mental health **AIDS**

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Biopsychosocial Update

HIV Prevention News

About Women & Men

Darbes, Crepaz, Lyles, Kennedy, and Rutherford (2008) conducted a "meta-analytic review of **HIV interventions for heterosexual African Americans** to determine the[ir] overall efficacy in reducing HIV-risk sex behaviors and incident sexually transmitted diseases [(STDs), i.e., the number of new cases each year,] and identify intervention characteristics associated with efficacy" (p. 1177). The investigators identified 38 randomized controlled trials (RCTs) published between 1988 and 2005 that met selection criteria. To aggregate these data, Darbes and colleagues "tested both fixed-effects and random-effects models, and both models yielded similar findings. . . . [The investigators] base[d] the final presentation on the random-effects model because it provides a more conservative estimate of variance and generates more accurate inferences about a population of trials beyond the set of trials included in this study" (p. 1179).

Darbes and colleagues report that "thirty-five RCTs provided data on self-reported HIV risk behavior from 14,682 participants. The aggregated effect size was significant . . . [and indicated] that the intervention groups had [a] 25% reduction in odds of reporting unprotected sexual behavior compared with comparison groups, at an average of 3 months after intervention" (p. 1180). In addition, "data on incident STDs were available from 10 RCTs that included 10,944 participants. The aggregated effect size was marginally significant . . . [and indicated] that the intervention group had a 12% reduction in the odds of incident STD compared with comparison groups" (p. 1188). "However, the effect became significant when eliminating the trial of the lowest methodological quality. . . . This evidence suggests that behavioral interventions can be not only efficacious in changing unprotected sex behaviors but may also reduce incident STDs in heterosexual African Americans" (p. 1191). "Intervention characteristics associated with efficacy include cultural tailoring, aiming to influence social norms in promoting safe[r] sex behavior, utilizing peer education, providing skills training on correct use of condoms and communication skills needed for negotiating safer sex, and multiple sessions and opportunities to practice learned skills" (p. 1177).

Finally, Darbes and colleagues observe that this "meta-analysis was . . . limited by the fact that . . . only . . . individual-level and group-level interventions [were included]. There were only a few randomized community-level and structural-level interventions available in the literature. . . . However, given that many risk factors associated with HIV risk-taking in heterosexual African Americans are structural (e.g., poverty, access to care), future research should evaluate community-level and structural-level interventions when more RTCs become available" (p. 1192).

Otto-Salaj et al. (2008) interviewed a convenience sample of 51 heterosexually active African American men and women recruited from an inner-city community-based service center. The purpose of the study was to examine "gender differences and preferences in the use of and response to six different styles of **condom use** negotiation with a hypothetical sexual partner of the opposite gender" (p. 150). The **negotiation strategies** were based on Raven's 1992 Power/Interaction Model of Interpersonal Influence.[1] Otto-Salaj and colleagues

> found that the type of condom negotiation strategy used may be an important determinant of the outcome of the request. Indeed, certain strategies may be more likely than others to elicit positive outcomes such as sexual partner agreement and cooperation or elicit negative outcomes[,] including noncooperation, anger,

[1] Otto-Salaj and colleagues (2008) describe the Power/Interaction Model of Interpersonal Influence (Raven, 1992) as follows: "Raven

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conflict, or even violence. Further, there were definite gender differences in response to types of negotiation strategies. Women participants . . . responded best to referent, reward, and legitimate strategies, and worst to informational tactics; under these circumstances, HIV prevention efforts targeted at men would be best advised to concentrate on skills training in condom use negotiation strategies utilizing reference to respect for the woman partner and sexual pleasure associated with condom use, and to avoid strategies emphasizing the provision of information related to disease prevention.

On the other hand, men responded best to reward strategies, and worst to coercion strategies. Responses given by a subset of both women – and to a greater extent, men – indicated that use of negotiation tactics involving coercion to use condoms may result in negative and even angry or violent reactions. Especially among some men, the potential for violent response to a "no condom, no sex" strategy was clear. Further, negative affect did not always correspond with refusal to use condoms, but it may have other consequences such as increasing the likelihood of intrapersonal violence between sexual partners. . . . [This] research strongly suggests that while coercive messages might work to persuade some partners to use condoms during sex, they also may produce unintended consequences for partners in relationships where the negotiator must decide in the moment how to handle an unpredicted reaction. (pp. 160-161)

The investigators stress that, "for women who have relationships with men who respond negatively to coercive strategies, use of these negotiation approaches may actually encourage problems in their relationships. Under these circumstances, use of coercive strategies . . . is not advised; rather, these results suggest that women will be more successful in negotiating condom use – and in avoiding negative affect from male sexual partners – if they emphasize the pleasure of sexual activity in the context of condom use" (p. 161).

On the topic of coercive strategies, Stoner et al. (2008)

> examined relationships among **adulthood victimization**, sexual assertiveness, **alcohol intoxication**, and sexual risk-taking in [161] female social drinkers. . . . Women completed measures of sexual assault and intimate partner violence history and **sexual assertiveness** before random assignment to 1 of 4 beverage conditions: control, placebo, low dose (.04%), or high dose (.08%). After drinking, women read a second-person story involving a sexual encounter with a new partner. As protagonist of the story, each woman rated her likelihood of condom insistence and unprotected sex. (p. 1167)

Stoner and colleagues found that "victimization history and self-reported sexual assertiveness were negatively related" (p. 1167) and that "alcohol did not promote unprotected sex directly, but reduced [the] perceived likelihood of health consequences of unprotected sex. In turn the less participants anticipated health consequences from unprotected sex, the less likely they were to insist on condom use" (p. 1174). On the other hand, "situational condom insistence was predicted by sexual assertiveness and perceived health consequences" (p. 1174). According to the investigators, "[t]his finding supports the value of sexual assertiveness training to enhance women's intentions to insist on condom use, especially since the relationship between sexual assertiveness and condom insistence was robust to alcohol intoxication: the more sexually assertive, the more likely to insist on condom use, regardless of intoxication level" (p. 1174).

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proposes six bases of power from which people derive strategies attempting to influence the behavior of others: (a) reward; (b) coercion; (c) legitimate; (d) expert; (e) referent; and (f) information. According to Raven, *coercive* and *reward power* can refer to real physical threats and tangible rewards, but they also can include personal rejection or approval. *Legitimate power* is derived from the structural relationship between the influencing agent and the target; the agent may implicitly or explicitly communicate that she or he has a 'right' to ask the target to engage in some behavior, and that the target has an obligation to comply. *Expert power* is acting on the assumption that the power-holder is 'correct,' while *referent power* refers to engaging in a behavior because of a sense of connection or relationship with the influencing agent. Finally, *informational power* is based on the logical argument that the influencing agent can present, either directly or indirectly, to the target in order to implement change" (p. 152).

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Although Stoner and colleagues echo the warning issued by Otto-Salaj and colleagues and counsel that "caution is warranted in asserting oneself in the face of a violent partner" (p. 1174), Stoner and colleagues maintain that their findings "suggest that lack of assertiveness associated with prior victimization extends to partners who exhibit no indication of being violent" (p. 1174) and that "sexual risk-taking by survivors of adult victimization may [therefore] be reduced by strengthening their sexual assertiveness" (p. 1174).

About Men Who Have Sex With Men

In Canada, Shuper and Fisher (2008) "use[d] an experimental approach to examine the **influence of sexual arousal and sexual partner characteristics** on [HIV-positive] MSM [men who have sex with men]'s risky sex intentions" (p. 451). "In a computer-based controlled experiment, 67 [HIV-positive] MSM underwent a sexual arousal manipulation and indicated their intentions to engage in unprotected sex with hypothetical partners who differed in terms of HIV serostatus, physical attractiveness, relationship type, and preference for condom use. . . . Computer-delivered questions assessed [HIV-positive] MSM's intentions to engage in various sexual acts with each hypothetical partner" (p. 445). Shuper and Fisher found that,

> consistent with hypotheses, sexual arousal led to stronger intentions to engage in unprotected sex and being presented with a physically attractive partner while sexually aroused led to the strongest intentions to engage in sex without condoms. Providing partial support for hypothesized relationships, partner serostatus also had a stronger influence on unprotected sex intentions for sexually aroused versus nonaroused [HIV-positive] MSM. Finally, and again consistent with hypotheses, partner serostatus was more influential in risky sex decisions when partners were long term versus short term. Such situations (involving the confluence of sexual arousal and partner attractiveness, perceived seropositivity, and longer term relationships) may be common and particular configurations associated with highly risky sexual behavior. (p. 451)

In short, according to Shuper and Fisher, "data from the present study demonstrate that a proportion of [HIV-positive] MSM continue to engage in risky sexual behavior. Results also demonstrate that [HIV-positive] MSM's risky sexual behavior intentions may be significantly affected by sexual arousal and by partner cues that are present" (p. 453). These findings

