

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Persons With Severe Mental Illnesses

Himelhoch, McCarthy, et al. (2007) "examined data from a **national sample** of veterans who received a diagnosis of serious mental illness [SMI] (schizophrenia, bipolar disorder, and other, nonorganic psychoses) in fiscal year 2002 (FY2002) (N=191,625) and from a national random sample of veterans in FY2002 who did not receive [SMI] diagnoses (N=67,965)" (p. 1165). Himelhoch and colleagues found that the crude recorded **prevalence of HIV** was 1.0% **among persons with SMI** and 0.5% among persons without SMI.

Multivariate analyses indicated that individuals with bipolar disorder were no more likely than those without ... [any SMI] to have a recorded HIV diagnosis ..., whereas those with other[, non-organic] psychoses were more likely to have one An interaction was observed between schizophrenia and substance use disorder. Compared with patients who had neither schizophrenia nor a substance use disorder, those with schizophrenia without a substance use disorder were less likely to have a recorded HIV diagnosis ..., whereas those with a substance use disorder were more likely to have ... [one]. (p. 1165)

The investigators reason that,

[g]iven the continued risk for HIV in this vulnerable population ..., ongoing efforts by mental health providers to provide consistent primary and secondary HIV prevention education ... [are] warranted This may be particularly important for individuals with schizophrenia who are known to be abusing drugs or alcohol, because the findings indicate that patients with schizophrenia who also had a substance use disorder were at greater risk of being diagnosed as having HIV. It also may be particularly important for mental health professionals to monitor ... and maximize psychiatric treatment interventions that may reduce the risk during an acute psychiatric episode of high-risk sexual behavior or use of illicit substances – for example, optimizing treatment of bipolar disorder to prevent mania. (p. 1171)

About Persons Who Use Substances

Hendershot, Stoner, George, and Norris (2007) explored **dispositional influences on sexual risk taking among** 611 heterosexual young adult **drinkers of alcohol**, a sample that was 49% female and 76% white, with an average age of 25 years. The investigators found that

sexual sensation seeking predicted HIV risk directly as well as indirectly via sex-related alco-

hol expectancies and drinking in sexual contexts. This finding suggests that alcohol expectancies and drinking before sex represent proximal pathways through which dispositional factors such as sexual sensation seeking influence sexual risk behavior. Gender differences in the relationships among the variables were not supported, demonstrating that sexual sensation seeking, alcohol expectancies, and drinking before sex function similarly in predicting sexual risk behavior among heterosexual men and women in the present study. (pp. 368-369)

On the basis of these findings, Hendershot and colleagues suggest that "[i]nterventions could benefit from targeting alcohol expectancies and drinking before sex in individuals with a dispositional tendency toward sexual risk taking" (p. 365). Even though

personality factors may pose intransigent targets for interventions ..., understanding the role of relevant personality constructs

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could nonetheless help to identify high-risk individuals and/or anticipate intervention effectiveness, perhaps enhancing the efficacy of individualized interventions In addition, the availability of efficacious cognitive-behavioral strategies for reducing substance use behavior ... as well as preliminary evidence that drinking patterns can be altered via manipulation of expectancies ... suggest[s] that drinking and expectancies could serve as viable intervention targets for individuals with a dispositional proclivity for risk taking. (p. 371)

On the subject of efficacious intervention strategies, Margolin et al. (2007) have built upon their previous work “by assessing the efficacy of 3-S [spiritual self-schema] therapy¹ in a different patient population – drug users living with HIV/AIDS – using a new 12-session version of the therapy (3-S⁺)” (p. 984). In brief, 3-S⁺ therapy is “a manual-guided, spirituality-focused, psychotherapy that integrates modern cognitive-behavioral psychotherapeutic techniques with Buddhist psychological

¹ More information on 3-S therapy may be found in the [Winter 2007](#) issue of *mental health AIDS*, under the heading “About Persons Who Use Substances.” In addition, “[d]etailed treatment manuals and patient workbooks for 3-S and 3-S⁺ can be downloaded free-of-charge under the Training link at the 3-S Web site (www.3-S.us). A Spanish translation of each of these versions of the therapy is also available” (p. 984).

principles” (p. 981). It is designed “to decrease impulsivity, and its associated maladaptive behaviors – substance abuse, HIV risk behavior, and lack of motivation for recovery – by increasing spiritual practices, such as meditation and mindfulness, and other practices consistent with each patient’s faith” (p. 994). Of 38 methadone maintenance recipients living with HIV, 21 consented to participate in this 12-week course of adjunctive treatment; the remaining 17 study participants received methadone maintenance only (i.e., standard care). “Relative to a standard care comparison condition, patients completing 3-S⁺ therapy reported greater decreases in impulsivity and intoxicant use, and greater increases in spiritual practices and motivation for abstinence, HIV prevention, and medication adherence” (p. 980). Although these results are encouraging, Margolin and colleagues recognize that preliminary findings such as these need to be corroborated through a randomized clinical trial.

Jaffe, Shoptaw, Stein, Reback, and Rotheram-Fuller (2007)

assessed relationships among dynamic changes tracked over time in **methamphetamine** [meth] use, depression symptoms, and ... unprotected anal intercourse [UAI] ... in a sample of 145 [meth]-dependent gay and bisexual males enrolled in a 16-

week outpatient drug treatment research program. Participants were randomly assigned into 1 of 4 conditions: contingency management (CM), cognitive behavioral therapy (CBT; the control condition), combined CM and CBT, and a tailored gay-specific version of the CBT condition. (p. 301)

Although all participants in this study demonstrated improvement over the 16-week period, the investigators found that “[p]articipants with the greatest downward trajectory in [meth] use (urine verified) reported the greatest and quickest decreases in ... depressive symptoms and sexual risk behaviors. The control group reported the most [meth] use over the 16 weeks; the tailored gay-specific group reported a more rapidly decreasing slope in [meth] use than the other participants” (p. 301).

One implication of these results, according to Jaffe and colleagues, is that

[meth]-abusing individuals seeking care should initially be provided interventions to reduce [meth] use, in order for the caregiver to observe the extent to which co-morbid disorders are reduced before starting treatment regimens that address depression or that target risk behavior reductions. The minority of individuals who continue to have problems with depression and sexual risk behaviors in the absence of [meth] use may be the ideal group who benefits maximally from additional intensive interventions. Findings from this modeling investigation suggest using this type of evidence-based approach in selecting appropriate and tailored interventions with [meth]-dependent men who have sex with men [MSM]. (p. 306)

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Good news comes from Latka et al. (2007) who, with the assistance of audio computer-assisted self-interviewing technology, studied a convenience sample of 1,114 injecting drug users (IDUs) who had been living with HIV for 9 years (on average) in four U.S. cities and found that

75% of this sample felt **responsible for protecting their sexual partners from HIV**. In cross-sectional multivariate analysis, HIV-positive IDUs who felt responsible were those with greater HIV knowledge ..., perceived social support ..., self-efficacy for safely injecting ..., and self-efficacy for using condoms Feeling responsible was associated with having relatively fewer sex partners ... and ... lower odds of unprotected sex ... but was not associated with safer injection practices. Feelings of responsibility did not vary by demographic characteristics, suggesting that prevention messages that encourage HIV-positive people to play a role in curbing HIV transmission may be acceptable to many HIV-positive IDUs. (p. S88)

Latka and colleagues suggest that

[i]ncreasing correct HIV knowledge, social support, and self-confidence in using condoms and injecting safely may represent alternative ways of increasing feelings of responsibility. Implications are that counseling for HIV-positive IDUs should be multidimensional and focus on supporting condom use when it occurs, improving skills to initiate and use condoms to boost or maintain self-confidence for safer sex, addressing gaps in knowledge about how HIV is transmitted and how HIV-positive people can care for themselves, and making social service referrals to enhance support networks as needed. (pp. S91, S93)

About Men Who Have Sex With Men

Continuing this focus on feelings of responsibility, Wolitski, Flores, O'Leary, Bimbi, and Gómez (2007) assessed beliefs about **responsibility for preventing the transmission of HIV to others** among a convenience sample of 1,163 MSM living with HIV in New York City and San Francisco. Fifty-five percent of those participating in the study were men of color. The study tested

[a] two-dimensional model that represents four orientations toward responsibility ...: (1) *self* – high personal and low partner responsibility, (2) *other* – low personal and high partner responsibility, (3) *shared* – high personal and high partner responsibility, and (4) *diminished* – low personal and low partner responsibility. As predicted, the *self-responsibility* group demonstrated the lowest risk of HIV transmission; the *other responsibility* group had the highest risk. Intermediate risk was observed in the *shared* and *diminished responsibility* groups. (p. 676)

Wolitski and colleagues found that

mean personal responsibility scores were generally high, indicating that most HIV-seropositive MSM in this sample believed that they have a special responsibility to protect their partners from HIV infection. ... [Conversely, s]cores on the partner responsibility scale were significantly lower than personal responsibility scores, indicating less support for the idea that HIV-seronegative partners bear primary responsibility for preventing HIV transmission. ...

