

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About the Severely Mentally Ill

In an exploratory study, Tucker, Kanouse, Miu, Koegel, and Sullivan (2003) examined HIV risk behavior in 154 noninstitutionalized individuals living with both HIV and severe mental illness (SMI) in Los Angeles, 56% of whom were sexually active. Among the characteristics they found to be most strongly associated with engaging in one or more behaviors posing risk for transmitting HIV were the individual not receiving HIV counseling, problem drinking behavior, receiving a psychiatric diagnosis other than bipolar disorder, and having a greater number of psychotic mental health symptoms. Tucker and colleagues urge clinicians who are the usual sources of care for the SMI population to routinely offer HIV counseling, a relatively inexpensive and easily administered intervention, in an effort to reduce sexual risk behaviors.

About Men Who Have Sex with Men

Researchers in Britain (Beck, McNally, & Petrak, 2003) surveyed 123 attendees at a gay men's sexual health clinic; 36% of the men surveyed reported sexual risk behavior during the preceding month and 26% reported non-consensual sex (NCS; primarily during adulthood); the latter was not directly linked to the former. On the other hand, depressive symptomatology was associated with sexual risk behavior; additionally, "a number of different beliefs are indicative of sexual risk behaviour in this population. These are feelings of the uncontrollability of risk (a variable associated with a history of NCS), of fidelity as a protective factor (despite the complex issues associated with negotiated risk in relationships) and reducing the risk to oneself by only practising insertive sex (despite

this [being] clearly identified as a risk factor ...). All of these beliefs can be conceptualized as erroneous and may be open to modification through cognitive behavioural interventions" (p. 145). Based on statistical analysis, the authors point out that "these cognitions are foremost in driving risk

It gives me great pleasure to welcome the Substance Abuse and Mental Health Services Administration (SAMHSA) as an additional sponsor of *mental health AIDS*.

In grateful recognition of this support, I will be highlighting the work of the Center for Mental Health Services (CMHS)/SAMHSA Mental Health HIV Services Collaborative (MHSC) Program in a new feature section of *mental health AIDS* entitled **From the Block**.

The MHSC Program, initiated in 2001, is designed to address unmet mental health treatment needs of individuals living with HIV/AIDS who are African-American, Hispanic/Latino and/or from other communities of color. Through this initiative, 21 community-based organizations received five-year grants to expand their current service capacity to reach and provide coordinated mental health services to individuals with a diagnosed mental illness who are also HIV-positive.

Materials appearing in **From the Block** were developed by the MHSC Program Coordinating Center.

– Abraham Feingold, Psy.D, Editor

behaviours irrespective of the mood and NCS history of the subject. Thus more notable reductions in risk behaviours may be achieved by ... modifying erroneous cognitions than identifying 'at-risk individuals' such as those who have depression or a history of NCS" (p. 145).

Patterson, Shaw, and Semple (2003) randomly assigned 387 people living with HIV – mostly gay men – who reported engaging in unprotected intercourse with partners who were HIV-negative or of unknown serostatus to one of four conditions: "(a) a single counseling session targeting problem areas identified by the participant in 3 possible intervention domains (i.e., condom use, negotiation, disclosure); (b) a single-session comprehensive intervention that covered all 3 intervention domains; (c) the same comprehensive intervention, plus 2

monthly booster sessions; or (d) a 3-session diet and exercise attention-control condition" (p. 137). The three counseling conditions utilized "skill-building exercises, demonstrations, role playing, rehearsal, and positive reinforcement ... to enhance knowledge, self-efficacy, and positive outcome expectancies in the process of attaining desired behavioral change" (p. 139). Interestingly, *all conditions* (including the atten-

tion-control condition) were associated with a decrease in the total number of unprotected acts of intercourse over a one-year period subsequent to the brief interventions. It should be noted that, in the counseling conditions, study participants were provided with two messages: "practice safer sex and

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protect others," and "unsafe sex may lead to infection with other [sexually transmitted diseases; STDs], which may further harm your health"; both messages appeared to be effective in reducing sexual risk behavior in people living with HIV. And yet, while "[t]hese findings suggest that a brief intervention can result in large reductions in HIV transmission risks among HIV+ individuals, ... the relative benefit of one intervention approach over another remains unclear" (p. 137).

Perhaps a more tailored approach will improve clarity in this area. EXPLORE is a randomized, controlled clinical trial currently underway, involving 4,295 HIV-negative men who have sex with men (MSM) in six U.S. cities who are at risk for HIV infection. Participants are receiving either an intensive cognitive-behavioral intervention or standard HIV counseling and testing. The intervention involves 10 individual counseling sessions conducted over a four- to six-month period, followed by quarterly "maintenance" sessions. Sessions are tailored to address specific risk factors for each participant within a manual-driven (and, therefore, potentially reproducible) framework of 10 treatment modules. HIV incidence will be monitored through semiannual HIV testing to assess the impact of the intervention by comparing rates of new HIV infection in each group.

The need for such individually-tailored interventions is supported by Chesney et al. (2003), who found wide variability in risk factors and combinations of risk factors

among the 4,295 study participants. For example, the two most prevalent risk factors – enjoying unprotected receptive anal intercourse and noninjection drug use – accounted for risk behavior in only one-third of this cohort. Findings such as these "support an individualized approach to behavioral risk reduction counseling in which the specific targets are those most salient to an individual's unique profile" (p. 936). Outcome data from this clinical trial will be presented as they become available.

While the EXPLORE intervention stresses a personalized approach to HIV prevention, the intervention may not fully address some of the underlying problems that contribute to HIV risk behavior among some MSM. Stall et al. (2003) conducted a telephone survey involving 2,881 MSM from New York City, Los Angeles, Chicago, and San Francisco to explore the additive effect of psychosocial health problems (e.g., depression, polydrug use, adults sequelae of childhood sexual abuse, partner violence) on HIV risk and found that a greater number of health problems correlated positively with HIV risk behavior and infection.

This analysis ... supports the view that additive psychosocial health problems – otherwise known collectively as a syndemic – exist among urban MSM and that the interconnection of these problems functions to magnify the effects of the HIV/AIDS epidemic in this population. ... [S]ubstantial literature now exists on the relationship between substance use and HIV/AIDS, depres-

sion and HIV/AIDS, childhood sexual abuse and HIV/AIDS, and violence and HIV/AIDS. Our analysis extends this literature to show that the connection among these epidemic health problems and HIV/AIDS is far more complex than a 1-to-1 relationship; rather it is the *additive interplay* of these health problems that magnifies the vulnerability of a population to serious health conditions such as HIV/AIDS. (p. 941)

Stall and colleagues conclude that, "HIV prevention might become more effective by addressing the broader health concerns of MSM while also focusing on sexual risks" (p. 939).