> suggest that risk-reduction interventionists need to recognize that decisions to use condoms are not necessarily based on rational thought and that sexual arousal may lead to a . . . motivated thought process to justify unprotected sex.[2] Therefore, . . . interventions should . . . focus on providing individuals with clear, simple, and relevant "rules" that remain automatic and salient, even while experiencing sexual arousal. In the present study, sexually aroused [HIV-positive] MSM were unable to ignore clear and simple information that their partner was [HIV-negative], leading to a decrease in risky intentions. Applying this to interventions, clear and simple decision rules could be discussed with . . . [a client], such as "Use a condom if you do not *know* with certainty that your partner is [HIV-positive]," or along the lines of negotiated safety . . . , "Use condoms with *all* partners *except* with your primary [HIV-positive] partner." If . . . [clients living with HIV/AIDS] adopt simple, clear, automatic, and salient risk-reduction rules, they may be less able to rationalize engaging in unprotected sex in risky situations, even when such decisions are made while sexually aroused. (p. 453)

Extending this focus on motivation and risk, Kalichman, Picciano, and Roffman (2008) examined **sexual risk-reduction motivation** among a convenience sample of 391 MSM engaging in high-risk behavior. In bivariate analysis, Kalichman and colleagues found that "men who practice higher-risk sexual behaviors have less intention to change their behavior, perceive themselves at higher risk and are more ambivalent about changing their risk behavior when compared to men at relatively lower risk" (p. 687). In multivariate analysis,

> self-perceived motivation to change and perceptions of risk were the two motivational markers that independently predicted engaging in high-risk sexual behavior four months later. These findings suggest that greater conscious awareness of one's own motivation to change and one's perceptions of risk predict engaging in less risk behaviors independent of other motivational indicators. Self-perceived motivation is a cognitive dimension of motivation that is likely amenable to interventions that target motivation-related beliefs. . . . [The investigators also found that] perceived risk is not a motivating factor at all and actually taps a self-assessment of risk without intention to reduce risk. In fact, . . . [these] data show that the greater one perceives . . . [his] risk the less . . . [he] endorse[s] intentions to change. (p. 687)

Kalichman and colleagues conclude that

[2] See the **Tool Box** on "New Thinking on *Not* Thinking About HIV Risk" in the Fall 2006 issue of *mental health* **AIDS** for more information on this topic.

motivating men to practice safer sex, particularly with their non-primary sex partners, will require motivation-specific interventions. . . . Brief and effective motivational counseling approaches developed for use in substance abuse treatment have been successfully adapted for use in HIV prevention interventions. . . . These interventions utilize multiple strategies for sensitizing individuals to their risk, increasing perceived social support for behavior change, facilitating intentions to change and reducing ambivalence for change. . . . [T]echniques for motivating behavior change should be included [in interventions] in combination with skills building experiences for enhancing behavior change self-efficacy. (pp. 687-688)

Johnson et al. (2008), from the Cochrane Collaboration, conducted a **systematic review of outcome studies evaluating the effects of behavioral HIV prevention interventions designed for use with MSM**. The investigators included both published and unpublished reports from the period 1988 through December 2007 in their review and

> found 44 studies evaluating 58 interventions with 18,585 participants. Formats included 26 small group interventions, 21 individual-level interventions, and 11 community-level interventions. Sixteen of the 58 interventions focused on . . . [MSM living with HIV]. The 40 interventions that were measured against minimal to no HIV prevention intervention reduced occasions of or partners for unprotected anal sex by 27%. . . . The other 18 interventions reduced unprotected anal sex by 17% beyond changes observed in standard or other interventions. (p. 2)

Elaborating on their findings, Johnson and colleagues stress that

> behavioral interventions reduce self-reported unprotected anal sex among MSM. These results indicate that HIV prevention for this population can work and should be supported.
>
> . . . [Among] small group and individual-level studies . . . , effects of the greatest magnitude have been observed in studies that used count outcomes and a shorter intervention span (up to 1 month).
>
> Among small group and individual-level studies, effects were also greatest when the comparison condition included minimal to no HIV prevention content. Nevertheless, statistically significant favorable effects were also seen when the comparison condition included standard or other HIV prevention content. . . .
>
> Because intervention effects were somewhat stronger (though not statistically significantly so) in studies with a greater attrition in the comparison condition, differential retention may be a threat to validity. . . .

Tool Box

Resources

Books & Articles

Benton, T.D. (2008). Depression and HIV/AIDS. *Current Psychiatry Reports, 10*(3), 280-285.
"In this article, we focus on depression, which is prevalent in HIV/AIDS. We review the evidence associating depression with HIV, the challenges in recognizing depression in HIV-positive individuals, and the psychopharmacologic strategies known to be effective in the treatment of HIV-positive individuals with depression" (p. 280).

Berg, C., Raminani, S., Greer, J., Harwood, M., & Safren, S. (2008). Participants' perspectives on cognitive-behavioral therapy for adherence and depression in HIV. *Psychotherapy Research, 18*(3), 271-280.
"The current study aimed to elicit patient feedback about the utility, strengths, barriers, and limitations of CBT-AD [cognitive-behavioral therapy for adherence and depression] for HIV patients" (p. 272). This feedback contributed to Berg and colleagues concluding that "CBT was structured yet flexible, developed self-awareness[,] emphasized social support, and involved therapist empathy and supportiveness. Limitations included the discomfort of discussing personal information and the impact of feeling ill on attendance and homework completion. Suggestions included more sessions, more flexibility in scheduling appointments, and more realistic and clear expectations regarding homework. These results provide insights about strengths and limitations of this psychotherapy with medically ill patients and may help to maximize intervention effectiveness and client acceptability" (p. 271).

Bhattacharya, R., Barton, S., & Catalan, J. (2008). When good news is bad news: Psychological impact of false positive diagnosis of HIV. *AIDS Care, 20*(5), 560-564.
"This is a series of four case [studies in which individuals] . . . developed psychological difficulties and psychiatric morbidities after being informed they had been misdiagnosed with HIV-positive status. . . . [M]isdiagnosis of HIV can lead to psychosocial difficulties and psychiatric morbidity, have public health and epidemiological implications and can lead to medico-legal conflict. . . . The implications of misdiagnosis are for the individual, their partners and social contacts, as well as for the community" (p. 560).

Hillman, J. (2008). Sexual issues and aging within the context of work with older adult patients. *Professional Psychology: Research & Practice, 39*(3), 290-297.
"The goal of this article is to provide psychologists with current information regarding sexuality and aging, including general prevalence data, age-related biological changes (e.g., menopause), incontinence, erectile dysfunction, prostate changes, male performance-enhancing drugs (e.g.,

Among community-level interventions, intervention effects were strongest among studies with random assignment of groups or communities. Therefore the inclusion of studies where assignment of groups or communities was by convenience did not exaggerate the summary effect. The greater effectiveness of interventions including more than 25% non-gay identifying MSM suggests that when they can be reached, these men may be more responsive than gay-identified men to risk reduction efforts. Non-gay identified MSM [(NGI-MSM)] may have had less exposure to previous prevention messages, so their initial exposure may have a greater impact.

The greater effectiveness of interventions that include efforts to promote personal skills such as keeping condoms available and behavioral self-management indicates that such content merits strong consideration in development and delivery of new interventions for MSM.

. . . Because most studies were conducted among mostly white men in the US and Europe, more evaluations of interventions are needed for African American and Hispanic MSM as well as MSM in the developing world. More research is also needed to further clarify which behavioral strategies (e.g., reducing unprotected anal sex, having oral sex instead of anal sex, reducing number of partners, avoiding serodiscordant partners, strategic positioning, or reducing anal sex even with condom use) are most effective in reducing transmission among MSM, the messages most effective in promoting these behaviors,

Viagra), medications' sexual side effects, and sexually transmitted diseases, including HIV/AIDS. Practice guidelines endorse a biopsychosocial perspective, in which stereotypes, gender, partner availability, socioeconomic status, ethnicity, religious beliefs, and sexual orientation are examined. Clinicians' potentially negative countertransference also should be recognized and worked through. Case examples illustrate many of these concepts, and directions for future research and patient care are offered" (p. 290).

Leserman, J., & Temoshok, L.R. (Eds.). (2008). Psychosocial influences in HIV/AIDS. *Psychosomatic Medicine, 70*(5), 521-619.
"The goal of this issue of *Psychosomatic Medicine* is to acquaint researchers and clinicians caring for HIV-infected persons with . . . research that documents the critical importance of psychological, social, and behavioral influences on biomedical aspects of HIV/AIDS" through the presentation of 13 "comprehensive, yet succinct reviews of important biobehavioral literature" (p. 521).

O'Cleirigh, C., & Safren, S. (2008). Optimizing the effects of stress management interventions in HIV. *Health Psychology, 27*(3), 297-301.
"Scott-Sheldon, Kalichman, Carey, and Fiedler (2008) present a thoughtful, important, and timely meta-analysis of randomized controlled trials of stress management interventions in HIV.[1] . . . The authors join Scott-Sheldon et al., in considering future directions for this type of clinical psychosocial intervention research in HIV. Recommendations for addressing the high prevalence of psychosocial problems including diagnosable mental health disorders comorbid with HIV are presented. Suggestions for addressing medication adherence and accommodating interventions with concomitant substance use treatment are also considered. . . . These recommendations are presented as realistic strategies for improving the modest treatment effect sizes for psychosocial outcomes and identifying meaningful effects on distal physiological outcomes associated with traditional stress management interventions in HIV" (p. 297).