... Personal and partner responsibility appeared to interact with each other such that partner responsibility exerted little influ-

ence when personal responsibility was high ..., but was associated with transmission risk when personal responsibility was low This pattern of findings suggests that personal responsibility would be an especially important target for prevention programs for MSM living with HIV.

... People living with HIV who would be classified in the *other responsibility* group may be especially important targets for HIV prevention efforts. Given that some HIV-seronegative MSM assume that HIV-seropositive MSM would act to protect their partners and would disclose their HIV status if they knew they were infected ..., helping HIV-seropositive MSM develop greater understanding [of] and empathy for the perspective of uninfected men may be a useful strategy to explore. (pp. 683-684)

Wolitski and colleagues emphasize that these findings

do not support the perspective that responsibility should be treated as equally shared between HIV-seropositive and HIV-seronegative persons. Persons in the *shared responsibility* group were significantly more likely to report URAI [unprotected receptive anal intercourse] than were men in the *self-responsibility* group. This same pattern was observed for UIAI [unprotected insertive anal intercourse] and UIOI [unprotected insertive oral intercourse], but the differences were not statistically significant. These results suggest that prevention programs should encourage HIV-seropositive persons to always view themselves as personally responsible for protecting their partners from HIV. A norm of universally caring for and protecting partners (regardless of whether they are primary or ca-

sual partners or are perceived as being aware of the consequences of their actions) should be promoted.

Such a perspective does not negate the responsibility of HIV-seronegative persons for protecting themselves. ... The promotion of a self-orientation toward responsibility among HIV-seropositive and HIV-seronegative persons may be the optimal approach for preventing the further spread of HIV. (p. 684)

Of course, it remains to be determined “whether attributions about responsibility can be changed by behavioral interventions and how norms supporting personal responsibility can best be promoted among HIV-seropositive and HIV-seronegative persons Ultimately, the success of HIV prevention efforts will likely depend upon the ability of prevention programs to empower HIV-seropositive and HIV-seronegative people to take action to protect themselves and others from HIV” (p. 685).

In Australia, Jin et al. (2007) interviewed 158 gay men recently diagnosed with primary HIV infection and found that “143 (91%) were able to **identify the high-risk event that they believed led to their HIV seroconversion**, and this involved UAI in 102 [cases] (71%). Among these 102 men, 21 (21%) reported they were certain that the source partner was HIV-negative. Ten men (10%) reported insertive UAI as the[ir] highest risk behavior. Of the 21 men who reported knowing the HIV-positive partner’s viral load, 9 reported that the man had an undetectable viral load (43%)” (p. 245). According to Jin and colleagues, these data

demonstrate that UAI in the context of risk reduction strategies²

² Gay men who engage in UAI “have adopted complex strategies to reduce the risk of HIV acquisition At least 3 prac-

is implicated in a substantial proportion of HIV infections in homosexual men. Knowledge of the partner’s serostatus was central in the occurrence of UAI. Approximately 1 in 5 HIV seroconverters in ... [this] study wrongly perceived that the source person was HIV-negative, despite the high level of HIV testing in this setting. ... It remains possible that some of these behavioral risk reduction strategies [i.e., serosorting, strategic positioning, UAI with a partner whose viral load was believed to be undetectable] might be effective on a population level. That depends on the degree to which these behaviors replace higher risk UAI behaviors, or replace “safe[r] sex” behaviors. ... [These] data demonstrate that, not infrequently, risk reduction strategies seem to fail to prevent HIV infection on an individual level. This finding should be communicated to the populations of gay men who might see these risk reduction strategies as an alternative to the more effective strategy of consistent condom use. (p. 247)

Parsons, Kelly, Bimbi, Muench, and Morenster (2007) interviewed a diverse sample 180 gay and bisexual men “who self-identified that their sex lives were spinning out of control” (p. 5) for the purpose of examining **social triggers of sexually compulsive behavior**. “Two types of social triggers emerged from the data:

tices have been reported. First, serosorting has been described as the practice of having UAI with a partner believed to be of the same HIV status. ... Second, strategic positioning is broadly defined as the practice of taking the sexual position believed to be less likely to result in HIV transmission, that is, the HIV-negative ... [man] in the insertive role and the HIV-positive man in the receptive role. ... Third, negotiation around viral load has been described, in which the HIV-negative partner is more likely to agree to UAI when he believes that his HIV-positive partner’s HIV viral load is low or undetectable” (p. 245).

event-centered triggers and contextual triggers. Event-centered triggers arise from sudden, unforeseen events. Two major event-centered triggers were identified: relationship turmoil and catastrophes [ranging from personal calamities to community/national tragedies]. Contextual triggers, on the other hand, have a certain element of predictability, and included such things as location, people, the use of drugs, and pornography” (p. 5).

Parsons and colleagues observe that “[c]linicians can utilize the framework of social triggers in the therapeutic process to provide insight into ways to effectively work through symptoms of sexual compulsivity. Awareness of the contextual aspects of sexual compulsivity may be critical to understanding the behaviors of sexually compulsive clients. Thus, therapeutic assessments should focus upon the social context in addition to the psychological components of the disorder” (pp. 5-6). More specifically, the investigators

suggest working with a “top-down” approach to identify the key social triggers of sexual compulsivity in a client’s life. The clinician may decipher the “worst” triggers in the individual’s life and work towards identifying the least problematic triggers using techniques such as a functional analysis for each trigger. This process enables the individualization of treatment and tailors efforts to modify interactions. Once a client’s triggers are identified, the next step ... is to come up with an effective means to discuss these triggers and identify how to eliminate the elements of them that lead the client to sexually compulsive behavior. The “worst” triggers should be dealt with first so that a foundation may be laid to contend with less severe triggers as the client manages the more severe ones. (p. 14)

Parsons and colleagues recommend different clinical approaches for each category of triggers. For event-centered triggers, the investigators encourage clinicians to focus on issues that inhibit the formation of healthy sexual outlets; these may include depressive symptomatology and poor stress management skills. Additionally,

[c]linicians should encourage clients to seek out treatment when event-centered triggers first arise such that they may be dealt with prior to the occurrence of compulsive sexual behaviors. Because event[-]level triggers are unpredictable, teaching clients to anticipate feelings that arise during time[s] of turmoil or uncertainty and learn to cope with them can be quite helpful. Additionally, ... [promoting the development of "surfing skills" ... to ride out a craving during these times may be particularly useful because ... [cravings] appear to be primarily a result of an affective reaction to an external situation.

... Since contextual triggers are rooted primarily in social encounters, it can be more difficult for clinicians to intervene directly than with the triggers rooted in stress and depression treatable through traditional clinical approaches. However, in such instances, clinicians may be inclined to use motivational interviewing or [CBTs] to enable the client to deal with such triggers. Clinicians may aid the client in identifying behaviors and uncover[ing] potential ways to work/cope through them. Clients and clinicians should work together on the identification of contextual triggers such as drug and alcohol abuse, visits to places that cater to sexual encounters (backrooms, bars, steam rooms, etc.), former lovers or friends who provoke the behavior, or places

that are common to sexual behavior. Upon the identification of these triggers, counter conditioning or stimulus control strategies may be devised as a way of reducing or eliminating contact with these triggers so as to reduce or eliminate the compulsive sexual behavior. (pp. 14-15)

About Adolescents & Young Adults

On the topic of behavioral triggers, Patel, Yoskowitz, and Kaufman (2007) presented a sexual encounter scenario to 56 heterosexual college students to assess

the **relationship between comprehension of sexual situations and decisions about safer sex practices**. Participants made decisions that were congruent with their prior beliefs and past behaviour and experiences, and they developed a hypothesis early in the scenario, then focused on selective scenario information to confirm their beliefs or to ignore or misinterpret information that did not correspond to their views. Indeed, participants inadvertently re-ordered the sequence of events to better fit a set of prior expectations. ...

Low-risk individuals ... processed the scenario focusing on cues related to "risks of unprotected sex". These participants have well-established and stable belief structures, and are more likely to change the information to fit their prior hypothesis than change their hypothesis to fit the information. High-risk individuals ... were more inconsistent regarding their sexual behaviour. Their decisions are dependent on context, and they largely rely on their emotions and gut reactions during sexual encounters. They selectively processed cues related to high emotional content. Emotion-

related variables make up much of the evidence used by these individuals when making decisions, contributing to their lack of stability in their decisions and behaviour. Both low- and high-risk individuals are goal-directed, although their goals vary. Low-risk individuals have the goal of ...["take no risk at any time ..."], whereas high-risk individuals have the goal of ...["immediate pleasure ..."]. (pp. 921-922)

By developing profiles of thinking and behavior patterns, one can develop

a tailored educational intervention based on such a profile. One possibility is the use of interactive scenarios that are personalized to relate to individuals on a deeper level, congruent with their own beliefs and experiences. Specifically, the scenarios should bring an individual's beliefs to the surface in order to make them more explicit and show how they are not consistent with or congruent with reality. Although ... [Patel and colleagues] view this as a promising strategy, future research is needed to see if such an approach is viable. This argues for a customized approach, where the goal is to intervene at appropriate weak links in the decision-making process, including any contradictory or unjustified beliefs, to promote safer sex behaviour. (p. 922)

Mosack, Gore-Felton, Chartier, and McGarvey (2007) "examined individual, peer, and family variables associated with adolescent sexual risk behavior ... [among] 1008 **adolescents** (857 males and 151 females) **incarcerated in Virginia juvenile correctional facilities**" (p. 115). The investigators found that,

[f]or boys, in particular, it appears as though family relationships, family structure, and peer rela-

Tool Box

For Whom the Tell Tolls: Curbing the Cost of Giving & Getting Distressing, HIV-Related News (Part 1)

"There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care."