About Substance Users

Semple, Patterson, and Grant (2003) compared binge and nonbinge use of methamphetamine (meth) in 90 MSM living with HIV and found that those who self-identified as binge users did not use any more meth over a 30-day period than nonbinge users, but reported more social difficulties, a greater number of mental and physical health problems, and riskier sexual behavior when compared to nonbinge users. The authors advise clinicians to: 1) gather data on a client's pattern of meth use, not just the amount used; 2) educate binge users about the potential for serious mental and physical health problems associated with this pattern of use; 3) help clients to recognize the risks associated with this pattern of use; 4) explore the complex psychological processes underlying binge use (e.g., triggers, motivations, meaning) and their connection to unsafe sexual behavior; and 5) assess and explore issues of self-esteem, self-image, and self-perception that may be associated with binge use of meth.

Sterk, Theall, Elifson, and Kidder (2003) randomly assigned 71 female, African-American out-of-treatment injecting drug users (IDUs) to one of three interventions: a four-session, enhanced HIV intervention focused on motivation, a four-session, enhanced HIV intervention focused on negotiation, or a two-session, National Institute on Drug Abuse (NIDA) standard condition. As in their earlier study involving African-American, out-of-treatment crack cocaine

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Summaries appearing in *mental healthAIDS* are presented to promote awareness and understanding of current and continuing research in the area of HIV and mental health. They are not intended for use as the sole basis for clinical treatment nor as a substitute for reading the original research.

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users, exposure to *any* of these conditions led to reductions in drug-use and sexual risk behavior at six-month follow-up, although greater reductions were noted following each of the enhanced HIV interventions. The authors conclude that “[c]omponents of both interventions used in this study may prove useful for reducing the risk of HIV infection among similar populations of African-American women [who inject drugs]” (p. 84).

Woody et al. (2003) assigned 487 cocaine-dependent (mainly crack-smoking) individuals at risk for HIV but without co-occurring disorders to one of four outpatient-based treatment modalities offered two-to-three times weekly for six months: group drug counseling (GDC), group counseling plus individual drug counseling (IDC), cognitive therapy, or supportive-expressive therapy. “Treatment was associated with a decrease in cocaine use ... [which] was associated with an average 40% decrease in HIV risk across all treatment, gender, and ethnic groups, mainly as a result of fewer sexual partners and less unprotected sex. The combination of IDC and GDC was associated with an equal or even greater reduction in HIV risk than the other treatment conditions and thus shows promise as an effective HIV prevention strategy, at least for some patients” (p. 82).

Finally, Fals-Stewart et al. (2003) studied 362 married couples (drug-abusing husbands entering outpatient treatment and their non-drug-abusing wives) and found that 40% of the husbands engaged in high risk sexual or drug use behaviors and 96% of the couples were concurrently sexually active during the year preceding treatment. Among these couples, 78% of wives reported irregular condom use; 71% of these women indicated that they were unaware of their husbands’ HIV risk behavior. HIV risk among the wives was associated with longer marriages, the husband being diagnosed with antisocial personality disorder, and the wife being unaware of her husband’s risky behavior. The authors suggest the following intervention:

In the context of conjoint psychoeducational sessions for husbands and

wives about HIV, a summary of the findings of this study is presented, indicating that many wives of substance-abusing partners are unaware of their husbands’ high risk behaviors and are unknowingly placed at high risk for exposure to HIV. ... [W]e have found that sharing this information ... has often served as an impetus for wives to discuss these issues with their husbands or for husbands to disclose their high risk behaviors. ... Additionally, partners are encouraged to participate in ... a ‘negotiated safety contract’ ... As part of this contract, both partners are asked to submit to HIV testing. If partners do not presently use condoms, they are encouraged to do so. However, if partners are unwilling or reluctant to do so, they are asked to agree to: (1) share with each other HIV-antibody status once testing is completed; (b) reach an unambiguous agreement for partners to use condoms in any sexual relationship outside the marriage; and (c) engage in safer needle practices if [injecting]. ... Although many studies have found that women in long-term relationships ... have difficulty negotiating safer sex practices, building this into our treatment program allows ... counselors to assist wives with this effort in ... [couple’s] sessions. (pp. 73-74)

About Women & Men

El-Bassel et al. (2003) conducted a randomized clinical trial to study the efficacy of “Project Connect,” a relationship-based HIV/STD prevention intervention designed for at-risk heterosexual couples. English- and/or Spanish-speaking, low-income women receiving outpatient medical care were recruited into the study and these women, in turn, recruited their regular male sexual partners. The 217 couples were randomized to one of three conditions: a six-session couples intervention ($n = 81$); the same intervention offered to the woman alone ($n = 73$); or a single educational session offered to the woman alone ($n = 63$). “The intervention emphasized the importance of relationship communication, negotiation, and problem-solving skills and highlighted how relationship dynamics may be affected by gender roles and expectations. The ses-

sion content emphasized each couple’s contribution to enhancing the future health of ethnic communities hardest hit by HIV/AIDS” (p. 965). In the first two conditions, *regardless of whether the male partner was present or not*, the intervention was associated with a reduction in the number of unprotected sex acts and an increase in the proportion of protected sex acts at a three-month follow-up session. “The results ... lend support to the desirability of delivering relationship-based HIV/STD interventions in primary care settings to African American and Latino couples at elevated risk for HIV/STD transmission. These study findings ... provide 2 alternative methods for an efficacious ... intervention for women in long-term relationships ... [and also demonstrate that] regular male sexual partners ... are willing to participate in an HIV/STD intervention with their partners” (p. 968).