Weidel, J.J., Provencio-Vasquez, E., Watson, S.D., & González-Guarda, R. (2008). Cultural considerations for intimate partner violence and HIV risk in Hispanics. *Journal of the Association of Nurses in AIDS Care, 19*(4), 247-251.
"The purpose of this report is to highlight culturally related issues that have been associated with HIV risk in Hispanics. Clinicians can . . . steer interventions toward more culturally competent care for this rapidly growing segment of American society" (p. 247).

[1] For more information on this study, see "Research on HIV-Related Cognitive-Behavioral Interventions, Stress Management Interventions, & Their Interface: A Confluence of Conclusions & Critiques," a **Tool Box** in the Summer 2008 issue of *mental health* **AIDS**.

Winningham, A., Gore-Felton, C., Galletly, C., Seal, D., & Thornton, M. (2008). Lessons learned from more than two decades of HIV/AIDS prevention efforts: Implications for people who are deaf or hard of hearing. *American Annals of the Deaf, 153*(1), 48-54.
"Although the few available estimates suggest that deaf and hard of hearing persons are disproportionately affected by HIV infection, . . . all empirically validated HIV prevention interventions have relied on communication strategies developed for persons who hear. Therefore, understanding and developing effective prevention methods is crucial for persons who are deaf or hard of hearing. The authors explore (a) factors among this population that may contribute to HIV-related behaviors, (b) four key concepts consistently included in successful interventions, and (c) practical ways in which to use this information to tailor effective intervention strategies for this population" (p. 48).

On the Web

The New York/New Jersey AIDS Education and Training Center (AETC), in collaboration with the Columbia University HIV Mental Health Training Project, has developed *Psychiatric Medications and HIV Antiretrovirals: A Guide to Interactions for Clinicians*, which may be downloaded here: http://aidsetc.org/pdf/tools/nynj_psych-guide.pdf.

—— *Compiled by Abraham Feingold, Psy.D.*

and the methods and settings in which these messages can be most effectively delivered. (pp. 2-3)

On the topic of MSM who do not identify as gay or bisexual, Operario, Smith, and Kegeles (2008) "used qualitative methods to explore the social and psychological context of sexual behavior and HIV risk among [21] **African American** [**NGI-MSM**]" (p. 347). Analysis of the men's narratives revealed that HIV sexual risk is, indeed,

> embedded in a larger social and psychological context, which includes internalized stigma about same-sex behavior that causes men to compartmentalize sex, masculine gender roles that reinforce images of toughness and ambivalent attitudes toward women, cultural norms that favor secrecy and privacy about personal matters, and spontaneous and unplanned sexual episodes with other men. For HIV prevention activities to reduce risk behaviors among these men, it is important to take into consideration the broad determinants of high-risk sexual activity such as those described here. (p. 356)

To this end, Operario and colleagues suggest that,

> because these men identify predominantly as straight/heterosexual, HIV prevention programs for African American NGI-MSM must deviate from intervention models that emphasize sexual minority identity in the counseling curriculum. Instead, HIV prevention programs for NGI-MSM must honor men's tendency to identify themselves first and foremost as African American men, and focus on HIV risk as an issue embedded in a broader social and cultural context. Moreover, addressing HIV risk with female partners is another priority for interventions targeting NGI-MSM. As observed here, it might not be feasible to counsel African American NGI-MSM on how to disclose to female partners (or to family member[s], friends, etc.) about their same-sex behavior, unless it is clear that the individual himself is ready for taking this step. Maintaining privacy and secrecy about same-sex behavior is fundamental to these men's sense of safety and stability in a potentially hostile and oppressive social context; thus, undermining men's privacy can have potentially harmful effects. Interventions can encourage NGI-MSM to view condoms as a component of all vaginal/anal insertive or anal receptive sexual behaviors and to have productive dialogues about condoms and HIV status with all sex partners, regardless of their partner's gender. Interventions must address men's tendency toward spontaneous and unplanned sexual risk episodes, which challenges the typical use of cognitive or rational theoretical models in many HIV prevention programs. Motivational interviewing strategies, which uncover and address personal motivations and emotions underlying unhealthy behaviors, might be more appropriate for changing unsafe sexual behaviors among these men. (pp. 356-357)

About Adolescents & Young Adults

Kiene, Tennen, and Armeli (2008) investigated "**day-to-day variability in condom use attitudes, self-efficacy, and behavioral intentions** and assess[ed] the utility of this variability in predicting the likelihood of condom use each day" (p. 463). A total of 116 sexually active college students offered daily reports on their sexual behaviors using a 30-day Web-based diary. The investigators found that "condom use attitudes, self-efficacy, and behavioral intentions demonstrated variability day-to-day, and, more important, that within-person daily decreases in attitudes and behavioral intentions were associated with failure to use condoms. Furthermore, . . . daily variation in negative affective states explained day-to-day changes in condom use intentions and self-efficacy" (p. 469). "Speculating as to why day-to-day changes appear to affect behavior more for individuals with stronger behavioral intentions" (p. 470), Kiene and colleagues

> posit that there may be a "tipping point" or a level of behavioral intentions at which condom use becomes more likely to occur. Individuals with weaker overall behavioral intentions may always be below this tipping point and therefore further decreases in intentions do not affect behavior. For individuals with stronger overall behavioral intentions, on most days their score is above the tipping point. However, on days when their behavioral intentions are weaker than normal they might cross this threshold; on these days, they are as likely to fail to use a condom as individuals with weaker overall behavioral intentions. (p. 470)

For this reason, "individuals with strong behavioral intentions still need to be targeted for interventions, as they may be just as likely to fail to use a condom on days when their behavioral intentions are weak as individuals with overall weaker behavioral intentions" (p. 470).

Continuing this focus on behavioral intentions, Dutch investigators (van Empelen & Kok, 2008) examined the circumstances under which 399 Dutch secondary school students were likely to **prepare** themselves **to use condoms** by buying and carrying them. The sample included students who had sexual experience as well as those who did not. The investigators found that "intended condom use was not sufficient to ensure

that adolescents plan and prepare for condom use. It was found that having the goal of condom use did not necessarily result in preparatory behavior, such as condom buying and condom carrying. . . . This suggests that interventions aimed at promoting condom use should focus not only on condom use itself, but should also motivate and encourage adolescents to buy and carry condoms" (p. 626).

Expanding on these findings, van Empelen and Kok suggest that "it may be important to focus on the sequence of steps that need to be followed, and the underlying social-cognitive factors, in order to attain and even maintain a complex behavior such as condom use. . . . Without specific planning and preparation, adolescents may engage in risky behavior simply because they find themselves in situations they had not anticipated" (p. 638).

About Persons With Severe Mental Illnesses

According to Collins, von Unger, and Armbrister (2008), "inner city women with severe mental illness [(SMI)] may carry **multiple stigmatized statuses**. In some contexts these include having a mental illness, being a member of an ethnic minority group, being an immigrant, being poor, and being a woman who does not live up to gendered expectations. These potentially stigmatizing identities influence both the way women's sexuality is viewed and their risk for HIV infection" (p. 389). With this framework in mind, the investigators conducted a qualitative study that "applies the concept of intersectionality to facilitate understanding of how these multiple identities intersect to **influence women's sexuality and HIV risk**" (p. 389).

Collins and colleagues interviewed 24 Latinas living with SMI in New York City and found that, among these women, "HIV . . . [s]exual risk occurred when they were in monogamous relationships with men who were unfaithful; when they experienced sexual abuse; when their loneliness and desire for relationships, combined with their symptoms, prevented leaving a risky relationship; when symptoms impaired their judgment; and when they engaged in unprotected intercourse without knowledge of a partner's serostatus" (p. 395). Importantly, "the social structures and institutions of mental health care in their urban neighborhood . . . can have protective effects in terms of HIV risks. Here, women find social support and health-related information. On the other hand, the clinic provides opportunities to meet partners who also live with a mental illness and may themselves engage in HIV risk behaviors" (p. 395).