— Figley, 1995, p. 1

In their recent systematic summary of literature on the sociobehavioral dimension of HIV counseling and testing, Obermeyer and Osborn (2007) observe that

[m]uch is expected of providers "on the front lines," but little is known about how they cope. In addition to practical difficulties, they must deal with their own emotional issues regarding HIV. ... They may be reluctant to be tested and themselves suffer stigma ...; they may fear contamination and feel helpless, pessimistic, and doubtful of their ability to provide care. ... This makes it difficult to communicate with clients and encourage them to adopt appropriate behaviors. Conversely, good rapport between providers and clients is an important determinant of patients' acceptance of clinic-based interventions, including testing. ... Attention should therefore be directed at providers to define the needed services and ascertain the training, time, and resources necessary to deliver them. (p. 1768)

On this point, Myers et al. (2007) offer "a first step to identifying the challenges and stress that test providers experience related to delivering an HIV-positive test result" (p. 1018). The investigators conducted a thematic analysis of interview data from 24 pro-

relationships are associated with the development of peer sexual relationships. For girls, peer-related factors appear to be more important correlates of risky sexual behavior than family factors.

For both boys and girls, external-

viders of HIV counseling and testing services. The sample included physicians as well as counselors who worked at anonymous testing sites in Ontario, Canada.

Myers and colleagues found that,

as with other healthcare professionals communicating 'bad news', HIV test providers experience an impact when delivering a positive HIV test result; however, this impact varies and is influenced by contextual factors such as history with the test recipient Implicit in the assessment of the impact of delivering an HIV-positive test result is the assumption that a positive result *is* 'bad news'. While a small number of the test providers indicated that they felt no or little impact of delivering the HIV-positive test result because the diagnosis is 'not the end of the world', most indicated it was difficult as it was anticipated that the test recipient would (or did) find the news distressing. (p. 1017)

With regard to approaches used by these providers to manage the impact of delivering a positive test result, "several coping strategies were employed, some active and some passive. The active strategies were focusing on the test recipient and use of social support. The literature suggests that 'shutting down' or depersonalisation (one of the dimensions of burnout), the use of dark humour (another manifestation of depersonalisation of the client/patient) and the use of alcohol or snack foods are not as adaptive ..." (p. 1018).

Trauma Tied to HIV

It is not only when clinicians must convey distressing news that their own coping mechanisms come into play. In the HIV-related clinical encounter, a clinician's coping mechanisms are also called upon when the client re-

izing behavior, which is defined as a combination of both delinquent and aggressive behaviors, was predictive of more lifetime sexual partners. ...

[P]erceived friend support was associated with more sexual

veals distressing, if not traumatic, life experiences that precede and/or follow from the detection of that individual's positive serostatus.

Indeed, according to Radcliffe et al. (2007), "HIV-infected adults have been found to present with high rates of ... [posttraumatic] stress (10.4% to 42%). ... Posttraumatic stress disorder [PTSD] has been linked both to receiving the HIV diagnosis itself as well as to other life stressors associated with HIV such as a history of sexual abuse and assault. ... Strikingly, symptoms of posttraumatic stress have been found to persist for long periods of time postdiagnosis, with one study reporting posttraumatic symptoms even after 8 years, on average, postdiagnosis" (p. 502). In their own study of posttraumatic stress and trauma history among teens and young adults living with HIV/AIDS who were predominantly male and African American, Radcliffe and colleagues found that

93% of the sample report[ed] ... that receiving a diagnosis of HIV was experienced as traumatic. Of these, 13.3% met criteria for [PTSD] in response to HIV diagnosis, while an additional 20% showed significant ... [posttraumatic] stress symptoms. Even greater rates of posttraumatic stress were reported in response to other trauma, with 47% of youth surveyed reporting symptoms of posttraumatic stress in response to such traumatic events as being a victim of a personal attack, sexual abuse, or being abandoned by a caregiver. (p. 501)

Such revelations can exert an impact on clinicians who journey with clients through their HIV-related pain and suffering. In 1994, "Gabriel reported that group therapists who experienced the death of group members from AIDS

partners for all groups. Although this bivariate association was suppressed in the multivariate analysis, this finding suggests that peers might encourage each other to have sexual intercourse with multiple sexual partners[,] particularly for adolescents who

were experiencing symptoms such as 'death imprints', 'indelible images' and 'psychic numbing' (pp. 170, 172)" (in Dunkley & Whelan, 2006, p. 110). More recently, Smith (2007) presented a series of anecdotal reports supporting his contention that "[m]any persons living with HIV/AIDS experience severe traumas that pose considerable challenges to the self-care strategies of mental health providers" (p. 193).

This is the first of a two-part series. Part 1 tackles the terminology used to describe how clinicians are thought to be affected by their work with trauma survivors. This section also summarizes literature on approaches to recognizing and alleviating the dangers facing clinicians practicing trauma-related psychotherapy. Part 2 (to be presented in the Spring 2008 issue of *mental health AIDS*) will expand on the current state of qualitative and quantitative research in this area and offer emerging evidence for the *positive* consequences of this work for clinicians.

Mind Your Phraseology!

A whole host of constructs has been used to describe the impact on clinicians of their work with trauma survivors; among the most prominent are countertransference, burnout, **vicarious traumatization (VT)**, compassion fatigue, and **secondary traumatic stress (STS)**. Unfortunately, "there still exists a lack of conceptual clarity in the literature ... [that] has made it difficult to use the literature to inform practice and training" (Baird & Kracen, 2006, p. 181).

A term familiar to mental health professionals, "**countertransference** involve[s] the therapist experiencing strong responses within the psychotherapeutic relationship in relation to the client. This can include emotional and behavioural responses (both con-

are engaging in antisocial behaviors

Most important, ... [Mosack and colleagues] found that family-related factors were associated with sexual risk such that perceived family support was significantly

scious and unconscious) to ... patient[s], the material they bring to therapy, reenactments, and transference" (Sabin-Farrell & Turpin, 2003, p. 454).

"In terms of countertransference, the counsellor's personal characteristics determine his or her response to the client's trauma, while **burnout**¹ places emphasis on the characteristics of the stressor By comparison, ... [in conceptualizations of VT,] the counsellor's response to the client's trauma material ... [is thought to be] formed by aspects intrinsic to the individual therapist as well as characteristics of the situation ..." (Dunkley & Whelan, 2006, p. 108).

First coined by McCann and Pearlman (1990), **VT** "is the process through which the therapist's inner experience is negatively transformed as a result of empathic engagement with clients' traumatic material ..." (Canfield, 2005, p. 88). Moreover,

[a] therapist's VT is evident across all relationships in her/his personal and professional life and is permanently transformative. It is different from countertransference in that countertransference is temporarily linked to a particular period, event, or issue in the therapeutic process or in the therapist's life. [VT] represents changes in the most intimate psychological workings of the therapist's self. Invariably such change shapes countertransference reactions. As a therapist experiences increasing levels of VT, ... [countertransference] responses become stronger and/or less available to conscious aware-

¹ For more information on interventions designed to address burnout, go to the **Tool Box** entitled "Sustaining Stamina at the Interface of HIV & Mental Health Practice" in the [Winter 2005](#) issue of *mental health AIDS*.

associated with *more* sexual partners for boys but *fewer* partners for girls. ...

Multivariate analyses revealed that family structure was independently associated with sexual risk behavior for both the full

ness. This interaction creates a spiral with potentially disastrous results for treatment. In addition, increased VT can have dire consequences for the therapist's personal and professional life, including loss of personal relationships and in some instances, preventable job or career changes (Canfield, 2005, pp. 87-88)

Importantly, "VT can be seen as a *normal* response to ongoing challenges to a helper's beliefs and values but can result in decreased motivation, efficacy, and empathy" (italics added; Baird & Kracen, 2006, p. 182).

As described by Dunkley and Whelan (2006), "trauma can disrupt the counsellor's cognitive schemata [i.e., intrapsychic structures] in one or more of five fundamental need areas: safety (feeling safe from harm by oneself or others), trust/dependency (being able to depend on or trust others and oneself), esteem (to feel valued by others and oneself and to value others), control (the need to be able to manage one's own feelings and behaviours, as well as to manage others[']), and intimacy (feeling connected to others or to oneself)" (pp. 109-110). "[S]pecific areas of disruption will differ for different individuals depending on which area is more or less salient for them as a reflection of their unique life experiences" (p. 111).