About Women

Salabarría-Peña, Lee, Montgomery, Hopp, and Muralles (2003) interviewed 174 women from Central America (largely El Salvador and Guatemala) with low acculturation receiving medical care in Los Angeles County regarding their intentions to use male and female condoms and found that subjective norms (with female friends influencing perceptions of male condoms and mothers influencing perceptions of female condoms), perceived behavioral control (related to condom accessibility and self-perceived sex negotiation skills), and attitudes (guided by beliefs related to reduced sexual sensation or discomfort [negative] and their ability to prevent STDs, vaginal infections, and pregnancy [positive]); trust from the woman’s sexual partner guided beliefs regarding female condoms only) contributed significantly to condom use intentions. Based on these findings, Salabarría-Peña and colleagues contend that HIV prevention programs targeting Central American women with low acculturation should highlight the purpose of condoms, include information on ways to minimize discomfort and heighten sexual pleasure while using condoms, speak to issues of trust between partners, and offer practical information and skills-building exercises involving female condoms to help women feel greater control over their use.

Tool Box

Resources

Books & Articles:

Chesney, M. (2003). Review: Adherence to HAART regimens. *AIDS Patient Care & STDs*, 17(4), 169-177.

"This review focuses on the current understanding of adherence reporting, improvement of adherence, and, hence, improvement of treatment outcomes in HIV infection and AIDS" (p. 169).

Ciambrone, D. (2003). *Women's experiences with HIV/AIDS: Mending fractured selves*. New York: Haworth Press.

Through the stories of 37 women living with HIV, Ciambrone examines "the everyday impact of an HIV diagnosis and the effect of the disease on women's social and familial roles."

Greene, K., Derlega, V.J., Yep, G.A., & Petronio, S. (2003). *Privacy and disclosure of HIV in interpersonal relationships: A sourcebook for researchers and practitioners*. Mahwah, NJ: Lawrence Erlbaum Associates. The authors provide "a broad overview of current research on privacy and disclosure, and [bring] together 2 areas of study: self-disclo-

Sterk, Klein, and Elifson (2003) interviewed 250 low-income, largely African-American women in Atlanta at risk for HIV infection and found that these women were generally at least moderately confident in their ability to use condoms consistently; greater self-perceived capability to use condoms was associated with being younger, not having experienced childhood neglect, having higher self-esteem, being better able to communicate with sexual partners, and having fewer drug problems. Based on these findings, Sterk and colleagues encourage clinicians to pay particular attention to the needs of older women as well as women who experienced childhood neglect when working to promote condom use self-efficacy.

About Perinatal Transmission

Bardequez et al. (2003) followed 226 of the women enrolled in the original Pediatric AIDS Clinical Trials Group (PACTG) 076 study – the study that demonstrated the potential benefit of zidovudine (ZDV, AZT or Retrovir®) in reducing perinatal HIV transmission – over an average of about four years and found no evidence that AZT

sure as a communication process and the social/relational consequences of HIV/AIDS."

Gushue, G.V., & Brazaitis, S.J. (2003). Lazarus and group psychotherapy: AIDS in the era of protease inhibitors. *Counseling Psychologist*, 31(3), 314-342.

"This article examines changes in the content, process, and salient leadership tasks of an ongoing therapy group for people with HIV and AIDS before and following the initial introduction of new medical treatments. It also considers how the group process continues to be affected by the more recent failure of these medications for many patients" (p. 314).

Levy, J.A., Ory, M.G., & Crystal, S. (Eds.). (2003). The graying of the AIDS epidemic: HIV/AIDS and people age 50 and older. *Journal of Acquired Immune Deficiency Syndromes*, 33(Suppl. 2), S57-S250.

"This special issue is organized around a series of subsections representing key issues and research findings related to HIV/AIDS and aging issues, including the epidemiology of HIV/AIDS and aging, HIV/AIDS risk and risk behavior, settings and situations as social contexts of risk, clinical challenges with older populations, living with and managing HIV/AIDS, interven-

monotherapy taken for this purpose by these relatively healthy women had any adverse effect on their subsequent physical health. "Based on our data, ZDV monotherapy could be considered as chemoprophylaxis to reduce perinatal HIV transmission for minimally symptomatic HIV-infected pregnant women with a low viral load and normal CD4 cell count who do not want to receive highly active antiretroviral therapy [HAART] because of concern about potential side effects or who wish to reduce fetal exposure to multiple drugs during pregnancy" (p. 170).

About Men

In Brazil, Barroso et al. (2003) followed 93 men living with HIV prior to and following their initiation of antiretroviral treatment. They found that adherence to antiretrovirals and, in particular, to HAART, was associated with the suppression of HIV in semen six months after beginning these medications. "Measures to improve adherence are urgently needed to reduce the sexual spread of potentially drug-resistant HIV among subjects using antiretrovirals" (p. 435), conclude the authors.

tions and research methods, new frontiers and challenges, and strategies for action" (p. S59).

Lindemann, D.F., & Brigham, T.A. (2003). A Guttman Scale for assessing condom use skills among college students. *AIDS & Behavior*, 7(1), 23-27.

The Measure of Observed Condom Use Skills (MOCUS) "is an initial step in an effort to evaluate both ... skill level and the effectiveness of intervention programs for teaching proper condom use skills" (p. 26).

Pedlow, C.T., & Carey, M.P. (2003). HIV sexual risk-reduction interventions for youth: A review and methodological critique of randomized controlled trials. *Behavior Modification*, 27(2), 135-190.

Pedlow and Carey review and critique 22 studies published between 1992 and 2000; 13 of the evaluated interventions were effective in reducing risky sexual behavior in adolescents.

Prachakul, W., & Grant, J.S. (2003). Informal caregivers of persons with HIV/AIDS: A review and analysis. *Journal of the Association of Nurses in AIDS Care*, 14(3), 55-71.

Prachakul and Grant review and analyze 14 empirical studies published between 1991 and

Safer sex discussion – and not status disclosure alone – appears to be important as well. Crepaz and Marks (2003) surveyed a random sample of 105 men, diverse in ethnicity and sexual orientation, receiving HIV outpatient medical care in Los Angeles and found that those who disclosed their HIV-positivity and discussed safer sex with their most recent HIV-negative or unknown serostatus partner were more likely to engage in protected vaginal or anal intercourse than those who merely disclosed their HIV-positivity. Crepaz and Marks urge clinicians to support serostatus disclosure to sex partners and work to enhance safer sex communication and negotiation skills among HIV-positive men to help reduce HIV incidence.

About Adolescents

Johnson, Carey, Marsh, Levin, and Scott-Sheldon (2003) reviewed 44 controlled studies presented or published between 1985 and 2000 evaluating 56 HIV sexual risk-reduction interventions implemented with 35,282 11- to 18-year-olds. Across all studies, the authors found that adolescents who received the intervention (rather than the

2001 that examine the physical health and psychosocial well-being of informal caregivers of people living with HIV/AIDS.