In analyzing the interconnected domains of these women's sexual lives, Collins and colleagues found that

> the women seek identities that define them in opposition to the stigmatizing label of *"loca"* (Spanish for crazy) and bestow respect and dignity. These identities . . . unfolded through the . . . themes of "good girls" and "church ladies". Therefore, in spite of their association with the *"loca"*, the women also identify with faith and religion ("church ladies") and uphold more traditional gender norms ("good girls") that are often undermined by the realities of life with a[n SMI] . . . and the stigma attached to it. However, the participants fall short of their gender ideals and engage in sexual relationships that they experience as disempowering and unsatisfying. The effects of their multiple identities as poor Latina women living with [SMI] in an urban ethnic minority community are not always additive, but the interlocking effects can facilitate increased HIV risks. (p. 389)

On the basis of these findings, Collins and colleagues stipulate that HIV prevention activities conducted in mental health settings must first acknowledge women's sexual desire; needs for respect, intimacy, and emotional support; and the barriers that gender oppression, poverty, and mental illness place before them in their communities. Ideally, prevention activities would target the institutional level (the clinic), the individual and interpersonal levels, and the community. At the institutional level, the familiar setting of the clinic can be used to create an environment that is safe and respectful of women's sexual needs. To do so providers must be comfortable discussing women's sexual lives and the relationships . . . [among] sex, symptoms, stigma, and economic need. Barriers to such conversations must be addressed. At the individual level, behavioral interventions focused on sexual risk can include new modules on stigma and its impact on relationships as well as relational styles that gently challenge gender oppression.[3] At the

[3] Collins, Geller, Miller, Toro, and Susser (2001) "developed the curriculum, 'Ourselves, Our Bodies, Our Realties' with the goal of increasing women's autonomy in sexual encounters by introducing female-initiated methods of HIV prevention in addition to the male condom. . . . Role plays facilitate negotiation skills, and participants are encouraged to share personal relationship experiences and receive support for making choices to leave abusive relationships. Culturally sensitive examples are used for discussing barriers to safer sex and group discussions are meant to foster a sense of empowerment and self-respect. . . . Useful additions could include sessions that enable women to assess their gender role attitudes, weigh their success in attaining their ideals, and work with their peers to reframe ideals that capture the strengths they display in their current circumstances. Similarly, sessions that utilize problem-solving around stigma management in relationships could be integrated [into the curriculum]. Stigma reduction activities that support self-esteem may help decrease women's vulnerability to dangerous relationships. Moving interventions from the individual focus to the interpersonal by including women's partners would permit couples to work toward satisfying and safe[r] sexual relationships" (Collins, von Unger, & Armbrister, 2008, p. 396).

community level, participatory research and advocacy may help to initiate change. (p. 396)

About Women

Tross et al. (2008) randomly assigned 515 women recruited from 12 methadone maintenance or psychosocial substance abuse treatment programs to one of two conditions: an **evidence-based HIV/STD safer sex skills building** (SSB) **intervention for women** in community drug treatment, or a single-session HIV/STD Education (HE) control condition. "In SSB, five 90-minute groups used problem solving and skills rehearsal to increase HIV/STD risk awareness, condom use, and partner negotiation skills. In HE, one 60-minute group covered HIV/STD disease, testing, treatment, and prevention information" (p. 581). Tross and colleagues found that "both the SSB intervention and the HE control condition, designed to reflect current usual care in the community, reduced unprotected sexual occasions at 3 months after the intervention. At 6 months after the intervention, . . . [u]nprotected sex returned to baseline level in the control condition whereas the reductions in high-risk sex were sustained and even further decreased . . . among patients who received SSB" (pp. 586-587).

The investigators point out that "the interventions in this trial were conducted by local drug counselors, after a brief initial training and with some ongoing supervision. This suggests that the SSB intervention does not necessarily require advanced degrees or specialized expertise but rather is effective in the hands of practicing community-based clinicians" (p. 587). Tross and colleagues further observe that, "by demonstrating the effectiveness of a brief, gender-specific, skills-oriented risk reduction intervention, delivered by drug treatment staff at community-based clinics, this study suggests a model that could be applied more widely in primary care settings where high-risk women are treated[, including] . . . urban primary care, obstetrics-gynecology, or HIV clinics" (p. 588).

HIV Assessment News

Psychiatric Assessment

Gaynes, Pence, Eron, and Miller (2008) report on **psychiatric comorbidity** (i.e., multiple simultaneous diagnoses) of past-month and past-year *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (*DSM-IV*) mood, anxiety, and substance use disorder diagnoses, in a consecutive population of 152 men and women presenting for HIV care at an infectious disease clinic in an academic medical center in the southeastern United States. In all,

> [50%] and 33% of patients had a past-year and past-month diagnosis, respectively. The most common diagnoses were mood disorders (32% past year/21% past month) followed by anxiety (21%/17%) and substance use disorders (22%/11%). Half of those with past-year disorders and 40% of those with past-month disorders met the criteria for multiple diagnoses. Of those with a mood disorder in the past month, 53% also had an anxiety or substance use disorder; of those with an anxiety disorder, 62% also had a mood or substance use disorder; and of those with a substance use disorder, 63% also had a mood or anxiety disorder. Psychiatric comorbidity was associated with younger age, White non-Hispanic race/ethnicity, and greater HIV symptomatology. (p. 505)

Given this frequency of co-occurring psychiatric disorders, Gaynes and colleagues offer the following pointers to HIV care professionals:

> First, for any patient in whom a single psychiatric disorder is identified, the possibility of additional co-occurring disorders should be strongly considered. Second, comorbidity may affect the psychiatric treatment plan. For example, a patient with major depression and a co-occurring anxiety disorder may require a lower initial antidepressant dose (because of susceptibility to activation side effects) and, in general, would require eventually a higher final antidepressant dose than a patient with major depression alone. . . . Similarly, substance abuse treatment programs may prove ineffective for individuals with a co-occurring depressive disorder that is not identified and addressed. . . . Third, if a patient with an identified psychiatric disorder fails to respond to the current psychiatric treatment plan, the clinician should consider a more thorough psychiatric diagnostic evaluation to assess for additional co-occurring disorders. (p. 509)

In a 2-year prospective study, Atkinson et al. (2008) compared both **cumulative rates and predictors of a major depressive episode** in a sample of 297 men who were living with HIV (HIV+) and a matched control sample of 90 men who were uninfected (HIV-) but at risk for infection at baseline. Participants were generally young, predominantly white, and well educated and, unlike participants in the study conducted by Gaynes and colleagues, entered without a current diagnosis of major depression, major anxiety disorder, or substance dependence. Atkinson and colleagues report that

> lifetime prevalence of major depression or other psychiatric disorder did not differ at baseline between HIV+ men and controls. On a two-year follow-up[,] those with symptomatic HIV disease were significantly more likely to experience a major depressive episode than were asymptomatic HIV+ individuals and HIV-controls. . . . Episodes were as likely

> to be first onset as recurrent depression. After baseline disease stage and medical variables associated with HIV infection were controlled, a lifetime history of major depression, or of lifetime psychiatric comorbidity (two or more psychiatric disorders), predicted [a] subsequent major depressive episode. . . . Neither HIV disease progression during follow-up, nor the baseline presence of neurocognitive impairment, clinical brain imaging abnormality, or marked life adversity[,] predicted a later major depressive episode. (p. 225)

To put these findings into perspective, the "two-year cumulative rate of a major depressive episode, ranging from 40% in those with stable symptomatic-advanced illness to about 20% for asymptomatic individuals and in controls, w[as] . . . higher than the cross-sectional and prospective twelve-month rates described in epidemiologic community surveys, which range from 4 to 10%" (p. 231). Additionally,

> although currently active substance abusers and injection drug users were excluded [from the study], lifetime prevalence of psychoactive substance use disorders was elevated in both HIV-infected and risk-group controls. . . . Lifetime generalized anxiety disorder rates were comparable in HIV-infected men and male controls, and to reports in the general population . . . and in HIV cross-sectional studies . . . , but are lower than in women. . . . Prior history of psychiatric disorder was the most potent predictor of a major depressive episode. (pp. 231-232)

As Atkinson and colleagues frame it, "the results suggest that surveillance for major depression in symptomatic HIV disease is particularly warranted, that psychiatric history provides a cue to increased risk, and advancing illness may also contribute to vulnerability" (p. 232).

The assessment of individuals from ethnic and cultural minority backgrounds requires an appreciation of contextual factors that influence symptom presentation. As an example, Shacham, Basta, and Reece (2008) "examine[d] the prevalence of symptoms of psychological distress experienced by **African Americans** upon self-enrollment in HIV-related mental health care" (p. 413). The investigators collected data from 575 African Americans living with HIV who presented for HIV-related mental health services in Atlanta, "and . . . compare[d] the symptoms in this sample to the Brief Symptom Inventory (BSI) normative sample" (p. 413). Shacham and colleagues "found that African Americans in the sample had significantly lower rates of depression, anxiety, interpersonal sensitivity, phobic anxiety, and overall global severity. Yet, [study participants] had markedly higher levels of **somatization**, **paranoid ideation**, and **psychoticism** than the normative sample" (p. 417). The investigators surmise that "the findings related to elevated levels of symptoms of paranoid ideation and psychoticism may be a reflection of cultural mistrust" (p. 418) and alert clinicians to the possibility that "African Americans living with HIV may underreport symptoms of psychological distress or may experience symptoms of psychological distress differently than other individuals. As a result, it is important that HIV-related service providers recognize these patterns of psychological distress and provide appropriate referrals to HIV-related mental health providers" (p. 413).

