupational Therapy in Health Care 13(3-4):113-131.

Brooks RA, Klosinski LE. 1999. Assisting persons living with HIV/AIDS to return to work: Programmatic steps for AIDS service organizations. AIDS Education and Prevention 11(3):212-223.

Burns SM, Young LR, Maniss S. 2006. Predictors of employment and disability among people living with HIV/AIDS. Rehabilitation Psychology 51:127-134.

Burns SM, Young LR, Maniss S. 2007. Factors associated with employment among Latinos living with HIV/AIDS. Journal of Rehabilitation 73:29-37.

Ciasullo E, Escovitz, K. 2005. Positive futures: The need for paradigm shift in HIV/AIDS services. Journal of Vocational Rehabilitation 22:125-128.

Citron K, Brioullette M, Beckett A, eds. 2005. HIV and Psychiatry: A Training and Resource Manual. 2nd ed. Cambridge (UK): Cambridge University Press.

Conyers LM, Datti P. 2009. Unmet vocational rehabilitation needs of women with HIV. Work: A Journal of Prevention, Assessment and Rehabilitation 31(3):277-290.

Conyers LM. 2008. HIV/AIDS and employment research: A need for an integrative approach. The Counseling Psychologist 36:108-117.

Conyers LM, Unger D, Rumrill P. 2005. A comparison of equal employment opportunity commission case resolution patterns of people with HIV/AIDS and other disabilities. Journal of Vocational Rehabilitation 22:171-178.

Conyers, LM. 2004a. The impact of vocational services and employment on people with HIV/AIDS. Work: A Journal of Prevention, Assessment and Rehabilitation 23:205-214.

Conyers LM. 2004b. Expanding understanding of HIV/AIDS and employment: Perspectives from focus groups. Rehabilitation Counseling Bulletin 48(1):5-18.

Dray-Spira R, Persoz A, Boufassa F, Gueguen A, Lert F, Allegre T, Goujard C, Meyer L. 2006. Employment loss following HIV infection in the era of highly active antiretroviral therapies [Electronic version]. European Journal of Public Health 16:89-95.

Escovitz K, Donegan K. 2005. Providing effective employment supports for persons living with HIV: The KEEP project. Journal of Vocational Rehabilitation 22:105-114.

Ezzy D, De Visser R, Bartos M. 1999. Poverty, disease progression, and employment among people living with HIV/AIDS in Australia. AIDS Care 11:405–414.

Fesko SL. 2001a. Disclosure of HIV status in the workplace: Considerations and strategies. Health and Social Work 26:235-244.

Fesko SL 2001b. Workplace experiences of individuals who are HIV+ and individuals with cancer. Rehabilitation Counseling Bulletin 45(1):2-11.

Fleishman JA. 1998. Transitions in insurance and employment among people with HIV infection [Electronic version]. Inquiry - Blue Cross and Blue Shield Association 35:36-48.

Glenn M, Ford JA, Moore D, Hollar D. 2003. Employment issues as related by individuals living with HIV or AIDS. Journal of Rehabilitation 69(1):30-36.

Herek G M, Capitanio JP, Widaman KF. 2002. HIV-related stigma and knowledge in the United States: Prevalence and trends. American Journal of Public Health 92(3):371-377.

Herek, GM, Glunt EK. 1988. An epidemic of stigma: Public reactions to AIDS. American Psychologist 43(11): 886-891.

Hergenrather KC, Rhodes SD 2008. Consumers with HIV/AIDS: Application of theory to explore beliefs impacting employment. Journal of Rehabilitation 74:32-43.

Hergenrather KC, Rhodes SD, Clark, G. 2006. Windows to work: Exploring employment-seeking behaviors of persons with HIV/AIDS through photovoice. AIDS Education and Prevention 18:243-259.

Hergenrather KC, Rhodes SD, Clark G. 2005. The Employment Perspectives Study: Identifying factors influencing job-seeking behavior of persons living with HIV/AIDS. AIDS Education and Prevention 17:131-143.