Somers, C.L., & Canivez, G.L. (2003). The Sexual Communication Scale: A measure of frequency of sexual communication between parents and adolescents. *Adolescence*, 38(149), 43-56.

Somers and Canivez report on the SCS, a brief instrument designed to measure how often communication regarding sexual topics occurs between a mother/mother figure and an adolescent (20 items) and between a father/father figure and an adolescent (the same 20 items).

Valente, S.M. (2003). Depression and HIV disease. *Journal of the Association of Nurses in AIDS Care*, 14(2), 41-51.

Valente reviews the diagnosis and treatment of depressive disorders in people living with HIV; screening instruments and medications with depressive side effects are noted.

Wilson, B.D.M., & Miller, R.L. (2003). Examining strategies for culturally grounded HIV prevention: A review. *AIDS Education & Prevention*, 15(2), 184-202.

Wilson and Miller review HIV prevention litera-

ture through 2001, describing how culture has been integrated into and evaluated within HIV prevention interventions.

Yarhouse, M.A. (2003). Working with families affected by HIV/AIDS. *American Journal of Family Therapy*, 31(2), 125-137.

Yarhouse reviews HIV prevention and treatment literature for use by marriage and family therapists.

Internet Resources:

Adherence to long-term therapies: Evidence for action has been published online by the World Health Organization: http://www.who.int/chronic_conditions/adherencereport/en/; Chapter 12 (pp. 87-97) focuses specifically on HIV/AIDS.

"Expanded Response Guide to Core Indicators for Monitoring and Reporting on HIV/AIDS Programs," from USAID, offers indicators that may be used to measure progress in HIV/AIDS programs. It may be found at: http://www.usaid.gov/pop_health/aids/TechAreas/monitoreval/expandedresponse.pdf

--Compiled by Abraham Feingold, Psy.D.

comparison condition) demonstrated greater reductions in sexual risk along five dimensions: communication with sexual partners, condom use negotiation skills, condom use, condom use skills, and sexual frequency (i.e., less frequent sex). Greater success was associated with noninstitutionalized adolescents, when condoms were supplied, when there was more condom information and skills training, when the comparison group was offered less HIV skills training, and when the comparison group was offered "generic" (i.e., non-HIV-related) sex education. The authors conclude that "[i]ntensive behavioral interventions reduced sexual HIV risk, especially because they increased skill acquisition, sexual communications, and condom use and decreased the onset of sexual intercourse or the number of sexual partners" (p. 381).

Lefkowitz, Boone, Au, and Sigman (2003) observed 50 mother-teen dyads (25 boys and 25 girls, ages 11-15) discussing two topics – sexuality/dating and HIV/AIDS – and noted that the areas of abstinence and safer sex were not covered frequently, al-

though more often during the latter conversation than the former; that mothers were more likely to raise these issues than their teens; and, importantly, that *dyads who discussed abstinence were more likely to discuss safer sex as well*. Those teens who discussed safer sex tended to be older, to be less religious, and to have mothers who were more educated than those who did not discuss safer sex. Despite the limited sample size, Lefkowitz and colleagues offer the following recommendations for clinicians: 1) focus parents specifically on the topic of AIDS when planning discussions with teens regarding preventive behaviors; 2) explicitly instruct parents to talk about abstinence and safer sex, rather than giving them the more general charge to talk about "sex" or "AIDS"; 3) help parents to frame their reasons for promoting abstinence and to develop ease in discussing safer sex should their children elect to become active sexually; 4) help parents to involve teens in these discussions, rather than talking "at" them; and 5) take a thoughtful approach in discussing safer sex with parents who have strong religious convictions in this area.

HIV Assessment News

Psychiatric Assessment

Perdue, Hagan, Thiede, and Valleroy (2003) studied 1,228 IDUs and 429 young MSM in Seattle and found that depression was associated with selected HIV risk behaviors (i.e., needle sharing in the former group, an increased number of sex partners in the latter group), highlighting the need to diagnose and address depressive symptomatology as an HIV risk-reduction intervention.

Haller and Miles (2003) explored suicidality among 190 individuals (68% male) receiving outpatient HIV mental health services. Within 30 days of service enrollment, 26% reported suicidal ideation and 6% were considered "at-risk" for suicidal behavior. From a diagnostic standpoint, increased risk for suicidality was associated with the following diagnoses: major depression, dysthymia, substance abuse, thought disorder, and posttraumatic stress disorder, as well as borderline and avoidant personality disorders; conversely, a diagnosis of narcissistic personality disorder was associated with decreased risk. Individuals with psychiatric *and* substance use disorders were at particularly high risk for suicidal ideation, demonstrating the need to assess and treat comorbid substance use disorders. Additionally, six of seven quality-of-life variables, most prominently leisure/social time and family life/friendships, were associated with suicidal ideation, and overall quality of life had the strongest association with suicidal ideation; this single item might serve as a screening tool to identify individuals at particular risk for suicidal ideation. The finding that avoidant personality disorder was associated with suicidality, coupled with findings related to quality of life, argue for "broader personality assessment among treatment-seeking samples. ... [Moreover,] the quality of one's interpersonal relations and activities must be considered during the assessment and treatment planning process" (p. 106).

HIV Treatment News

Medical Care

In recent weeks, the U.S. Food and Drug Administration (FDA) has announced the approval of several products that may reduce pill burden for antiretroviral users:

o On April 30, 2003, the FDA (2003a) approved a 625 mg. dosing formulation of nelfinavir (NFV or Viracept®). The new formulation reduces pill burden from five-250 mg. tablets twice daily to two-625 mg. tablets twice daily, potentially increasing adherence to medication regimens. While this higher exposure does not appear to affect safety, diarrhea may be a more common side effect in those receiving the new formulation.

o On June 20, 2003, the FDA (2003b) approved atazanavir (ATZ or Reyataz™), the first once-daily protease inhibitor (PI) for use in combination with other antiretrovirals for the treatment of HIV infection. The recommended dosage is 400 mg. (two 200 mg. capsules) once each day, with food. While ATZ does not appear to cause the increase in cholesterol seen with the use of other PIs, side effects may include jaundice, headache, nausea, vomiting, diarrhea, abdominal pain, drowsiness, difficulty sleeping, and fever.

o On July 2, 2003, the FDA (2003c) approved emtricitabine (FTC or Emtriva™), a new nucleoside reverse transcriptase inhibitor (NRTI) for use in combination with other antiretrovirals for the treatment of HIV infection in adults. The recommended dosage is one daily 200 mg. capsule, with or without food. Side effects may include headache, diarrhea, nausea, rash, and skin discoloration (i.e., excess pigmentation on the palms and/or soles, predominantly observed in non-Caucasian study participants). As with other NRTIs, FTC may cause lactic acidosis (i.e., the buildup of an acid in the blood) and serious liver problems, including hepatomegaly (i.e., liver enlargement) and steatosis (i.e., fat in the liver).