Mental health providers play a central role in evaluating suicidal ideation and intent. Sherr et al. (2008) assessed the 7-day prevalence of **suicidal ideation** among 778 men and women receiving HIV primary care services at five clinics located in London and southeastern England. The investigators found

> a 31% prevalence of suicidal ideation. Factors associated with suicidal ideation were being a heterosexual man, black ethnicity, unemployment, lack of disclosure of HIV status, having stopped antiretroviral treatment (compared to treatment or treatment naive), physical symptoms, psychological symptoms and poorer quality of life. There was no association with sexual risk behaviour. Sex/sexuality and ethnicity were independently associated with suicidal ideation: the odds of suicidal ideation increased almost two-fold for heterosexual men compared with gay men or women and for black respondents compared with White or Asian respondents. Lack of disclosure was independently associated with a two-fold increase in odds of suicidal ideation. Elevated physical and psychological symptoms were strong independent predictors of suicidal ideation. Independent predictors of suicidal ideation were very similar among the subgroup of 492 patients on antiretroviral treatment. (p. 1651)

Sherr and colleagues conclude that, "despite advances in treatment, suicidal ideation rates among HIV-positive clinic attenders are high" (p. 1651). According to the investigators,

> these data indicate the urgent need to address the underlying predictors of such ideation in treatment plans and highlight the ongoing need for mental health services despite the availability of life-prolonging treatments. Furthermore, some of the traditional mental health triggers of suicidal ideation may need rethinking in the era of HIV, where a host of other infection-related burdens, perhaps not well addressed by mental health services, may contribute to suicidal ideation, such

Tool Box

Cut to the "Quick": Brief Psychodynamic Treatment for Persons Living with HIV/AIDS

In their recent paper, Lewis, Dennerstein, and Gibbs (2008) point out that psychodynamic psychotherapy frequently has been criticized as "lacking the evidence that would justify its use. . . . It is therefore notable that during the last decade high-quality empirical studies have been produced that respond to this deficit" (p. 445).

With this evolutionary process in mind, Lewis and colleagues set out to "evaluate the efficacy of short-term psychodynamic psychotherapy (STPP) using a systematic literature review of studies produced in the decade 1996-2006. The review is structured so that findings can be used to inform the clinical use of STPP according to DSM-IV diagnostic categories" (p. 445). Expanding on the term STPP, Lewis and colleagues highlight the fact that

> psychodynamic practice today differs from traditional psychoanalysis in many ways, reflecting an attempt to increase its application and effectiveness for a wider range of patients. . . . The postulate of unconscious mental processes remains an underlying principle. Contemporary psychodynamic psychotherapy aims to elucidate a patient's unconscious conflicts, encourage the expression and resolution of disturbing emotional states, create conditions in which the patient gains insight, and explore predisposing factors arising from the patient's developmental history. These aims are achieved by focusing on current and past interpersonal relationships and via the therapeutic effects of the patient-therapist relationship, which is considered to be the core mechanism of therapeutic change. . . . For the purposes of this review, STPP is defined as an explicitly time-limited and focused therapy that clearly applies these concepts in its therapeutic techniques. Such a definition covers a variety of treatments that may be called psychodynamic psychotherapy and time-limited psychoanalytic psychotherapy in the literature. The short-term nature of the treatments reviewed is here defined as being a maximum of 40 sessions and a minimum of seven sessions; a definition used because it is the standard applied in previous meta-analyses. (p. 446)

Referencing one review in particular which, according to Lewis and colleagues, "concluded that there was a lack of confirming evidence for STPP, the current review is focused on studies published between 1996 and 2006 that evaluate the efficacy of STPP. As a result of a systematic literature review, 18 studies were found that met inclusion criteria consistent with those used by Roth and Fonagy (1996) for selection of studies, patient groupings and definition of therapeutic method" (Lewis et al., 2008, p. 445). However, the investigators indicate that

> the present review differs from previous ones in several ways. First, the review is focused specifically on short-term therapy as defined here. Second, because there has been considerable debate on the restriction of the evidence base for psychotherapies to RCTs [(randomized controlled trials)], the current review adopts a broader definition. The evidence used in the present review is not limited to RCTs but also includes open trial investigations provided that they are replicable. The review also gives consideration to the interaction between therapeutic processes and outcomes. . . . Although process studies do not in themselves establish evidence for the efficacy of a given therapy, such studies contribute to understanding the mechanisms that are associated with therapeutic change. The third major difference is that the present review is limited to trials published in the last decade, thereby creating an updated review of the most current evidence base for contemporary forms of STPP. (pp. 446-447)

On the basis of their review, Lewis and colleagues report that, in general,

as immigration law, access to services and structural violence. As suicidal acts are still notable among causes of death for HIV-positive people . . . , these data suggest that full attention to suicide prevention initiatives should be incorporated into routine care. (p. 1657)

HIV Treatment News

Medical Care

According to Stebbing et al. (2008), "preclinical and cohort studies suggest that certain antidepressants are associated with a predisposition to cancer whereas others decrease the risk" (p. 2305). Additionally, "despite extensive data demonstrating that HIV infection and associated immunosuppression predisposes individuals to a wide range of cancers . . . (including non-AIDS-related malignancies . . .), no studies have specifically investigated the association between **antidepressant use**, length of antidepressant exposure, and the **development of** both AIDS-related and non-AIDS-related **cancers** in the highly active antiretroviral therapy (HAART) and pre-HAART eras" (p. 2306).

Stebbing and colleagues therefore set out "to assess whether different classes of antidepressants were associated with changes in cancer incidence in a population of HIV-1 infected individuals, based on duration of exposure" (p. 2305). The investigators found that, within a "cohort of 10,997 patients . . . attending a large HIV center during the pre-HAART and HAART eras, a total of 2,004 (18%) were prescribed antidepressants. . . . A total of 1,607 (15%) individuals were diagnosed with cancer. There were no significant associations between any class of antidepressant

these studies add to an increasing body of evidence suggesting that STPP can be an effective psychological treatment for individuals experiencing mental health problems. Specifically, for depression STPP can be equal in effects to other psychological treatments and is significantly better than no treatment in the short term. Furthermore, emerging process data indicate that there is a significant relationship between the use of specific psychodynamic therapeutic techniques and the alleviation of depressive symptoms. Increasing evidence has emerged to support STPP as a treatment for generalized anxiety disorder, panic disorder and some personality disorders. There remains limited evidence for the use of STPP treatment for patients with anxiety disorders that relate more to stress. Very limited and inconclusive evidence currently exists to support STPP as a treatment for bipolar disorder, eating disorders and drug dependency. Future research needs to include broader assessment measures, long-term follow up, studies that maintain an identifiable focus, and research that includes a focus on psychotherapy process variables as they interact with outcomes. (p. 445)

It's About Time

Pobuda, Crothers, Goldblum, Dilley, and Koopman (2008) examined "changes in distress associated with receiving time-limited dynamic psychotherapy (TLDP) among men who have sex with men (MSM) who are also living with HIV and AIDS" (p. 561) and receiving community-based mental health services through San Francisco's AIDS Health Project (AHP). As described by these investigators, TLDP emerged from

> the many years of scientific inquiry and clinical practice of Hans Strupp and Jeffrey Binder and colleagues, as well as the continued work of Hanna Levenson and colleagues. TLDP is based on a psychodynamic approach, . . . with the dyadic relationship between therapist and patient the central focus of the therapeutic work. . . .
>
> There are seven assumptions inherent to TLDP. First, it is assumed that the patient needs interpersonal therapy, because psychological problems stem from disturbed interpersonal relationships. Second, the TLDP therapist assumes that dysfunctional interpersonal styles were learned in the past and that, third, these dysfunctional interpersonal styles are being maintained in the present. Fourth, it is assumed that the patient will reenact the dysfunctional interpersonal style that was learned in the past, with the therapist in the present. Fifth, the therapist operating from a TLDP perspective takes the role of the participant-observer, and from this perspective, sixth, will become "hooked" into reenacting the interpersonal difficulties with the patient. Finally, the patient will present with one identifiable relationship pattern on which the therapy can focus. That is not to say that the patient does not have several different dysfunctional ways of relating, but the assumption in TLDP is there is one primary dysfunctional interpersonal style that most often causes strife in the patient's interpersonal life. (p. 562)

Moreover, according to Bein and colleagues,

> TLDP was created . . . to be an effective treatment for a wider range of patients than prior brief psychodynamic therapies . . . had been. A loosening of such treatments' selection criteria was deemed possible because "in TLDP, a 'good' therapeutic relationship is not a prerequisite for treatment; rather the *obstacles* to developing such a relationship, as they emerge in the patient-therapist interaction, are considered the primary area of work" (Strupp & Binder, 1984, p. 58). Patients with an unrealized potential to work collaboratively in treatment would be helped to develop this capacity through the active facilitation of a positive therapeutic alliance and through the early and consistent examination, in the here-and-now, of hostile, suspicious, and resistant behaviors toward the therapist. (Bein et al., 2000, p. 120)

(Tool Box is continued on Page 12)

and any type of cancer . . . , in either the pre-HAART or HAART era" (p. 2305). Stebbing and colleagues conclude that "antidepressants, irrespective of their class, do not affect cancer risk in HIV-infected individuals" (p. 2305).