According to Baird and Kracen (2006), **STS** "refers to a syndrome among professional helpers that mimics [PTSD] and occurs as a result of exposure to the traumatic experiences of others" (p. 182). The term was first used by Figley (1995), who also referred to this syndrome as **compassion fatigue**. "The focus here is not specifically on cognitive phenomenon (as in cases of VT), but on a wider syndrome of experiences quite directly linked to the

(*Tool Box is continued on Page 8*)

sample and for the subsample of boys. Living in a two-parent household appeared to have a buffering effect for the sample as a whole. Compared with individuals living in a single-parent household with a biological parent,

(*Biopsychosocial Update is continued on Page 10*)

(Tool Box -- continued from Page 7)

symptoms of PTSD. In addition, the precipitating experience(s) of the helper can be of quite short duration ... This kind of exposure is both qualitatively and quantitatively different from the experience of a psychotherapist bearing witness to years of sexual abuse” (Baird & Kracen, 2006, pp. 182-183). STS is also different from burnout;

[t]he key difference ... lies in the cause, since both conditions are characterized by depression, insomnia, loss of intimacy with friends and family, and both are cumulative.

[STS], however, is the direct result of hearing emotionally shocking material from clients, while burnout can result from work with any client group. Treating traumatized clients involves assisting them in managing PTSD symptoms, helping them tell their stories of traumatic events, and providing a safe place where feelings of helplessness, anger, and fear can be expressed. Since [STS] symptoms are considered a normal reaction to engagement with traumatic material, many therapists will experience STS, and some are likely to experience it for extended periods of time ... Self-care practices are preventative and can reduce the likelihood that STS symptoms will develop into STSD. The difference between [STS] reactions (STSR) and [STS] disorder (STSD) lies in the duration of the symptoms experienced by therapists. Symptoms under one month [in] duration are considered normal, acute, crisis-related reactions. Symptoms that last for six months or more following the triggering event reflect [STSD] ... STSD is a syndrome nearly identical to PTSD except that exposure to a traumatizing event experienced by one person becomes a traumatizing event for the second person, be it a family member, friend, mental health professional, or some other helper. (Canfield, 2005, pp. 84-85)

“Based on the diagnostic conceptualization of ... PTSD ..., the symptoms [of

Kicking It Upstairs

Bell, Kulkarni, and Dalton (2003) drew from multiple sources to offer a number of prevention and intervention strategies that merit consideration as an agency’s administrative response to the vicarious traumatization of its workers. Four areas – organizational culture, workload, work environment, and education – of the seven identified by Bell and colleagues are briefly discussed here:

o **Organizational culture** – An organizational culture that “normalizes” the effect of working with trauma survivors can provide a supportive environment for ... workers to address those effects in their own work and lives. It also gives permission for ... workers to take care of themselves. ... A supportive organization is one that not only allows for vacations, but also creates opportunities for ... workers to vary their caseload and work activities, take time off for illness, participate in continuing education, and make time for other self-care activities. Small agencies might signal their commitment to staff by making staff self-care a part of the mission statement, understanding that ultimately it does affect client care. Administrators might also monitor staff vacation time and encourage staff with too much accrued time to take time off. Self-care issues could be addressed in staff meetings, and opportunities for continuing education could be circulated to staff. (p. 466)

o **Workload** – Research has shown that having a more diverse caseload is associated with decreased vicarious trauma ... Such diversity can help the ... worker keep the traumatic material in perspective and prevent the formation of a traumatic worldview ... Agencies could develop intake procedures that attempt to distribute clients among staff in a way that pays attention to the risk of vicarious trauma certain clients might present to workers. When possible, trauma cases should be distributed among a number of ... workers who possess the necessary skills [to provide care] ... In addition, ... workers whose primary job is to provide direct services to traumatized people may benefit from opportunities to participate in social change activities[.] ... Such activities can provide a sense of hope and empowerment that can be energizing and can neutralize some of the negative effects of trauma work.

Organizations can also maintain an “attitude of respect” ... for both clients and workers by acknowledging that work with trauma survivors often involves multiple, long-term services. Organizations that are proactive in developing or linking clients with adjunct services ... will support not only clients, but also decrease the workload of their staff ... Developing collaborations between agencies that work with traumatized clients can provide material support and prevent a sense of isolation and frustration at having to “go it alone.” (p. 466)

o **Work environment** – A safe, comfortable, and private work environment is crucial for those ... workers in settings that may expose them to violence[.] ... Although it is more of a challenge in certain settings, protecting workers’ safety should be the primary concern of agency administration. Paying for security systems or security guards may be a necessary cost of doing business[.] ... [Also], agencies may consider developing a buddy system for coworkers so that if one worker is threatened by a client, another can summon the police [or other assistance].

STSD] include reexperiencing, avoidance or numbing reminders, and persistent arousal ... Unlike [VT], [STSD] gives limited attention to context and aetiology, restricting its focus to observable symptoms ... [VT] involves a consideration of the individual as a whole and places the observable symptoms in context ...” (Dunkley & Whelan, 2006, p. 109).

“**Who Counsels the Counselors?**”²
According to Bober and Regehr (2006),

[t]heorists in the area of secondary

² Obermeyer & Osborn, 2007, p. 1768.

or vicarious trauma recommend a variety of strategies for reducing levels of symptoms and disruption. Several authors point to the importance of maintaining a balance between work and personal life ... Seeking psychotherapeutic treatment to assist with countertransference issues related to unresolved events in ones’ personal history and secondary trauma ... [is] recommended ... Peer consultation, supervision, and professional training to reduce the sense of isolation and increase feelings of efficacy are suggested ... Finally, stemming from the association

between exposure and symptoms, reducing the number of trauma cases is frequently suggested These strategies are mirrored by therapists participating in qualitative studies and in anecdotal reports by therapists whose suggestions include peer support, physical activity and self-care, reading and watching TV shows or movies that are nonviolent, limiting their trauma counseling workload, and political activism (pp. 2-3)

A number of these prevention and intervention strategies may also be incorporated into an agency's administrative response to the VT of its

workers (see [sidebar](#)). Additionally, several approaches to recognizing and alleviating VT – a single-session VT group model for agency-based trauma workers (Clemans, 2004), certified compassion fatigue specialist training (Gentry, Baggerly, & Baranowsky, 2004), and a mindfulness-based trauma prevention program (Berceli & Napoli, 2006) – were identified in recent professional literature. As of yet, findings from rigorous evaluation of these approaches do not appear to have been published.

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In addition to attention to basic safety, ... workers need to have personally meaningful items in their workplace. These can include pictures of their children or of places they have visited, scenes of nature or quotes that help them remember who they are and why they do this work. ...

Agency administrators can encourage staff to make these small investments in their work environment. By placing inspiring posters or pictures of scenic environments (rather than agency rules and regulations) in the waiting rooms, staff meeting rooms, and break rooms, the organization can model the importance of the personal in the professional. In addition, workers also need places for rest at the job site, such as a break room that is separate from clients With a space such as this, the organization could address the self-care needs of staff by providing a coffee maker, soft music, and comfortable furniture. (pp. 466-467)

o **Education** – Trauma-specific education also diminishes the potential of vicarious trauma. Information can help individuals to name the experience and provide a framework for understanding and responding to it. ...

Efforts to educate staff about vicarious trauma can begin in the job interview Agencies have a duty to warn applicants of the potential risks of trauma work and to assess new workers' resilience New employees can be educated about the risks and effects associated with trauma, as new and inexperienced workers are likely to experience the most impact Ongoing education about trauma theory and the effects of vicarious trauma can be included in staff training ... and discussed on an ongoing basis as part of staff meetings. Agencies can take advantage of ... workshops ... at professional conferences ... by sending a staff member for training and asking that worker to share what he or she has learned with the rest of the staff. This information provides a useful context and helps ... workers to feel more competent and have more realistic expectations about what they can accomplish in their professional role. ...

Learning new ways to address clients' trauma may also help prevent vicarious trauma. Theories, such as constructive self-development theory ... on which the theory of vicarious trauma is based, maintain a dual focus between past traumas and the client's current strengths and resources. Working from a theoretical framework that acknowledges and enhances client strengths and focuses on solutions in the present can feel empowering for client and worker and reduce the risk of vicarious trauma. (p. 467)

The three remaining areas highlighted by Bell and colleagues – group support, supervision, and resources for self-care – will be discussed in the Spring 2008 issue of *mental health AIDS*.