On the topic of reducing pill burden, Spanish investigators (Ena & Pasquau, 2003) reviewed six uncontrolled and two randomized studies involving the administration of once-a-day HAART over at least a 24-week period. The regimens included:

o didanosine (ddl or Videx®), FTC, and efavirenz (EFV or Sustiva®) (two studies, total $n = 326$);

o ddl, lamivudine (3TC or Epivir®), and EFV (three studies, total $n = 147$);

o ddl, 3TC, EFV, and adefovir (Hepsera®) (one study, $n = 11$);

o ddl, nevirapine (NVP or Viramune®), and EFV (one study, $n = 15$); and

o ddl, 3TC, indinavir (IDV or Crixivan®), and ritonavir (RTV or Norvir®) (one study, $n = 10$).

These regimens were capable of reducing viral loads to undetectable levels in 70% to 91% of study participants, with good tolerability and few study drop-outs. Moreover, the two randomized studies demonstrated that the combinations ddl, 3TC, and EFV and ddl, FTC, and EFV were at least as effective as conventional HAART. Although preliminary, these studies offer promise with regard to increasing antiretroviral adherence through ease of administration.

More challenging (and costly) to administer is enfuvirtide (ENF or Fuzeon™, also known as T-20), the first fusion inhibitor approved by the FDA. Utilizing nearly identical methodologies, two studies, one involving individuals living in both North and South America (Lalezari et al., 2003) and the other individuals living in nine European countries and Australia (Lazzarin et al., 2003) demonstrated that ENF, when added to an "optimized" antiretroviral regimen, offered significant increases in CD4 cell counts and decreases in viral load over a 24-week period among highly antiretroviral-experienced individuals, many of whom had developed resistance to the other three classes of antiretrovirals.

What is the impact of alcohol use on HAART? Samet, Horton, Traphagen, Lyon, and Freedberg (2003) studied 349 people living with HIV and found that, "[a]mong patients who have a history of alcohol problems and are receiving antiretroviral treatment, alcohol consumption was associated with higher HIV RNA levels and lower CD4 counts. No comparable association was found for similar patients who were not receiving HAART. Addressing alcohol use in HIV-infected patients, especially those who are receiving HAART, may have a substantial impact on HIV disease progression" (p. 862).

Psychiatric/Psychological Psychosocial/Spiritual Care Psychopharmacology

Vitiello, Burnam, Bing, Beckman, and Shapiro (2003) conducted additional evaluation on a group of 1,489 individuals within a nationally representative sample of 2,864 adults receiving HIV medical care in 1996 and estimated that 27.2% of people receiving HIV care at that time took psychotropic medication; antidepressants (20.9%), anxiolytics (16.7%), antipsychotics (4.7%), and psychostimulants (3.0%) were the most frequently prescribed psychotropics. Among those with a diagnosed mood disorder (i.e., major depression or dysthymia), 43.2% were prescribed antidepressants and 34.3% anxiolytics. General use of psychotropics, and particular use of antidepressants, was lower among African Americans when compared with whites or Latinos. And so, while psychotropic use is common among HIV-positive individuals engaged in medical care, more than half of those diagnosed with mood disorders may not be receiving antidepressants, and African Americans are less likely than other racial/ethnic groups to utilize medications for mental disorders (although this may be balanced by greater use of psychosocial interventions).

Neuropsychiatric Impairment

Based on semiannual assessments of 141 gay and bisexual men, Ferrando, Rabkin, van Gorp, Lin, and McElhiney (2003) note that "increasingly potent antiretroviral therapy was associated with improvement in tests of psychomotor processing speed." This study contributes to the growing literature documenting the longitudinal benefit provided by potent antiretroviral therapy for neuropsychological [NP] function, particularly psychomotor processing speed, in patients with HIV illness" (p. 208).

The key, however, appears to be *ongoing* use of these medications. Polis et al. (2003) evaluated cerebrospinal fluid (CSF) over a six-month period in 25 PI-naïve individuals who initiated a four-drug HAART regimen and found, after two months of treatment, that 36% of study participants continued to have a detectable viral load. By Month 6, all participants achieved an undetectable viral load, suggesting that "[p]rolonged

therapy may be required to suppress HIV levels within the central nervous system" (p. 1167).

In a pilot study involving 16 monolingual Spanish-speaking adults living with HIV, Mindt et al. (2003) discovered that Spanish-language translations of an existing functional battery assessing the domains of medication management, cooking, shopping skills, financial skills, and restaurant behavior appear to be culturally relevant (with minor modifications) and could discern cognitive impairment when compared to comprehensive, Spanish-language NP testing, as well as employment status and quality of life. "These results, though preliminary, suggest that Spanish language functional assessments are potentially valid tools for detecting everyday functioning deficits

associated with NP impairments in HIV-infected Spanish-speakers" (p. 122).

The choice of assessment tools is, however, critical to obtaining meaningful results, as suggested by Smith, van Gorp, Ryan, Ferrando, and Rabkin (2003), who administered the HIV Dementia Scale (HDS) to 90 men and women living with HIV who had *not* been diagnosed with moderate or severe HIV-associated dementia and found that, "in contrast to previously published findings, the HDS lacks sufficient sensitivity to screen for NP abnormality beyond frank dementia. Intact performance (i.e., performance above established cutoff levels) contributes to a significant number of false-negative errors, suggesting that a more complete NP battery should be administered in those cases in which subtle

neurocognitive deficits are suspected" (p. 117).