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Neuropsychological Impairment

In a racially diverse sample of 93 children living with HIV, Hochhauser, Gaur, Marone, and Lewis (2008) "examined the **impact of environmental risk factors on** the **cognitive decline** normally observed with **pediatric HIV disease progression**" (p. 695). The investigators found that "immunosuppression was clearly associated with poorer cognitive outcome in the high-risk children" (p. 695); in other words, there was greater risk for HIV-associated cognitive decline among children living in highly stressful environments. Notably, "this relationship was not seen in those with lower levels of environmental risk" (p. 695). These findings have several implications, according to Hochhauser and colleagues:

First, while medication adherence has been shown to be worse in stressed or disorganized families . . . , it may also be most crucial for those children, as it is they whose neuropsychological functioning is at greatest risk from HIV neurotoxicity. Second, reducing environmental stressors may prove to be neuroprotective. This may be particularly important for patients for whom reducing immunosuppression . . . may be difficult or impossible. In these cases, perhaps their impact on

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(Tool Box -- continued from Page 11)

A more detailed summary of this model, drawn from writings by Levenson (2003), may be found in the sidebar.

Rapid Change, But No Quick Fix

Regarding their rationale for selecting TLDP as an approach to addressing the concerns of MSM living with HIV/AIDS, Pobuda and colleagues (2008) observe that a "therapeutic alliance is likely to be an effective tool in helping the patient who may have experienced little in the way of unconditional positive regard. . . . [For this reason], TLDP may be an excellent choice of psychological treatment intervention for HIV-positive MSM . . . , who may have been faced with homophobia and discrimination throughout life. TLDP offers the client the opportunity to enhance interpersonal interactions and to increase his expectations for the creation of healthy relationships" (p. 562).

The study sample consisted of 79 MSM living with HIV/AIDS who sought psychotherapy from the AHP. Participants ranged in age from 26 to 60 years (mean age = 42 years) and were "predominantly European American (77%), although Latinos (13%), African Americans (5%), and Asian Americans (4%) were also included. Each participant completed a pretest on a self-report measure of subjective distress, . . . received 20 sessions of TLDP over the course of 20 weeks, and then completed a posttest . . . to examine changes associated with TLDP" (Pobuda et al., 2008, p. 561). Subscales assessed progress along three dimensions: subjective discomfort (primarily depression and anxiety), interpersonal relationships, and social role performance.

Pobuda and colleagues found that, among study participants, "self-reported distress showed statistically significant decreases after 20 sessions of TLDP. Furthermore, the overall effects were strong, suggesting that decreases in distress were clinically meaningful as well as statistically significant. These results are particularly significant in light of . . . AHP's . . . policy of assigning higher functioning clients to TLDP therapists at intake, indicating that the participants in this study began treatment with lower pretest scores than mental health clients in the general population" (p. 561). Furthermore, according to the investigators, "given the lower than average pretest scores of TLDP clients at AHP, the scores represented in the current study are likely to be a more conservative reflection of the change that may occur in more typical commu-

Time-Limited Dynamic Psychotherapy in Brief

Continuing the pioneering work of Strupp and Binder (1984), Levenson (2003) characterizes time-limited dynamic psychotherapy (TLDP) this way:

> TLDP is an interpersonal, time-sensitive approach for patients with chronic, pervasive, dysfunctional ways of relating to others. Its premises and techniques are broadly applicable regardless of time limits. However, its method of formulating and intervening makes it particularly well suited for the so-called difficult patient seen in a brief or time-limited therapy. The brevity of the treatment promotes therapist pragmatism, flexibility, and accountability. . . . Furthermore, time pressures help keep the therapist attuned to circumscribed goals using an active, directive stance. . . . The focus is not on the reduction of symptoms per se (although such improvements are expected to occur) but rather on changing ingrained patterns of interpersonal relatedness or personality style. TLDP makes use of the relationship that develops between therapist and patient to kindle fundamental changes in the way the patient interacts with others and with himself or herself. (p. 301)

Who Can Be Helped?

According to Levenson (2003):

> there are five major selection criteria for determining a patient's appropriateness for TLDP: First, patients must be in *emotional discomfort* so they are motivated to endure the often challenging and painful change process and to make sacrifices of time, effort, and money as required by therapy. Second, patients must *come for appointments and engage with the therapist* – or at least talk. Initially, such an attitude may be fostered by hope or faith in a positive outcome. Later it might stem from actual experiences of the therapist as a helpful partner.
>
> Third, patients must be *willing to consider how their relationships have contributed* to distressing symptoms, negative attitudes, and/or behavioral difficulties. The operative word here is *willing*. Suitable patients do not actually have to walk in the door indicating that they have made this connection. Rather, in the give and take of the therapeutic encounters, they evidence signs of being willing to entertain the possibility. It should be noted that they do not have to understand the nature of interpersonal difficulties or admit responsibility for them to meet this selection criterion.
>
> Fourth, patients need to be *willing to examine feelings* that may hinder more successful relationships and may foster more dysfunctional ones. . . .
>
> And fifth, patients should be capable of having a *meaningful relationship* with the therapist. Again, it is not expected that the patient initially relates in a collaborative manner. But the potential for establishing such a relationship should exist. Patients cannot be out of touch with reality or so impaired that they have difficulty appreciating that their therapist is a separate person. (p. 309)

Five Fundamental Assumptions

In Levenson's (2003) articulation of the TLDP model, five basic assumptions greatly affect treatment:

> 1. Maladaptive relationship patterns are learned in the past. . . .
>
> 2. Such maladaptive patterns are maintained in the present. . . .
>
> 3. Dysfunctional relationship patterns are reenacted in vivo in the therapy. . . .
>
> 4. The therapeutic relationship has a dyadic quality. . . .
>
> 5. The TLDP focus is on the chief problematic relationship pattern. (pp. 303-305)

Speaking to the brevity of this intervention, Levenson observes that, "because dysfunc-

tional interactions are presumed to be sustained in the present, including the current patient-therapist relationship, the therapist can concentrate on the present to alter the patient's dysfunctional interactive style. Working in the present allows change to happen more quickly because there is no assumption that one needs to work through childhood conflicts and discover historical truths. This emphasis on the present has tremendous implications for treating interpersonal difficulties in a brief time frame" (p. 304).

The CMP Formulation

A well-defined procedure for case formulation is key to the practice of TLDP. This procedure centers on identifying the client's cyclical maladaptive pattern (CMP), his or her "most pervasive and problematic style of relating. . . . This is not to say that other relationship patterns may not be important. However, focusing on the most frequently troublesome type of interaction should have ramifications for other, less central interpersonal schemas and is pragmatically essential when time is of the essence" (Levenson, 2003, p. 305).

In brief, the CMP formulation

> outlines the idiosyncratic vicious cycle . . . of maladaptive interactions that a particular patient manifests in conjunction with others. These cycles or patterns involve inflexible, self-defeating expectations and behaviors and negative self-appraisals that lead to dysfunctional and maladaptive interactions. . . . A successful TLDP formulation should provide a *blueprint* for the therapy. It describes the nature of the problem, leads to the delineation of the goals, serves as a guide for interventions, enables the therapist to anticipate reenactments within the context of the therapeutic interaction, and provides a way to assess whether the therapy is on the right track – in terms of outcome at termination as well as in-session mini-outcomes. The focus provided by the CMP permits the therapist to intervene in ways that have the greatest likelihood of being therapeutic. Thus, there are possibilities for the therapy to be briefer and more effective. (pp. 310-311)

According to Levenson, "the CMP can be used to foresee likely transference-countertransference reenactments that might inhibit treatment progress. By anticipating patient resistances, ruptures in the therapeutic alliance, and so on, the therapist is able to plan appropriately. Thus, when therapeutic impasses occur, the therapist is not caught off guard but rather is prepared to capitalize on the situation and maximize its clinical impact – a necessity when time is of the essence" (p. 312).

The therapist uses this working formulation to discern the goals for treatment, which encompass both new experiences and new understandings.

New Experiences/New Understandings

Therapists who practice within the TLDP framework attempt to "help patients change . . . dysfunctional interpersonal patterns by fostering new experiences and new understandings that emanate from the therapeutic relationship" (Levenson, 2003, p. 300). Levenson describes *new experiences* in this fashion:

> The therapist identifies what he or she could say or do (within the therapeutic role) that would most likely subvert or interrupt the patient's maladaptive interactive style. . . . The patient can actively try out (consciously or unconsciously) new behaviors in the therapy, see how they feel, and notice how the therapist responds. This information then informs the patient's internal representations of what can be expected from himself or herself and from others. This in vivo learning is a critical component in the practice of TLDP.
>
> These experiential forays into what, for the patient, has been frightening territory make for heightened affective learning. A tension is created when the familiar (though detrimental) responses to the patient's presentation are not provided. Out of this tension new learning takes place. Such an emotionally intense, here-and-now process is thought to "heat up" the therapeutic process and permit progress to be made

(TLDP in Brief is continued on Page 14)

munity mental health samples" (p. 565).