Hergenrather KC, Rhodes SD, McDaniel RS 2005. Correlates of job placement: Public rehabilitation counselors and consumers living with AIDS. Rehabilitation Counseling Bulletin 48:157-167.

Hergenrather KC, Rhodes SD, Clark G. 2004. Using a theory-based approach to identify factors facilitating the employment-seeking behavior of persons living with HIV/AIDS. Journal of Rehabilitation 70:22-33.

Hunt B, Niles S, Jaques J, Wierzalis E. 2003. Career concerns for people living with HIV/Aids. Journal of Counseling and Development 81:55-60.

Kielhofner G, Braveman B, Goldbaum L, Goldstein K, Finalyson M, & Paul-Ward A. 2003. Outcomes of a vocational program for persons with AIDS. American Journal of Occupational Therapy.

Kohlenberg B, Watts MW. 2003. Considering work for people living with HIV/AIDS: Evaluation of a group employment counseling program. Journal of Rehabilitation: 22-29.

Lange T. 2004. HIV and civil rights: A report from the frontiers of the HIV/AIDS epidemic. Retrieved May 16, 2004 from www.aclu.org/HIVAIDS.

Leonard AS. 1985. Employment discrimination against persons with AIDS. University of Dayton Law Review 10(3):681-703.

Lightfoot M, Healy C. 2001. Career development, coping, and emotional distress in youth living with HIV. Journal of Counseling Psychology 48:484-489.

Martin D. 1999. Working with HIV: Issues for people with HIV/AIDS contemplating workforce reentry. Psychology and AIDS Exchange 26(1):3-4,6-7.

Martin DJ, Brooks RA, Ortiz DJ, Veniegas RC. 2003. Perceived employment barriers and their relation to workforce-entry intent among people with HIV/AIDS. Journal of Occupational Health Psychology 8(3):181-194.

Martin DJ, Chernoff RA, Buitron M. 2005. Tailoring a vocational rehabilitation program to the needs of people with HIV/AIDS: The Harbor-UCLA experience. Journal of Vocational Rehabilitation 22:95-106.

Max B, Sherer R. 2000. Management of the adverse effects of antiretroviral therapy and medication adherence. Clinical Infectious Diseases 30:96-116.

McReynolds CJ. 2001. The meaning of work in the lives of people living with HIV disease and AIDS. Rehabilitation Counseling Bulletin 44:104-115.

Miceli NS, Harvey M, Buckley MR. 2001. Potential discrimination in structured employment interviews. Employee Responsibilities and Rights Journal 13(1):15-38.

Panther LA, Libman H. 2005. Medical overview. In: Citron K, Brioullette M, Beckett A, editors. HIV and Psychiatry: A Training and Resource Manual 2nd ed. Cambridge (UK): Cambridge University Press. p. 1-29.

Pranschke SC, Wright BM. 1995. HIV and AIDS: Employers grapple with difficult issues. Benefits Quarterly 11(3):41-49.

Razzano LA, Hamilton MM. 2005. Health related barriers to employment among people with HIV/AIDS. Journal of Vocational Rehabilitation 22:179-188.

Siegel K, Schrimshaw, EW 2006. The stress moderating role of benefit finding on psychological distress and well-being among women living with HIV/AIDS. AIDS and Behavior 11:421-434.

Sontag S. 1978. Illness as Metaphor. New York: Farrar, Strauss, and Giroux.

Sontag S. 1989. AIDS and its Metaphors. New York: Farrar, Strauss, and Giroux.

Studdert DM. 2002. Charges of Human Immunodeficiency Virus discrimination in the workplace: The Americans with Disabilities Act in action. American Journal of Epidemiology 156:219-226.

Timmons JC, Fesko, SL. 2004. The impact, meaning, and challenges of work: Perspectives of individuals with HIV/AIDS. Health and Social Work 29(2):137-144.