Adherence to Treatment

Tucker, Burnam, Sherbourne, Kung, and Gifford (2003) assessed antiretroviral adherence in a nationally representative sample of 1,910 adults receiving HIV medical care and found nonadherence to be associated with: probable diagnoses of depressive disorder, generalized anxiety disorder, or panic disorder; use of cocaine/crack/freebase, marijuana/hashish, amphetamines, or sedatives during the preceding month; and moderate, heavy, or frequent heavy use of alcohol during the preceding month. "These findings suggest the need for screening and treatment for mental health and substance use problems among HIV-positive patients to improve adherence to antiretroviral medi-

Tool Box

Remain Objective Regarding Subjective, HIV-Related Cognitive Complaints

While some studies have found an association between subjective cognitive complaints and objective cognitive impairment in people living with symptomatic HIV disease (e.g., Poutiainen & Elovaara, 1996), others have not. For example, in a sample of 92 adults living with symptomatic HIV disease, Moore et al. (1997) compared subjective complaints (cognitive, motor, and affective) to actual neuropsychological (NP) functioning and found *no* relationship between the former and the latter, although a relationship *was* discerned between these self-reported difficulties and symptoms of depression and anxiety. The authors observe that "mood state appears to contribute to increased complaints of cognitive status in general" (p. 43) and, conversely, that "complaints of cognitive decline may be attributable to emotional factors" (p. 37) in individuals with symptomatic HIV disease.

More recently, Canadian investigators (Millikin, Rourke, Halman, & Power, 2003) studied 27 men diagnosed with HIV infection and 41 diagnosed with AIDS and found, across both groups, that fatigue was associated with depressive symptoms and that both were associated with *subjective* neurocognitive complaints, but not with *objective* NP test performance. The authors conclude that neither fatigue nor depressive symptoms seems to interfere with the evaluation of NP functioning in people living with HIV.

The Power of Perception

What happens as HIV disease advances? Pessin, Rosenfeld, Burton, and Breitbart (2003) evaluated 128 people admitted to long-term care facilities with advanced AIDS and found that cognitive impairment was *modestly* associated with a desire for hastened death, even after controlling for the effect of depressive symptoms on such desire. Impairments in memory and psychomotor coordination, rather than abstract reasoning or executive functioning, were more salient in this regard. Pessin and colleagues urge clinicians to aggressively treat cognitive symptoms in those who are terminally ill to reduce their impact on end-of-life decision-making.

Importantly, Pessin and colleagues also observed an association between the desire for hastened death and *subjective* cognitive complaints. "The hypothesis that awareness represents a crucial link between cognitive impairment and desire for hastened death is bolstered by our finding that ... 'difficulty concentrating' ... was also associated with desire for hastened death. Even though awareness of cognitive deficits was only modestly associated with actual cognitive impairment, patients who perceived themselves as having cognitive difficulties demonstrated greater desire for hastened death than those who were either cognitively intact or are impaired but unaware of their deficits" (p. 197).

Always Assess and Attend to Symptoms

Pessin and colleagues encourage clinicians to inquire about symptoms of cognitive impairment in people living with HIV for, in the final analy-

sis, cognitive impairment – *whether objective in nature or subjective* – requires intervention. "Despite intact cognitive functioning, those patients who are more depressed or anxious tend to complain that they are cognitively impaired. ... If cognitive complaints are present, a thorough evaluation must first rule out a mood disorder before dementia is considered. It is therefore recommended that patients' self-report of cognitive decline be supported by objective [NP] and affective measures before a definitive diagnosis is made" (Moore et al., 1997, p. 43). And, of course, if an anxiety disorder or a mood disorder is identified, it should be treated.

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cations" (p. 573).

Similarly, Turner, Laine, Cosler, and Hauck (2003) conducted a retrospective analysis involving 5,073 drug-using, Medicaid enrollees in New York State who were prescribed HAART and found that male study participants had better pharmacy-measured adherence than female study participants, who were more likely to be diagnosed with depression. Of note: mental health care (psychotherapy with or without antidepressants) was associated with adherence among women, while regular drug treatment was associated with adherence among men.

Remien et al. (2003) interviewed a convenience sample of 110 urban men and women living with HIV – diverse with regard to ethnicity, transmission risk, and place of residence – to identify facilitators and barriers to antiretroviral adherence. Their discussion of findings offers clinicians useful perspectives when thinking about antiretroviral adherence:

Foremost, ... there are typically *multiple* emotional, cognitive, and behavioral factors that influence people's medication-taking behavior. Adherence is not a static, one-dimensional behavior (e.g. only dependent on "reminders"), but rather is dynamic and influenced by changing internal and external variables. Thus, the same individual may exhibit poor adherence at one time in his or her life, but can demonstrate good adherence at another time. ...

[P]eople make decisions about medication-taking behavior that is dependent on personal experience, the experience of others, and beliefs they have about medication effects. It was striking [when] people discussed their *intention* to *not* follow the prescription as directed (e.g., to avoid side effects or because it would be better to give their body a break). Thus, ... providers may measure a behavior and label it as "nonadherence," whereas from the ... patient's perspective they are behaving in accordance with decisions they have made for themselves, with their own best intention in mind.

... The complex and highly individual structures of treatment and illness representation, attitudes, and experiences impact adherence from a variety of angles. This may fluctuate with both past and current experiences, as well as shifting expectations. [However,] there may be a range of compensating factors that can influence adherence in the desired direction. For example, a negative attitude toward medication taking may be overridden by strong social supports for strict compliance, or improving one's understanding of the relevance of strict adherence may be able to compensate for a lack of social supports and/or the experience of negative physical side effects. ... Clearly, the patient *as a whole* (all of their beliefs, attitudes, feelings, and social influences) must be considered when trying to understand and address adherence in HIV care. (p. 70)

With regard to improving adherence, Malcolm, Ng, Rosen, and Stone (2003) interviewed 28 men and 16 women receiving HIV medical care in Rhode Island to draw distinctions between those who demonstrated "excellent" adherence to HAART and those whose adherence was suboptimal. They found that the former, when compared to the latter, "(1) believed adherence rates needed to be 90-100% for medication efficacy; (2) trusted their primary providers greatly; (3) took medications even when actively abusing substances; (4) were open about their HIV status and received substantial social support; (5) cited staying healthy as their key motivator; [and] (6) were not actively depressed..." (p. 251). "Incorporating strategies utilized by patients with excellent adherence [into interventions] offers the opportunity to improve adherence rates in all patients." (p. 260), according to Malcolm and colleagues.