Pobuda and colleagues recognize the methodological strengths of their study; these include good statistical power, the use of a valid and reliable measure of distress, the selection of a narrowly defined sample, and the administration of the intervention by well-supervised graduate students in clinical psychology.

The investigators also recognize the limitations of their methodology, including the lack of a control group; the possible influence of institutional transference (i.e., strong positive feelings about the setting in which the study was conducted) on measured outcomes; the reliance on self-report alone to assess progress; the selection of a narrowly defined sample, limiting the generalizability of findings; and the administration of the intervention by graduate students in clinical psychology (discussed below).

Nevertheless, Pobuda and colleagues conclude that "TLDP shows promise for alleviating distress associated with depression, anxiety, interpersonal functioning and social role in HIV-positive MSM" (p. 566).

Take the Long Train

In the study just described, "the graduate student status of the therapists administering TLDP can be seen as a limitation . . . [in that m]ost of the therapists . . . had no exposure to TLDP prior to the onset of their practicum placements at AHP. Their skills as therapists in general, and specifically as therapists operating from a TLDP model, may therefore not be comparable to the clinical skills of more seasoned psychotherapists" (Pobuda et al., 2008, p. 566). On the other hand, although these graduate students in clinical psychology "may not have had as much experience administering TLDP as more seasoned professionals, their student status can be seen as a strength. . . . Trainees received hours of direct supervision weekly that were focused on their practice of TLDP. Furthermore, the use of students indicates the generalizability of TLDP to less experienced clinicians, who are more often used in outcome research" (p. 565).

It bears mentioning in this context that Bein et al. (2000) conducted a study in which they explored the impact of therapist training in TLDP on therapeutic outcomes among a sample of 64 adults between the ages of 24 and 64 years. In this study,

> each of 16 therapists (8 psychiatrists and 8 clinical psychologists)

(Tool Box is continued on Page 14)

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more quickly than in therapies that depend solely on more abstract learning (usually through interpretation and clarification). (p. 306)

Levenson draws a distinction between new experiences and *new understanding* by emphasizing that this

> second goal . . . focuses more specifically on cognitive changes than the first goal . . . [of new experiences], which emphasizes more the affective-behavioral arena. The patient's new understanding usually involves an identification and comprehension of his or her dysfunctional patterns. To facilitate such a new understanding, the TLDP therapist can point out repetitive patterns that have originated in experiences with past significant others, with present significant others, and in the here and now with the therapist. Therapists' disclosing their own reactions to the patients' behaviors can also be beneficial. In this way patients begin to recognize how they have similar relationship patterns with different people in their life, and this new perspective enables them to examine their active role in perpetuating dysfunctional interactions. (p. 308)

Implementation Strategies

Levenson (2003) stresses that "TLDP does not rely on a set of techniques. Rather, it depends on therapeutic *strategies* that are useful only to the extent that they are *embedded in a larger interpersonal relationship*. Because the focus is on experiential interpersonal learning, in theory any intervention that could facilitate this goal could be used. However, it is critical for the therapist to understand how the meaning and impact of such interventions taken out of their original context might shift when they are incorporated within TLDP" (p. 313).

In essence, "the therapist needs to provide opportunities for the patient to have new experiences of himself or herself and/or the therapist that are designed to help disrupt, revise, and improve the patient's CMP" (p. 314). Behaviors enacted by therapists must give clients "a new interpersonal experience – an opportunity to disconfirm their own interpersonal schemata. With sufficient quality and/or quantity of these experiences, patients can develop different internalized working models of relationships. In this way, TLDP is thought to promote change by altering the basic infrastructure of the patient's transactional world, which then reverberates to influence the concept of self" (p. 314).

All Done?

As a time-limited intervention, termination considerations are monumental for concluding a course of TLDP. Levenson (2003) poses the key question this way:

> How does the TLDP therapist know when the patient has had "enough" therapy? In doing TLDP, . . . [Levenson uses] five sets of questions to help judge when termination is appropriate. First and foremost, has the patient evidenced interactional changes with significant others in his or her life? Does the patient report more rewarding transactions? Second, has the patient had a new experience (or a series of new experiences) of himself or herself and the therapist within the therapy? Third, has there been a change in the level on which the therapist and patient are relating (from parent-child to adult-adult)? Fourth, has the therapist's countertransferential reaction to the patient shifted (usually from negative to positive)? And fifth, does the patient manifest some understanding about his or her dynamics and the role he or she was playing to maintain them?
>
> If the answer is "no" to more than one of these questions, then the therapist should seriously consider whether the patient has had an adequate course of therapy. (p. 315)

Levenson observes that, "as with most brief therapies, TLDP is not considered to be the final or definitive intervention. At some point in the future, the patient may feel the need to obtain more therapy for similar or different issues. Such additional therapy would not be viewed as evidence of a TLDP treatment failure. In fact, it is hoped that patients will view their TLDP therapies as helpful and as a resource to which they could return over time" (p. 315).

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> treated 2 moderately disturbed adult patients using his or her customary short-term treatment methods; they then received a year of training in . . . TLDP . . . [and subsequently] administered TLDP to 2 additional patients. It was hypothesized that training would result in improved outcomes generally and that differentially greater improvement would be seen in patients commonly considered less suitable for brief dynamic therapy. Outcome data obtained at termination failed to support either hypothesis. Measurements of interpersonal dependency obtained at a one-year follow-up were consistent with the first hypothesis, but the follow-up data were inconsistent with the second. A systematic review of the 32 posttraining cases suggested that the majority of the therapists had not achieved basic competence at TLDP. (p. 119)

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– Compiled by Abraham Feingold, Psy.D.

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cognitive functioning could be moderated by taking measures to reduce stress. Such interventions might include concrete actions to improve the child's home or family environment . . . or perhaps stress-reduction interventions like psychotherapy or massage therapy. (p. 696)

Adherence to Treatment

Leserman, Ironson, O'Cleirigh, Fordiani, and Balbin (2008) "examine[d] demographic, health behavior and psychosocial correlates (e.g., **stressful life events**, depressive symptoms) of nonadherence" (p. 403) among 105 men and women residing in South Florida and taking antiretrovirals. Within this sample,

> 44.8% had missed a medication dose in the past 2 weeks, and 22.1% had missed their medication during the previous weekend. Those with three or more stressful life events in the previous 6 months were 2.5 to more than 3 times as likely to be nonadherent (in the past 2 weeks and previous weekend, respectively) compared to those without such events. Fully 86.7% of those with six or more stresses were nonadherent during the prior 2 weeks compared to 22.2% of those with no stressors. Although alcohol consumption, drug use, and symptoms of depression were related to nonadherence in the bivariate analyses, the effects of these predictors were reduced to nonsignificance by the stressful event measure. (p. 403)

Leserman and colleagues suggest that "having many stressful events may be a more robust correlate of nonadherence than depression. Persons who report more stressful events may have more chaotic lifestyles that may account for their missed medications. . . . These findings suggest that while interventions for depression may be useful, cognitive behavioral interventions that address stress and coping may have a greater impact on adherence to HIV medication" (p. 409).

Malta, Strathdee, Magnanini, and Bastos (2008) conducted a "systematic review of studies assessing **adherence to HAART among HIV-positive drug users** (DU[s]) and identif[ied] . . . factors associated with non-adherence to HIV treatment" (p. 1242). The investigators selected 41 peer-reviewed studies published between 1996 and 2007; these studies included

> a total of 15,194 patients, the majority of whom were HIV-positive DU[s] (*n* = 11,628, 76.5%). Twenty-two studies assessed adherence using patient self-reports, eight used pharmacy records, three used electronic monitoring [i.e., Medication Event Monitoring Systems (MEMS) caps], six studies used a combination of patient self-report, clinical data and MEMS-caps, and two analyzed secondary data. Overall, active substance use was associated with poor adherence, as well as depression and low social support. Higher adherence was found in patients receiving care in structured settings (e.g.[,] directly observed therapy) and/or drug addiction treatment (especially substitution therapy). (p. 1242)

Malta and colleagues conclude that, although HAART adherence was lower among DUs "than other populations – especially among users of stimulants, incarcerated DU[s,] and patients with psychiatric comorbidities – adherence to HAART among HIV-positive DU[s] can be achieved. Better adherence was identified among those engaged in comprehensive services providing HIV and addiction treatment with psychosocial support" (p. 1242). Moreover, "most papers [included in this review] suggest that the adherence to HAART among HIV-positive [DU]s can be similar to those found among other [people living with HIV/AIDS], once proper timing to initiate treatment is followed, comorbidities are properly managed and treated, psychosocial support is provided, and drug treatment, particularly substitution therapy, is instituted" (p. 1253).