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(Biopsychosocial Update – continued from Page 7)

those living in a two-parent household with at least one biological parent had fewer lifetime sexual partners. ... [The investigators] also found that compared to living with a single biological parent, living with nonbiological parents was associated with a *higher* number of lifetime sexual partners for boys. Taken together, these results suggest that although living with two parents might improve parental monitoring of adolescent behavior, living with a single biological parent alone or with one biological parent and another parent might provide a greater degree of familial connectedness than living in a home without at least one biological parent. Therefore, both parental monitoring and parental support or attachment could have a protective effect on adolescent sexual risk behavior ... (pp. 125-127)

Drawing on these findings, Mosack and colleagues speculate on the possibility that

incarcerated youth would be more receptive to interventions that provide them with the means to improve peer and family relationships than interventions that focus solely on HIV knowledge or dismiss the relative importance of sexual exploration and healthy sexual development Thus, besides focusing efforts on decreasing sexual risk per se (defined by limiting the number of sexual partners one has, or decreasing the number of encounters in which condoms are not used), perhaps a more general relational communication skills-building intervention would be useful to indirectly influence sexual risk decision-making. For example, interventions that incorporate strategies to improve parent or guardian-adolescent com-

munication on the one hand, and sexual partner perspective-taking and safer sexual negotiation on the other could be particularly powerful.

Moreover, given that perceived peer support was associated with more sexual partners, it is also important, particularly for girls, to address peer relationships that are destructive to healthy decision-making and facilitate the development of more supportive relationships. Likewise, it would also be important for the intervention to enhance coping skills so that adolescents can develop effective strategies to reduce impulsiveness and other externalizing behaviors.

Interventions at the parental level could be useful ... as well. Developing an environment which promotes honest communication while helping parents or guardians to set specific intergenerational boundaries and clear behavioral expectations could also have an impact on adolescent decision-making, perhaps for boys in particular. Evidenced-based interventions designed for general adolescent samples will need to be tailored to incarcerated adolescent populations in order to address the environmental contexts, which contribute to and are affected by adolescent sexual risk-taking behavior. For example, given these adolescents' already tenuous social position, it might be necessary to facilitate the development of relationships with trusted adult community mentors who will contribute to the monitoring of the adolescents once they leave detention. Attempting to involve family members in interventions provided at a detention center could prove complicated. Thus, developing partnerships with detention center staff and collaborating with family

members are critical to the process of a family intervention delivered in such a context. (p. 129)

About Women

A multilevel response also comes into play when violence is threatened or perpetrated against a woman. Lang, Salazar, Wingood, DiClemente, and Mikhail (2007) documented the prevalence of **recent gender-based violence (rGBV)** among 304 sexually active women receiving HIV medical care who reported that they were sexually active with a single male partner. The investigators sought to ascertain the association between rGBV and pregnancy, sexually transmitted infections (STIs), condom use, and the negotiation of safer sexual practices. Within this sample, 10.2% of women reported rGBV during the preceding 3 months and rGBV was associated with inconsistent condom use, pregnancy, and abuse stemming from requests for condom use. More specifically, the investigators found that "women who experienced rGBV and who asked their partners to use a condom were 8 times more likely to report being threatened with violence and, most notably, were 14 times more likely to be hit" (p. 220). There was no association found between rGBV and the presence of STIs. As Lang and colleagues see it, study findings

emphasize the need to address the adverse impact of rGBV in the lives of HIV-positive women and their sexual partners. Multiple levels of interventions must be considered in addressing these ... issues. First, intervention efforts targeting HIV-positive women must take into consideration that rGBV is a present reality for this population. Efforts should be first directed toward screening efforts to identify women who are in abusive relationships so that they can receive additional services (... [e.g.], advocacy programs for

abused women) that go beyond treating their HIV. These services may help to empower them so that they can protect themselves from abusive partners by accessing resources and venues where they can receive ... necessary support and protection. ... Only within this context of an external support system can intervention programs hope to be effective in increasing self-efficacy and skills development designed to empower women to obtain the support they need. ... Outside of such a context where women can have a reasonable expectation of safety, skills such as assertiveness and negotiation of sexual practices may aggravate existing abusive circumstances, as was found in the present study when women requested condoms.

Second, these findings emphasize the need to address the perpetrators of rGBV. There are many intervention programs designed to teach anger management and address the underlying attitudes toward GBV. ... [T]hese programs ... also need to focus on the serodiscordant relationship. Appealing to the perpetrators' need to remain HIV-negative and to protect themselves in their sexual relationships may be an approach worth trying. Nevertheless, the most successful approach would have to involve multisystems in which the police, hospitals, courts, and abused women's advocates work together with perpetrators' programs to address these issues. ... (p. 220)

In some situations, self-protection can assume secondary importance. Tucker, Elliott, Wenzel, and Hambarsoomian (2007) analyzed survey data from "a probability sample of 445 women initially sampled from shelters and low-income housing in Los Angeles

County" (p. 644) and found that

relationship commitment is a key determinant of unprotected sex among impoverished women ... A particularly noteworthy finding is that relationship commitment appears to be a stronger predictor of unprotected sex than several psychosocial and behavioral factors that have been identified through meta-analysis as important predictors of heterosexual condom use ...: perceptions of partner monogamy, feelings of susceptibility to HIV/AIDS, self-efficacy toward condom use, and communication about condoms. This finding is striking in that these other factors, specifically reflecting women's HIV-related attitudes and behaviors, should be more proximal determinants of their decision making about condom use than general feelings about their relationship. (pp. 647-648)

Tucker and colleagues

emphasize the importance of addressing issues related to relationship commitment in HIV prevention interventions with impoverished women. Given that stronger relationship commitment may be associated with an illusion of safety or greater fear of losing the relationship ..., there is a need to increase women's recognition of partner risk and their ability to negotiate safer sex in ways that do not threaten the relationship. Although introducing condoms into an ongoing relationship can be challenging, there is some evidence that interventions that emphasize communication and negotiation skills, strategies to develop assertiveness, and effective conflict resolution³ may be effective ... (p. 648)

³ El-Bassel et al. (2003, 2005) have studied the efficacy of *Project Connect*, a relationship-based HIV/sexually transmitted dis-

HIV Treatment News

Medical Care

On October 16, the U.S. Food and Drug Administration (FDA) approved **raltegravir** (RGV or Isentress™) tablets for use in combination with other antiretroviral agents in the treatment of antiretroviral-experienced adults with drug-resistant strains of HIV. Of note is the fact that

[RGV] is the first agent of the pharmacological class known as HIV integrase ... inhibitors, designed to interfere with the enzyme that HIV-1 needs to multiply.⁴ ... When used with other anti-HIV medicines, [RGV] may reduce the amount of HIV in the blood and may increase white blood cells, called CD4+ (T) cells, that help fight off other infections. ... The most common adverse events reported with [RGV] were diarrhea, nausea, and headache. Blood tests also showed abnormal elevated levels of a muscle enzyme in some patients receiving [RGV]. Caution is advised when using [RGV] in patients at increased risk for certain types of muscle problems, including those who use other medications that can cause muscle problems. ... The long-term effects of [RGV] are not known, and its safety and effectiveness in children less than

ease prevention intervention designed for at-risk heterosexual couples. The six-session intervention, administered to either couples or to women alone, "emphasize[s] ... the importance of relationship communication, negotiation, and problem-solving skills and highlight[s] ... how relationship dynamics may be affected by gender roles and expectations" (El-Bassel et al., 2003, p. 965). Both forms of the intervention were associated with a reduction in the number of unprotected sex acts and an increase in the proportion of protected sex acts at 3 (2003) and 12 months (2005).

⁴ RGV blocks the HIV enzyme known as integrase, one of three enzymes needed for HIV replication. The other two enzymes, reverse transcriptase and protease, are already targeted by a number of antiretrovirals.

16 years of age ... [have] not been studied. [RGV] also has not been studied in pregnant women. (FDA, 2007)

Psychiatric/Psychological/ Psychosocial/Spiritual Care Adherence to Treatment

Over a nearly 4-year period, Petersen et al. (2007) used unannounced pill counts and viral load measurements to monitor antiretroviral adherence among a cohort of 245 homeless and marginally housed men and women living with HIV in San Francisco. Petersen and colleagues “found that **pillbox organizers** are associated with improved adherence to HIV antiretroviral therapy and improved viral suppression in a diverse population with a wide distribution of adherence. ... [G]iven the simplicity and low cost of the intervention, clinicians should consider including pillbox organizers in their routine treatment of chronic disease” (pp. 914-915).

Drawing data from a diverse sample of 858 individuals living with HIV and engaging in self-reported transmission risk behavior, Carrico et al. (2007) looked at associations among **regular use of cocaine, crack, or amphetamines (i.e., stimulants)**; affect regulation;⁵ nonadherence to antiretroviral therapy; and immune status. The investigators report that

[a]mong individuals on [antiretroviral therapy], regular stimulant users had a five-fold ... higher HIV viral load than those who denied regular stimulant use. The association between regular stimulant

⁵ “Affect regulation describes the degree to which individuals effectively manage depressive symptoms as well as the capacity of individuals to achieve and maintain positive psychological states that promote resilience in the face of negative life events ...” (p. 787). In this study, affect regulation was measured with two different instruments, one assessing positive psychological states (the 6-item Positive States of Mind scale) and the other assessing depressive symptoms (the 13-item Beck Depression Inventory – Affective subscale).

use and elevated HIV viral load remained after accounting for demographics, differences in CD4+ counts, and polysubstance use. In the final model, [every] 1 unit increase in affect regulation (decreased severity of depressive symptoms as well as enhanced positive states of mind) was associated with a 23% decrease in the likelihood of reporting regular stimulant use and 15% decrease in the likelihood of being classified as nonadherent to [antiretroviral therapy]. Regular stimulant users, in turn, were more than twice as likely to be nonadherent to [antiretroviral therapy]. Even after accounting for the effects of nonadherence and CD4+ counts, regular stimulant use was independently associated with 50% higher HIV viral load. (p. 785)

Carrico and colleagues concur that these findings

have important implications for the medical care of stimulant users who are HIV-positive. ... [M]ental health treatment as well as more intensive referrals to substance abuse treatment or 12-step self-help groups may be crucial to assist stimulant users with successfully initiating [antiretroviral therapy and improving] ... adherence among those who are currently prescribed [antiretroviral therapy] Including pharmacologic and cognitive-behavioral interventions to assist HIV-positive stimulant users with improving affect regulation may also substantially enhance the efficacy of adherence interventions for HIV-positive substance users that have been developed to date (p. 790)

On the subject of psychopharmacology, Varela, Montbach, and Shipe (2007) explored **psychoactive medication adherence** among 38

men and women, predominantly African American or Latino, who were living with HIV/AIDS, residing in long-term substance abuse treatment settings, and participating in day treatment programs. “All participants had some kind of psychiatric diagnosis, ranging from mood disorders ... to chronic schizophrenia. Prescribed psychiatric medication included antidepressants, anxiolytics, and frequently newer, atypical antipsychotics. Crack/cocaine, heroin and alcohol were the main drugs of choice” (p. 7) in this purposive sample, which participated in five focus groups. These “triple-diagnosed” individuals “stated that the role that others [i.e., partners, family members, friends, and health care providers] play in their lives was influential in their decisions to adhere to psychoactive regimens. However, they also cited fear of relapse, medication side effects, drug toxicity, stigma, lack of control over treatments, and strong incentives for selling medication as reasons for non-adherence” (p. 5). Varela and colleagues offer “strategies that may be utilized by health care professionals to improve adherence. All of the following suggestions are based on the premise that *building rapport between health care consumers and health care practitioners is a basic tool* ... [that] can not be over-emphasized” (p. 10):

Allow Sufficient Time – A lack of time in various health settings ... often impedes the development of client rapport. One must make time to create a therapeutic alliance, however, in an effort to show genuine interest in a client. Practitioners can build better relationships with clients simply by asking a well-intentioned question that expresses an interest.

Communicate about the Broad Side Effects of Medication – Some undesirable side effects of medication can be minimized by

gradually increasing doses or by emphasizing the importance of taking food before, or with, the medication. Other side effects – if properly managed and understood – can prove helpful in addressing concurrent concerns such as sleeping problems or weight gain or loss. ...

Provide Flexible Scheduling – Evening or weekend classes and groups are essential to clients and family members who are engaged in daytime school and work schedules. Another scheduling consideration is childcare. ...

Use Tools to Promote Adherence – Practitioners can use a number of tools to improve adherence, including the following:

- o Diaries or journals can help remind clients about their treatment plans.
- o Using laboratory values as indicators ... [is] helpful in concretizing psychoactive medication blood levels.
- o Calendars may also be used as journals over an extended period of time.
- o Simple suggestions like “leave a message on your answering machine while you’re here” can help to remind ... client[s] to take their medications when they go home.
- o Daily medication dispenser boxes can hold HIV and psychoactive medication simultaneously.

Make Referrals to Support Groups – Referrals to support, 12 Step, and education groups for both HIV/AIDS and mental health issues, “Double Trouble” groups[,] are available on both in- and outpatient bases. While it may seem time-consuming to make referral phone calls, arranging the details for clients helps

Tool Box

Books & Articles

Baumgartner, L.M. (2007). The incorporation of the HIV/AIDS identity into the self over time. *Qualitative Health Research, 17*(7), 919-931.

“In this qualitative study the author examines how people incorporate the HIV/AIDS identity into their selves at three points in time. Findings demonstrate a five-component process, including diagnosis, postdiagnosis turning point, immersion, post-immersion turning point, and integration. In addition, the disclosure process corresponds to ... component[s] of [the identity] incorporation [process]. ... Findings augment the literature on HIV/AIDS, chronic illness, and identity and have practical implications for HIV/AIDS educators” (p. 919).

Bouis, S., Reif, S., Whetten, K., Scovil, J., Murray, A., & Swartz, M. (2007). An integrated, multidimensional treatment model for individuals living with HIV, mental illness, and substance abuse. *Health & Social Work, 32*(4), 268-278.

“This article describes a treatment model that was created for a study of integrated treatment for HIV-positive individuals with substance use and mental disorders. The treatment model was based on the transtheoretical model of behavior change as well as evidence-based practices that are widely used in the treatment of individuals dually diagnosed with substance use and mental disorders. The model involved collaboration between medical and behavioral health care professionals and emphasized the importance of goal reinforcement across disciplines. Furthermore, it included the development and enhancement of client motivation to modify medical and behavioral health-risk behaviors using individual readiness for change and offered comprehen-

to foster better attendance at these worthwhile groups and settings. Contrary to a commonly expressed view that calling on behalf of the client promotes dependence, many clients are uncomfortable with or incapable of navigating complicated auto-

sive care addressing a continuum of client needs that may influence treatment outcomes. Treatment modalities included individual therapy, group therapy, and psychiatric medication management. This treatment intervention was associated with positive outcomes in the integrated treatment study and can be adapted for use in a variety of psychiatric or medical treatment settings” (p. 268).

DiClemente, R.J., Salazar, L.F., & Crosby, R.A. (2007). A review of STD/HIV preventive interventions for adolescents: Sustaining effects using an ecological approach. *Journal of Pediatric Psychology, 32*(8), 888-906.

“In this article, we identify and briefly review antecedents to adolescents’ STD/HIV risk. Next, we discuss previous preventive approaches and highlight the strengths and weaknesses in those approaches. Subsequently, we articulate directions for future research to address gaps in the literature, while proposing an integrated strategy that targets the social ecology of the STD epidemic among adolescents” (pp. 888-889).

Edgar, T., Noar, S.M., & Freimuth, V.S. (Eds.). (2007). *Communication perspectives on HIV/AIDS for the 21st century*. New York: Routledge.

From the publisher: “With new topics, new contributors, and a broadened scope, this book goes beyond a revision of the 1992 volume to reflect the current state of communication research on HIV/AIDS across key contexts. It is designed for academics, researchers, practitioners, and students in health communication, health psychology, and other areas of AIDS research. As a unique examination of communication research, it makes an indelible contribution to the growing knowledge base of communication approaches to combating HIV/AIDS.”

(Tool Box is continued on Page 14)

mated telephone menus, and/or have language barriers.

Enlist Trained Peer Volunteers – Peer volunteers provide trainings and act as support networks. As individuals who can both identify with the problems experienced by

the clients and act as positive role models, peer volunteers provide invaluable assistance. ...

Support Positive Family Relationships – Clinicians need to help build and support positive family relationships. Groups and social events (e.g., dances with refreshments), can diminish the sense of stigma, or the sense of “going it alone” that may not only affect the primary client but also the family as a whole. Use these events to teach about medications and their effects, and to help

create or structure routines important to treatment adherence. (pp. 10-11)

Does HIV/AIDS-specific quality of life predict antiretroviral adherence? Holmes, Bilker, Wang, Chapman, and Gross (2007) monitored 116 recipients of antiretroviral therapy – primarily middle-aged, African American men – for up to 1 year and found that 56 (48%) of the study participants had low adherence (i.e., < 95% of prescribed doses taken). “Baseline financial worries ... were greater in those with low versus high

adherence Those with low versus high adherence also were more likely to [be] us[ing] ... alcohol ... and other drugs ... at baseline. Regression analysis led to a model that included only current alcohol use ... and financial worries ...” (p. 323). Holmes and colleagues suggest “that asking patients about how frequently they experience worries about financial matters (... [e.g.], fixed income, paying bills, caring for themselves as they think they should), at initiation and periodically while on [antiretroviral therapy], might provide useful information about their likelihood for

(Tool Box -- continued from Page 13)

Goggin, K., Liston, R.J., & Mitty, J.A. (2007). Modified directly observed therapy for antiretroviral therapy: A primer from the field. *Public Health Reports*, 122(4), 472-481.

“Modified directly observed therapy (mDOT), in which a portion of total doses of a medication regime is ingested under supervision, has demonstrated efficacy as an intervention to assist patients in maintaining adherence to complicated antiretroviral therapy[.] ... The aim of this article is to provide a primer for practitioners and researchers who wish to implement mDOT interventions” (p. 472).

Kelly, A. (2007). Hope is forked: Hope, loss, treatments, and AIDS dementia. *Qualitative Health Research*, 17(7), 866-872.

“In this article, the author explores ethnographically personal hope from the perspective of ‘Matthew,’ a significant other to a person with AIDS dementia, and how treatments influence this [hope]. Hope is present in Matthew’s narrative, but its nature is complex and fluctuates with the arrival and perceived failure of HAART [highly active antiretroviral therapy]. The author concludes by suggesting that hope in this context is forked, which is suggestive of the tenacious nature of hope in the context of AIDS dementia in the era of HAART” (p. 866).

Malitz, F.E., & Eldred, L. (2007). Evolution of the Special Projects of National Significance Prevention with HIV-Infected Persons Seen in Primary Care Settings Initiative. *AIDS & Behavior*,

11(Suppl. 1), S1-S5.

“This special supplement [pp. S1-S137] details the implementation of behavioral prevention interventions in 10 of the 15 demonstration sites funded as part of the Prevention with Positives Initiative. HRSA [the Health Resources and Services Administration] also funded an evaluation center to conduct both quantitative and qualitative evaluations of the initiative. Baseline findings from these cross-site evaluations also are presented in this supplemental issue” (p. S1).

Masten, J., Kochman, A., Hansen, N.B., & Sikkema, K.J. (2007). A short-term group treatment model for gay male survivors of childhood sexual abuse living with HIV/AIDS. *International Journal of Group Psychotherapy*, 57(4), 475-496.

“HIV-positive gay male survivors of childhood sexual abuse (CSA) face three layers of trauma: childhood abuse, homophobic oppression, and HIV/AIDS. Additionally, CSA has been shown to increase HIV risk behavior among gay men, and the trauma of HIV infection often parallels the experience of CSA. ... This article presents a [15-session coping] group model found to be efficacious for treating gay male survivors of CSA living with HIV/AIDS” (p. 475).

Meyer, I.H., & Northridge, M.E. (Eds.). (2007). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual, and transgender populations*. New York: Springer Science + Business Media.

From the publisher: “*The Health of*

Sexual Minorities is written for social and behavioral scientists and students in public health and health-related fields, public health professionals and health practitioners (including physicians and nurses, social workers, therapists and counselors) interested in the health of lesbians, gay men, bisexuals and transgender [LGBT] people. With over 50 contributions from the field, the book encourages clear thinking, informed practice and effective, progressive policy for improved health and well-being of LGBT individuals and communities.”

Ramsey, S.W., Engler, P.A., & Stein, M.D. (2007). Addressing HIV risk behavior among pregnant drug abusers: An overview. *Professional Psychology: Research & Practice*, 38(5), 518-522. “[T]here is a need to develop new interventions that directly target sex- and drug-related HIV risk behavior among pregnant drug abusers, taking advantage of a period in the women’s lives in which the potential negative consequences of risk behavior are more significant given the possible impact on their unborn children and in which there may be a heightened desire to make healthier behavior choices. Recent work suggests that a promising new direction for the field may be incorporating motivational interviewing components into traditional HIV risk reduction interventions, which focus on providing HIV risk information and building sex- and drug-related HIV risk reduction skills” (p. 518).

Remien, R.H., & Mellins, C.A. (2007). Long-term psychosocial challenges

high-level adherence in the future” (p. 326).

Stress Management

O’Cleirigh, Ironson, and Smits (2007) investigated whether **distress tolerance** – “the capacity to experience and withstand emotional discomfort” (p. 315) – moderates the impact of major life events on psychosocial variables and behaviors important in the management of HIV. The study drew upon data from a sample of 116 men and women living with HIV that was diverse with respect to age, race, ethnicity, and

for people living with HIV: Let’s not forget the individual in our global response to the pandemic. *AIDS*, 21(Suppl. 5), S55-S63.

“This paper highlights several critical psychological and behavioral aspects of HIV disease, a few of which require focused attention, including mental health, stigma and disclosure, adherence, and sexual behavior. Although the focus is primarily on adults living with HIV, we also comment on some of the additional challenges for children and young people. Our critical examination in these areas draws upon the lessons learned in contexts in which [antiretroviral therapy] has been available for a decade, and we explore what is currently happening in settings with more recent treatment access. In the end we offer our insights into what we may expect in the future, and provide recommendations for ongoing prevention and care initiatives with adults, children, and young people affected by this disease” (p. S55).

Smith, B.D. (2007). Sifting through trauma: Compassion fatigue and HIV/AIDS. *Clinical Social Work Journal*, 35(3), 193-198.

“This article explores the compassion fatigue of the author and the graduate students he supervised while conducting psychotherapy with persons living with HIV/AIDS at a counseling center in Atlanta, Georgia. The metaphor of a sifter is suggested to represent the self-care strategies that providers employ to avoid and manage compassion fatigue. Several vignettes are presented and discussed from the

sexual orientation. The investigators found that “distress tolerance significantly moderated the relationship between major life events in the previous 6 months and relevant outcomes in HIV populations, namely depressive symptoms, substance use coping, alcohol and cocaine use in the past month, and the number of reported reasons for missed medication doses. That is, low distress tolerance appeared to combine with a high frequency of major life events to significantly increase the strength of these relationships” (p. 320).

perspective of the provider. The vignettes facilitate an examination of the contribution of trauma experienced by persons living with HIV/AIDS to the compassion fatigue of social service providers” (p. 193).

Wainberg, M.L., McKinnon, K., Mattos, P.E., Pinto, D., Mann, C.G., dos Santos de Oliveira, C.S., de Oliveira, S.B., Remien, R.H., Elkington, K.S., Cournois, F., & the PRISMA Project. (2007). A model for adapting evidence-based behavioral interventions to a new culture: HIV prevention for psychiatric patients in Rio de Janeiro, Brazil. *AIDS & Behavior*, 11(6), 872-883. “[N]o HIV prevention interventions have been tested for efficacy with psychiatric patients in Brazil. We conducted participatory research with local providers, community leaders, patient advocates, and patients using an intervention adaptation process designed to balance fidelity to efficacious interventions developed elsewhere with fit to a new context and culture. Our process for adapting these interventions comprised four steps: (1) optimizing fidelity; (2) optimizing fit; (3) balancing fidelity and fit; and (4) pilot testing and refining the intervention. This paper describes how these steps were carried out to produce a Brazilian HIV prevention intervention for people with severe mental illness. Our process may serve as a model for adapting existing efficacious interventions to new groups and cultures, whether at a local, national, or international level” (p. 872).

– Compiled by
Abraham Feingold, Psy.D.

These results

provide preliminary evidence suggesting that the treatment of depression, substance use coping, substance use, and medication adherence in HIV may well benefit from an assessment of the patient’s distress-tolerance profile [Simons & Gaher, 2005]. Specifically, the direct relationship between distress tolerance and reported HIV symptoms suggests that an assessment of the patient’s distress-tolerance profile may inform medical care by helping to interpret symptom reports. Another clinical implication of ... [these] findings is that the efficacy of traditional behavioral medicine components of relaxation/meditation training and problem solving, which already provide strategies for approach-oriented coping and management of negative affect ..., may be enhanced by the inclusion of emotional acceptance strategies (e.g., mindfulness training, exposure-based treatments). (p. 321)

Riggs, Vosvick, and Stallings (2007)

investigated the association of **adult romantic attachment style**⁶ to psychological symp-

⁶ “[S]ecure adult attachment style is characterized by positive internal working models of self and other, which translate ... into low attachment anxiety and low attachment avoidance. Three insecure adult attachment styles, on the other hand, are characterized by negative internal working models of self and/or other. Preoccupied individuals experience high levels of attachment anxiety because they believe they are unworthy of love and fear abandonment by others. In contrast, dismissing-avoidant adults view themselves as competent and capable and thus experience low levels of anxiety, while they view others as rejecting or unavailable and consequently seek to avoid emotional intimacy. Fearful-avoidant attachment style is characterized by negative internal models of both self and other with high levels of both attachment anxiety and avoidance, and is associated with the poorest adjustment of the four adult prototypes ...” (p. 923).

toms of distress (i.e., perceived stress, depression) and HIV-related stigma in a [stratified convenience] sample of [288] HIV+ adults [recruited from AIDS service organizations in the Dallas-Fort Worth Metroplex in Texas], and further explored how attachment style and HIV stigma together might predict stress and depression levels beyond what can be accounted for by demographic and HIV-related medical variables (medication, HIV-related symptoms). (p. 925)

The investigators found that, beyond demographic and health-related variables, “[a]dult romantic attachment style was significantly associated with perceived stress, depression and HIV-related stigma” (p. 922). Riggs and colleagues make special note of the finding that “[t]he distribution of attachment style in this ... sample was highly skewed, with 90 percent of participants reporting an insecure romantic attachment style” (p. 930). In particular,

[t]his sample's prevalence of fearful attachment style [i.e., 57.8% of sample], which is associated with disorganized behavior and psychological distress, suggests that many HIV+ adults may benefit from therapeutic intervention focusing on interpersonal attachment. Moreover, current results imply that the diagnosis of HIV entails not only the trauma of a life-threatening illness stigmatized by our society, but also imposes serious limitations on the ability to seek and form supportive attachment relationships with romantic partners. ... In addition to examining internalized stigma among HIV+ clients, counselors may find it useful to explore the potential impact of romantic attachment style on physical and mental health. Psychosocial interventions addressing interpersonal functioning in

the context of romantic attachments may be particularly helpful to HIV+ persons. For example, individual or couples therapy focusing on attachment-related sexual and emotional concerns may provide an opportunity to foster the development of secure attachment, which can increase psychological well-being and in turn possibly influence disease progression and outcome. (p. 932)

Coping, Social Support, & Quality of Life

Continuing the focus on cigarette smoking among people living with HIV that was highlighted in the [Fall 2007](#) issue of *mental health AIDS*, Vidrine, Arduino, and Gritz (2007) “examined the **effects of changes in smoking status on HIV-related symptom burden and health-related quality of life** outcomes in a multiethnic, low-income population of [95] persons living with HIV/AIDS” (p. 659) who were participating in a smoking cessation trial. Vidrine and colleagues found that

length of time quit can significantly impact perceived symptom burden in persons living with HIV/AIDS. That is, longer periods of continuous abstinence within a 3-month follow-up period ... [were] associated with lower levels of symptom burden. Thus, the results from this study suggest that smoking cessation treatment may represent an effective way to help reduce commonly experienced HIV-related symptoms; and the length of smoking abstinence is directly related to symptom burden. However, the results from this study did not reveal a significant association between point prevalence abstinence, defined as not smoking a cigarette in the past 24 hours, and symptom burden. This indicates that the benefits of cessation, in terms of reduced HIV-related symptom

burden, may take some time to be realized. (p. 663)

In their continuing analysis of longitudinal data, Lee, Detels, Rotheram-Borus, and Duan (2007) report on **413 children of parents living with (or having died from) HIV/AIDS**. This study examines associations between social support and mental and behavioral outcomes 2 years after the children took part in a time-limited, family-based, cognitive-behavioral, skill-focused intervention or a standard care group. Lee and colleagues found that “[a]dolescents who had more **social support providers** reported significantly lower levels of depression and fewer conduct problems; adolescents who had more negative influence from role models reported more behavior problems. Reductions in depression, multiple problem behaviors, and conduct problems were significantly associated with better social support” (p. 1820). With regard to depression,

adolescents who ha[d] ... 3 support providers reported significantly lower levels of depression up to the 9-month follow-up, compared with adolescents who reported 1 provider. Although adolescents who had 4 providers reported lower depression than those who had 3 providers, the differences were not significant, which suggests that 3 providers may be the threshold point. Research on the relationship between mental health and behavioral outcomes and social support among adolescents affected by HIV/AIDS is limited, and ... [these] findings point to the need for future prevention programs to facilitate better social support for this unique group of adolescents. (p. 1824)

Continuing with data from this participant pool, Stein, Rotheram-Borus, and Lester (2007) report on 213 of the children 6 years after completing

the baseline interview for the study described above. According to Stein and colleagues,

[t]he main research question in the current study was whether **early parentification** was a precursor of later dysfunctional attitudes and behaviors among children of parents with HIV/AIDS. There was concern that their often obligatory assumption of adult, spousal, or parental roles in the face of the parental HIV illness would lead to more maladaptive parenting attitudes, [including expecting role reversals with their own children,] emotional problems, substance use, and poorer coping skills in subsequent years. However, at the 6-year follow-up, ... [the investigators] did not observe any negative outcomes among the variables selected for these analyses. Rather, the only significant effects of parentification in this ... sample are beneficial: better coping skills and less tobacco and alcohol use. This outcome supports the notion that resilience, defined as positive outcome despite serious threats to adaptation or development ..., is common even among those with many serious risk factors for negative outcomes. (p. 328)

Among cohort members who participated in the intervention,

[p]arenting attitudes ... were significantly and positively impacted by the intervention even though it had been implemented several years before the 6-year assessment. There may have been both a direct effect on the youth and an intergenerational effect through their [parents with HIV/AIDS]. The family-based intervention focused in part on parenting skills for the [parents with HIV/AIDS], including developmentally appropriate monitoring and com-

munication, which may have translated to positive modeling of parental attitudes for the intervention youth. In addition, this intervention had demonstrated benefits for the intervention youth, including less emotional distress, better self esteem, and fewer risk behaviors at the 2-year follow-up ..., and, at long term follow up, fewer teen pregnancies, less dependency on federal subsidies, and greater employment and school enrollment Perhaps the intervention provided a window of opportunity for the youth to gain positive skills in emotional regulation and coping strategies that are reflected in parenting attitudes over time. (p. 330)

Drawing on these findings, Stein and colleagues

suggest that clinicians consider the positive personal and cultural aspects of a child's contributions to the maintenance of family life in the context of a parent's physical illness such as HIV/AIDS. For youth living with a seriously ill parent, increased expectations to assist the parent and family are often an unavoidable reality. Clinicians should recommend support for children of parents with HIV and conduct brief assessments with them to evaluate if the children are coping well with the increased responsibility or becoming overwhelmed. Clinical interventions for adolescents of [parents with HIV/AIDS] should include a focus on skill building for youth that increases their positive coping with increased family responsibilities and that helps them maintain developmental opportunities in the context of parentification. (p. 331)

In Canada, Husbands et al. (2007) randomly assigned new and current users of support services at an AIDS service organization in Toronto to one

of two conditions:

The control group received the Usual Care or Self-directed Use of Support Services Program (six months). The Support Services Program included psychosocial counselling, employment counselling, social support and support groups with or without practical assistance as needed (e.g., meals, furniture, good food box, buddies, drives to medical appointments, congregate dining, referrals to other agencies). These services are provided if a ... [person living with HIV/AIDS] asks; that is, services are provided on demand or at the request of the ... [person living with HIV/AIDS].

The experimental group received Self-directed Use of Services Augmented by Case Management (six months). This **strengths-based model of case management** ... [Rapp & Goscha, 2006] not only assisted ... [people living with HIV/AIDS] to access natural supports, but also through the system of human services (health, social, leisure, housing, employment and volunteerism) attempted to actively link ... [people living with HIV/AIDS] with the range of services as needed. Strengths-based case management empowers ... individual[s] to achieve their goals and acquire the competencies, assets and confidence to fulfil these through the use of social relations, opportunities and resources. The case manager works with the client to assess and prioritize the range and mix of their challenges and strengths in the areas of daily living, housing, finances, social supports, vocation, health, leisure or meaningful activity. A manual was available and used when training case managers in the use of this model. (p. 1066)

"Results indicated that those who benefited most from case management were very depressed at baseline. Strengths-based case management compared to usual self-directed care markedly improved the physical, social and mental health function of very depressed ... [people living with HIV/AIDS], and reduced their risk behaviours" (p. 1065).

Husbands and colleagues observe that

[t]he findings concerning very depressed study participants suggest that less depressed clients, who may be more functional in their day-to-day lives, may receive better care from directing their own use of services, due to the increased freedom and control that self-directed care can create in their lives. Less depressed clients may need assistance in feeling empowered and independent in their use of services, whereas more depressed, and possibly less functional, clients may require assistance in becoming functional before they can progress to a stage where they are ready to become independent in their day-to-day activities and use of health and social services. Thus, agencies that are looking to effectively use their limited resources may consider strategically placing clients who are more depressed with a case manager. This would ensure that a case management programme is utilized in the most effective way and that clients who require the most support receive a level of services commensurate with their greater needs. (p. 1071)

Should group psychotherapy be used to address depressive symptoms among people living with HIV? To answer this question, Himelhoch, Medoff, and Oyenyiyi (2007) "performed a systematic review and meta-analysis of double-blinded, ran-

domized controlled trials" (p. 732) "to examine whether **depressive symptoms** respond to **group psychotherapy** treatment among HIV-infected people" (p. 733). The investigators identified eight controlled clinical trials that included 665 study participants; "5 used ... CBT ..., 2 used supportive therapy, and 1 used coping effectiveness training. Three of the 8 studies reported significant effects. The pooled effect size from the random effects model was 0.38 ... representing a moderate effect. ... Studies reporting use of group CBT had a pooled effect size from the random effects model of 0.37 ... and was significant. Studies reporting the use of group supportive psychotherapy had a pooled effect size from the random effects model [of] 0.58 ... and was nonsignificant" (p. 732).

Himelhoch and colleagues conclude that "group therapy, and particularly group [CBT.] may be efficacious in treating depressive symptoms among those infected with HIV" (p. 737). Additionally, the investigators observe that,

[a]lthough the theoretical underpinnings of the group therapy interventions included in the meta-analysis were diverse[,] they did share several features in common. ... [A]ll sessions were at least 90 minutes and occurred on average for 10 sessions ... [and] each study used techniques specifically tailored to improve coping strategies and improve social support. Most, but not all, also provided some form of relaxation training. These elements may represent common components of successful group psychotherapy for HIV-infected individuals with distress. (pp. 736-737)

Finally, Himelhoch and colleagues point out that "the underrepresentation of women limits the generalizability of these findings. Because women may be at risk for depres-

sion and are an emerging population at risk for HIV[,] future studies should be directed to remedy this disparity" (pp. 737-738).

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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/hiv/aids/>); and information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

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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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