Smith, Rublein, Marcus, Brock, and Chesney (2003) randomly assigned 43 individuals who were initiating or changing their HAART regimen to either a clinic-based medication self-management program or standard care and followed them for three months. "Key components of the medication self-management program were

comprehensive medication counseling by a specially trained health professional, written medication information, skills development exercises, [three] monthly visits for medication consultations, and monthly feedback of adherence performance using electronic monitors" (p. 196). They found that self-management group participants were more likely to take at least 80% of their medication doses each week when compared to those receiving standard care. "This study found preliminary evidence that a clinic-based intervention based on feedback and discussion of adherence performance and principles of self-regulation improves adherence to dosing schedules for antiretrovirals" (p. 196).

Within a highly selected sample of convenience (73 men and women living with HIV) that excluded individuals with severe or untreated mental health issues, Power et al. (2003) found that heterosexual participants, Latino participants, and those using drugs and alcohol to cope with HIV were more likely to report missed doses over a four-day period than participants with other demographics. Additionally, perceived satisfaction with a partner's support was associated with antiretroviral adherence, while satisfaction with support from family and friends was not. Given this latter finding, Power and colleagues suggest that "couple-based approaches enlisting partner support may help persons living with HIV to adhere to antiretroviral regimens" (p. 245).

Murphy, Roberts, Hoffman, Molina, and Lu (2003) collected both qualitative and quantitative data from 81 monolingual Spanish speakers taking antiretrovirals and found that these individuals faced many of the same adherence challenges as their English-speaking counterparts. Important differences were, however, noted, including: the need among Spanish speakers to learn more about their medications and to accept the need to take them, possibly reflecting some of the language and cultural barriers encountered by these individuals within the health care system; and the importance of having someone to live for as a motivator for medication adherence. Murphy and colleagues note that, while clinicians in the U.S. typically encourage their clients to take care

From the Block Hispanos Unidos

Hispanos Unidos, Inc., a non-profit, community-based organization established in 1987, is the leading Hispanic/Latino organization addressing HIV/AIDS in New Haven, Connecticut.

The goal of *Nuevos Horizontes* – Hispanos Unidos' mental health program – is to fill the mental health care gap for Hispanics/Latinos living with HIV/AIDS in the Greater New Haven area through the enhancement and expansion of its four basic service components: 1) individual, group, couple, and family therapy; 2) support groups; 3) psychiatric treatment; and 4) alternative therapies (massage, relaxation, art, and physical exercise). All services are provided by bilingual/bicultural staff.

The Principal Investigator is Luz González, M.S., M.B.A.; the Program Director is Juan Díaz, L.C.S.W. For more information, please call 203/781-0226 or write to hunidos@yahoo.com.

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Program Coordinating Center

of themselves, monolingual Spanish speakers may respond more readily to messages that stress concern for the family as an adherence motivator.

Australian investigators (Goode, McMaugh, Crisp, Wales, & Ziegler, 2003) interviewed 18 parents of children and adolescents on HAART, who reported high levels of adherence despite multiple challenges (e.g., medication taste, number of medications prescribed, the interface with day-to-day family life). "The high levels of stress experienced by families when HAART is first introduced means that the form and timing of initial information are crucial. ... Individualized information needs to address both the medication regimen and ongoing developmental needs of the child or adolescent. In addition, practical tips on how best to give the medication, as well as strategies to deal with social circumstances such as attendance at school or birthday parties, should be included. ... Information should [also] be regularly reviewed ... to encompass changes in parent beliefs and child development" (p. 407).

Johnson, Stallworth, and Neilands (2003) interviewed a convenience sample of 109

adults receiving HAART and found that these individuals drew distinctions between HIV disease symptoms (e.g., swollen lymph nodes, night sweats, fever, weight loss, a reduction in strength) and medication side effects (e.g., stomach upset, nausea/vomiting, constipation, changes in taste), although both were taking their toll on physical and social functioning. And yet, interestingly, disease-related symptoms *alone* related to perceptions of general health status; side effects are not taken into consideration. The authors recommend that clinicians: 1) inquire about treatment expectations and fears prior to the initiation of pharmacotherapy and correct distortions and inaccuracies regarding side effects; 2) once treatment has begun, assess beliefs regarding the cause of physical symptoms through respectful, open-ended queries (e.g., "How have these medications affected you?" or "What problems have you noticed since starting these medications?" [p. 115]), correct inaccuracies and promote problem-solving to address physical complaints; 3) evaluate subjective reports of side effects, not just side effects known to be related to particular treatment regimens, to further identify inaccurate appraisals regarding the cause of physical symptoms; and 4) focus on gains in general health despite side effects when disease symptoms do improve in individuals who separate the dimension of general health from the dimension of functioning.

Johnson and colleagues further observe that, "[s]ide effects can have as strong an impact on quality of life as symptoms of HIV. A clarification of symptom appraisal processes is crucial to the development of effective coping interventions. Opportunities to assist patients with correctly identifying and managing side effects may have beneficial impact on physical and social functioning. The development of effective coping interventions can promote maximum benefit from available HIV treatments" (pp. 115-116).

Speaking of quality of life, Chan et al. (2003) looked at reductions in psychiatric symptoms eight months post-baseline within a nationally representative sample of 2,466 adults receiving HIV medical care in 1996-

1997 and concluded that HAART "appears to be responsible for both a treatment-specific and global improvement in the mental health of HIV+ patients, possibly through the promise of extended survival and a better quality of life" (p. 154).

Care for Caregivers

Land, Hudson, and Stiefel (2003) surveyed 416 gay and bisexual caregivers of people living with AIDS, 164 of whom were themselves HIV-infected. While role-related stress, low self-esteem, and younger age were predictive of depressive symptomatology in both groups, caregivers who were themselves living with HIV reported higher levels of depression than those who were not. Among those who were HIV-positive, depression was associated with poorer health and financial worries; among HIV-negative caregivers, depression was associated with stress related to direct acts of caregiving (i.e., assisting with activities of daily living). To address the risk for depression among gay and bisexual caregivers of people living with AIDS, clinicians can offer interventions that reduce role-related stress, including: 1) in-home respite or attendant care services to decrease fatigue and isolation; 2) in-home psychoeducational services on improving physical and psychological support for the person living with AIDS, to increase self-efficacy and competence on the part of the caregiver and augment self-esteem related to caregiving; 3) cognitive-behavioral or interpersonal therapy for caregivers who manifest depressive symptomatology; and 4) therapeutic case management services, to provide direct support for both the physical and the financial needs of HIV-positive caregivers. As this last point suggests, serostatus should be considered when planning supportive services, since HIV-positive and HIV-negative caregivers may have different requirements.

Stress Management

Pereira et al. (2003a) followed 34 African-American and Caribbean-American women living with HIV as well as herpes simplex virus type 2 (HSV-2 or genital herpes) and found that life stress may predict the recurrence of symptomatic genital herpes in HIV-positive women. The authors suggest that "[s]tress management interventions may

buffer HSV-related morbidity and mortality in women with HIV" (p. 237).

This same group (Pereira et al., 2003b) followed 32 African-American and Caribbean-American women living with HIV as well as human papillomavirus (HPV) and found that life stress may pose risk for squamous intraepithelial lesions (SIL) progression and/or persistence (suggestive of cervical dysplasia or cervical cancer) in HIV-positive women. Similarly, the authors suggest that "[s]tress management interventions may decrease risk for SIL progression/persistence in women living with HIV" (p. 427).

Coping, Social Support, & Quality of Life
Neidig, Smith, and Brashers (2003) randomized 60 adults living with HIV to one of two conditions – a supervised, 12-week program of aerobic exercise, or a group maintaining their usual activities – and found that those who exercised demonstrated reductions in depressive symptoms when compared to controls. "This study provides preliminary evidence that a program of moderately intense aerobic exercise might be an effective approach to preventing or reducing prevalent symptoms of depression in persons with HIV infection. ... [C]linicians can recommend habitual exercise for their HIV-infected patients after a health appraisal as is suggested for all persons before beginning an exercise program" (p. 38).

Derlega, Winstead, Oldfield, and Barbee (2003) drew information from 125 men and women living with HIV in southeastern Virginia and found that study participants were more likely to directly request support – and were also more likely to receive support – from a friend or intimate partner than a parent. Parents were also more likely to avoid participants than would a close friend; avoidance was associated with depressive symptoms across all relationship types. According to the authors,

[c]lients need to be reassured that seeking and receiving support may be a difficult undertaking ... For instance, asking for help directly from friends, intimate partners, and parents may be a fairly successful strategy On the other hand, expressing intensely negative

emotions directly as a plea for help may have mixed effects. [Crying] may access help from a close friend, but it may turn away an intimate partner. ... [Sighing] may be counterproductive, perhaps leading to less helpful support behaviors by relationship partners. Counselors could also discuss with clients and potential support providers the possible pitfalls of [a]voidance behaviors as support. Avoidance may be well intentioned as a technique for distracting someone from their difficulties, but [a]voidance (especially if it is perceived as unhelpful) may compound the psychological distress of clients with HIV and possibly estrange them from support providers. (pp. 128-129)

Owens (2003) interviewed 18 African-American women living with HIV and characterized family as both a source of support (e.g., an extended family support network could be mobilized to assist the HIV-infected woman) as well as a source of stress (e.g., family denial blocked the ability of the infected women to express concerns about becoming sicker). Owens encourages clinicians to assist African-American women living with HIV to resolve communication difficulties related to expressing HIV concerns to family members and suggests that groups that allow women and their families to tell stories about their experiences with HIV may be beneficial.

Golub et al. (2003) followed 451 IDUs – largely African-American and male – living with HIV over a two-year period and found that psychological distress was associated with the more rapid onset of AIDS and that this association was strongest among IDUs with the lowest CD4 cell counts. Golub and colleagues urge clinicians to initiate interventions to reduce psychological distress among IDUs as soon after HIV seroconversion as possible.

Penedo et al. (2003) assessed 211 well-educated, white and Latino MSM living with symptomatic HIV disease and, as expected, found that greater use of approach-oriented coping strategies (e.g., active coping, support seeking) was associated with lower levels of psychological distress, while greater

use of avoidance-oriented coping strategies (e.g., denial, behavioral disengagement) was associated with higher levels of distress. Importantly, these associations were *independent* of disease status as well as personal loss. "The results suggest that HIV+ MSM who do not have the coping skills or resources necessary to use adequate coping strategies to face the chronic burdens associated with HIV illness are likely to experience higher levels of psychological distress, independent of life stress and ongoing HIV-related symptoms" (p. 203). The authors encourage work to enhance approach-oriented coping skills to promote reductions in psychological distress.

Sikkema, Kochman, DiFranceisco, Kelly, and Hoffmann (2003) studied a diverse convenience sample of 268 people living with HIV who were also experiencing AIDS-related bereavement and found that these individuals displayed a more acute grief reaction – the severity of which was associated with escape-avoidance (e.g., "I tried to make myself feel better by eating, drinking, smoking, or using drugs.") as well as self-controlling (e.g., "I tried to keep my feelings to myself" and "kept others from knowing how bad things were.") coping strategies, the loss of a spouse/partner or close family member, depressive symptomatology, and a history of IDU – as well as psychological distress associated with their losses. "The results of this study suggest that interventions for coping with AIDS-related bereavement among people living with HIV disease should address the reduction of avoidant coping strategies, including abuse of substances" (p. 178).

Lastly, Rotheram-Borus et al. (2003) published another two years of data on a randomized controlled trial originally involving 307 parents (largely single, Latino or African-American drug users, either active or in recovery) living with AIDS and their adolescent children (413 in all), assigned to either an intensive cognitive-behavioral coping skills intervention (see <http://chipts.ucla.edu>) or standard care. They found that, while some gains were maintained by teens (e.g., fewer became parents as teenagers, exhibited fewer conduct problems) as well as parents (e.g., less drug dependency and

drug relapse, less use of a passive coping style) in the intervention group over the four years of this study, other gains eroded between Years 2 and 4 (e.g., reductions in problem behaviors and emotional distress in both teens and their parents). The authors observe that “programs must be redesigned to ensure strategies for maintenance of the impact of an intervention over the long term, ... [since sessions that teach skills to deal with relapse incidents are not successful in achieving long-term behavioral maintenance of emotional disorders or problem behaviors. ... [I]nterventionists must plan for ongoing support, in order to sustain the effects over time as a standard aspect of intervention delivery” (p. 1224).

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Tool Box

A Note About 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 literature reviews e-mailed by Florida International University researcher Robert Malow, Ph.D. Other sources

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of information are identified when appropriate.

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

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