Stress Management

In a departure from the traditional cognitive-behavioral approach to HIV-related stress management (research about which is coincidently and conveniently summarized in the **Tool Box** in the Summer 2008 issue of *mental health* **AIDS**), McCain et al. (2008) conducted a "randomized clinical trial . . . to test effects of **three 10-week stress management approaches** – **cognitive-behavioral relaxation training** (RLXN),[4] **focused tai chi training** (TCHI),[5] and **spiritual growth groups** (SPRT)[6] – in comparison to

[4] The structured RLXN training intervention "consisted of physical and mental relaxation skills training, with a focus on individualized combinations of relaxation techniques, as well as active coping strategies for stress management. Participants were expected to routinely practice relaxation techniques during and following the intervention, and daily practice frequency was recorded each week. Each participant was given a set of eight 30-min audiotapes specifically produced for use in this study" (p. 433).

[5] A focused short form of TCHI "involving eight movements was developed for this study. The intervention sequence began with a focus on breathing and balance, both key elements in all tai chi exercises. The sequence of movements taught was focused on developing each individual's skills in balancing, focused breathing, gentle physical posturing and movement, and the active use of consciousness for relaxation. Training videotapes were provided to participants for weekly and ongoing practice of the techniques" (p. 434).

[6] "The SPRT . . . intervention was designed to facilitate personal exploration of spirituality and to enhance exploration of the spiritual self and awareness of the meaning and expression of spirituality. Each session was designed to explore an aspect of spirituality and included the intellectual process of knowing or apprehending spirituality; the experiential component of interconnecting one's spirit with self, others, nature, God, or a higher

a wait-listed control group (CTRL) among 252 individuals with HIV infection" (p. 431). According to the investigators, the "purpose of the research was to determine whether the three 10-week stress management interventions would improve and sustain improvements 6 months later in the domains of psychosocial functioning, quality of life, and physical health among persons with varying stages of HIV infection. These three outcome domains, along with neuroendocrine and immune mediating variables, were measured by multiple indicators derived from the psychoneuroimmunology (PNI) paradigm" (p. 431). "Interventions were conducted with groups of 6-10 participants who met in suitably equipped conference rooms in an office setting for 90-min sessions weekly for 10 weeks. Participants who attended less than 8 of the 10 intervention sessions were deemed as having incomplete treatments and classified as withdrawn from the study" (p. 433).

McCain and colleagues found that, "in comparison to the CTRL group, both the RLXN and TCHI groups less frequently used emotion-focused coping strategies, and all three intervention groups had higher lymphocyte proliferative function. Generally, decreased emotion-focused coping can be considered an enhancement in coping strategies; however, there was no concurrent increase in problem-focused or appraisal-focused coping, making interpretation of this change more tenuous" (p. 437). Similarly, "the consistent finding of increased lymphocyte proliferation indicates the interventions were associated with enhancement in immune system functional status. . . . However, because there was no significant change in salivary cortisol, the mechanism of increased lymphocyte function is not clear. Ongoing assessment of cytokine activity or patterns of production may ultimately yield insight into other mechanisms involved in immune function changes" (pp. 437-438).

power; and an appreciation of the multisensory experience of spirituality. The process of weekly journal entries facilitated increased awareness and the integration of spirituality into daily life" (p. 434).

Despite these challenges in interpreting the study findings, McCain and colleagues contend that, in general,

> study findings support use of the PNI-based model for stress management in individuals living with HIV infection. Despite modest effects of the interventions on psychosocial functioning in this sample, the robust finding of improved immune function with these stress management approaches has important clinical implications, particularly for persons with immune-mediated illnesses. . . . Findings of this study indicate that immune function and possibly coping and quality of life may be enhanced with cognitive-behavioral stress management, tai chi, and spirituality-based interventions. While further research is needed to examine specific effects of various stress management interventions and to expand the repertoire of alternative approaches that might be effective in enhancing adaptational outcomes, this study contributes to a growing body of well-designed research that generally lends support to the integration of stress management strategies into the standard care of individuals living with HIV infection. (p. 439)

Coping, Social Support, & Quality of Life

Murphy, Greenwell, Resell, Brecht, and Schuster (2008) "investigated current autonomy among early and middle adolescents affected by maternal HIV (*N* = 108), as well as examined longitudinally the children's responsibility taking when they were younger (age 6-11; *N* = 81) in response to their mother's illness and their current autonomy as early/middle adolescents" (p. 253). Within this sample of primarily low-income Latino and African American families residing in Los Angeles County, "children with greater attachment to their mothers had higher autonomy [when performing household-centered activities], and there was a trend for children who drink or use drugs alone to have lower autonomy. In analyses of management autonomy[, which encompasses activities performed outside the home], attachment to peers was associated with higher autonomy" (p. 253). In their longitudinal analysis of this cohort, Murphy and colleagues found that "those children who had taken on more responsibility for instrumental caretaking roles directly because of their mother's illness showed better autonomy development as early and middle age adolescents" (p. 253). Importantly, the investigators also found that autonomy was associated "with 'positive' characteristics such a mother-child bond and coping self-efficacy" (p. 271). Murphy and colleagues conclude that

> "**parentification**" **of young children with a mother with HIV/AIDS** – that is, the young children taking on household responsibilities due to the mother's illness – may not negatively affect later autonomy development in these children. While it may indeed have other detrimental effects, such as more absence from school and school performance . . . , in at least this limited sample of children affected by HIV, higher responsibility taking as a result of maternal HIV/AIDS among young children was associated with later early/middle adolescent higher autonomy functioning. . . . Thus, even if they experienced some distress from parentification at an earlier age, it did not interfere with their long-term early and middle adolescent autonomous functioning. (p. 272)

Murphy and colleagues acknowledge

that these findings require additional exploration with larger samples. Nevertheless, the investigators stress that if

> HIV-positive mothers, due to their fatigue or illness, must rely on their young children at times to perform behaviors that most children their age do not typically perform, then it is critical that there be a strong focus on the mother developing or maintaining: (1) A high level of attachment and bond between herself and the child; and (2) strong support of the child to assist in the child developing strong coping self-efficacy. . . . [I]f a child does indeed have to sometimes function in a "parentified" role, then the data from this study indicate that children with a close attachment to their mother and who have good coping self-efficacy will have higher autonomy as they develop; these are both issues that can be worked on and improved in family therapy. (p. 272)

With a sample of 104 MSM averaging 50 years of age and living with HIV, Dutch investigators (Kraaij, van der Veek, et al., 2008) assessed relationships among "coping strategies, goal adjustment, and symptoms of **depression and anxiety**" (p. 395). The investigators found that "**cognitive coping strategies** had a stronger influence on well-being than . . . behavioral coping strategies: positive refocusing, positive reappraisal, putting into perspective, catastrophizing, and other-blame were all significantly related to symptoms of depression and anxiety. In addition, withdrawing effort and commitment from unattainable goals, and reengaging in alternative meaningful goals, in [the] case that preexisting goals can no longer be reached, seemed to be a fruitful way to cope with being HIV[-]positive" (p. 395). With regard to intervention, as Kraaij and colleagues see it, "the focus of treatment could be the content of thoughts and bringing about effective cognitive change, combined with working on goal adjustment. Various studies showed the positive effects of cognitive-behavioral oriented interventions . . . and coping effectiveness training . . . in improving psychological states in HIV-infected men. Future studies should be undertaken looking at the effectiveness of intervention programs focusing on cognitions and life goals" (p. 400).

In another study by this research group with the same sample of MSM (Kraaij, Garnefski, et al., 2008), the investigators found that greater

> use of positive refocusing, refocus[ing] on planning, positive reappraisal, putting into perspective, and less use of other-blame, was related to higher levels of **personal growth**. . . . [P]ositive reappraisal appears to be the most powerful predictor of personal growth.
>
> Another important predictor . . . was goal self-efficacy. Respondents who reported a higher belief in their ability to adjust their goals when important goals are obstructed by being HIV-positive, reported higher levels of personal growth. (p. 303)

As in the study described above (Kraajj, van der Veek, et al., 2008), Kraajj, Garnefski, and colleagues conclude that cognitive-behavioral oriented interventions and coping effectiveness training "could be offered to improve personal growth. The specific focus of treatment could be then the content of thoughts, combined with working on **goal adjustment**. Ingredients of treatment should be a combination of (positive) cognitive coping strategies and goal self-efficacy" (p. 303).

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– Compiled by
Abraham Feingold, Psy.D.

Tool Box

A Note on Content

This publication has been developed to help the frontline provider of HIV-related mental health services, allied professionals, and consumers stay up-to-date on research-based developments in HIV care. The contents for the "Biopsychosocial Update" are drawn from a variety of sources including, but not limited to: the *CDC HIV/STD/TB Prevention News Update* (http://www.cdcnpin.org/news/prevnews.htm); the *Kaiser Daily HIV/AIDS Report* (http://report.kff.org/hivaids/); and information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

It is presumed that readers have at least a fundamental understanding of medical, psychiatric, psychological, psychosocial, and spiritual considerations when assessing and intervening with people who are living with HIV/AIDS and their families. For additional background information on these aspects of care, the following resources may be of assistance:

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HIV/AIDS Education, Prevention, and Services Programs
Division of Prevention, Traumatic Stress, and Special Programs
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
One Choke Cherry Road, Suite 2-1009
Rockville, MD 20857
Web site: http://www.samhsa.gov/

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov