

# mental health AIDS

A Quarterly Update from the AIDS Education and Training Centers (AETC) National Resource Center Volume 4(2), Winter 2003

## Biopsychosocial Update

### HIV Prevention News

#### About Men Who Have Sex with Men

Several recent studies have focused on the confluence of racial/ethnic identity, sexual identity, and HIV risk behavior among men of color:

- o Crawford, Allison, Zamboni, and Soto (2002) assessed racial/ethnic identity development, sexual identity development, and psychosocial functioning among 174 self-selected, urban, educated, middle-class

African-American gay and bisexual men and found that those with more integrated self-identification as African-American gay men reported higher self-esteem, stronger social support networks, greater HIV prevention self-efficacy, higher levels of life satisfaction, and lower levels of male gender role stress and psychological distress than those who reported less well-integrated dual identity development. "[O]ur findings suggest that to whatever degree [these men] are not able or allowed to simultaneously value their dual

identities and be a part of both the African-American and gay and lesbian subcultures, their levels of life satisfaction and self-esteem are diminished" (p. 186). Importantly, while higher levels of racial/ethnic identity development (i.e., attachment to one's cultural heritage and African-American identity) were associated with higher levels of life satisfaction, the same did not hold for higher levels of sexual identity development. On the other hand, higher levels of gay identity, higher levels of psychosocial distress, and lower levels of life satisfaction were associated with more sexual risk-taking.

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The format for this publication reflects a systems-oriented approach to the understanding of health and disease. In this model, HIV mental health treatment planning considers not only the psychiatric and psychological aspects of infection, but the biological, social, and spiritual aspects as well, so that treatment may be offered from a "biopsychosocial" perspective. Additionally, a "systemic" model of this type reinforces the use of the provider-client relationship in delivering health and mental health care.

The contents of this "Biopsychosocial Update" are organized as follows:

- o HIV Prevention News, with current information on issues of risk and response to a variety

of subpopulations disproportionately affected by HIV;

- o HIV Assessment News, focusing on current understandings of the HIV counseling and testing process as well as baseline mental health evaluation for people living with or affected by HIV; and

- o HIV Treatment News, organized within a "biopsychosocial" framework and highlighting current findings on medical, psychiatric, psychological, psychosocial, and spiritual aspects of care for people living with or affected by HIV.

The update is interspersed with two types of sidebars:

- o "Building Blocks," which summarize recent major conferences and meetings that address HIV-related prevention, assessment, and/or treatment concerns; and

- o "Tool Boxes," which contain practical information and resources for the frontline provider of HIV-related prevention, assessment, and/or treatment services.

I provide a wealth of information in this update for the diverse audience receiving training through the AETC program. Feel free to explore the contents, taking what will be of use to you in your work. And thank you for the contribution you are making to improve the lives of people living with HIV and AIDS.

—Abraham Feingold, Psy.D., Editor

Our results suggest that more "out" [African-American gay and bisexual men] may be in need of HIV/AIDS prevention programs that will not only assist them in gaining condom self-efficacy, but will also provide them with effective coping strategies that will facilitate their ability to contend with negative mood states that develop as a result of their dual minority status. Components of an intervention of this nature would need to include strategies for managing racism and heterosexism both within and outside the African-American community, and should also focus on elevating self-esteem and promoting positive life experiences.<sup>1</sup> (p. 187)

<sup>1</sup>For more information on minority status management strategies, see: Wilson, B.D.M., & Miller, R.L. (2002). Strategies for managing heterosexism used among African American gay and bisexual men. *Journal of Black Psychology, 28*(4), 371-391.

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o Similarly, O'Donnell et al. (2002) surveyed 465 Latino young men who have sex with men (MSM) at community venues away from the "gay-identified" area of lower Manhattan and found that 68% of these men felt an attachment to their ethnic community, while about 34% felt an attachment to both their "local" gay community as well as the broader gay community in New York City. While greater social support regarding sexual matters was associated with attachments to both communities, those with ethnic community ties were about 40% less likely to report recent, same-sex unprotected anal intercourse (UAI) and 60% less likely to report UAI during their most recent sexual encounter with a casual male partner; in this study, attachment to the gay community was not significantly related to engaging in risky behavior. In conclusion, O'Donnell and colleagues emphasize the importance of ethnic community attachments for young, Latino MSM as a potential hedge against HIV sexual risk behavior.

o Finally, Choi, Han, Hudes, and Kegeles (2002) interviewed 253 Asian and Pacific Islander (API) MSM between the ages of 15 and 25 who attended gay-identified venues and found that one-third reported UAI during the preceding three-month period. UAI was associated, in this sample, with self-identification as gay or bisexual, having sex with a main partner, having sex with multiple partners, having been tested for HIV, and not perceiving that peers supported safer sexual behavior. Choi and colleagues stress the need to address affinities for the "sexual freedom" promoted within parts of

the mainstream gay community among young API MSM as an HIV prevention intervention. Additionally, they encourage exploration of the use of HIV testing as a risk-reduction strategy, the potential for HIV transmission through multiple sexual encounters and within steady relationships (potentially addressed by promoting discussion of sexual risk and joint HIV testing for couples), and the promotion of safer sex as a norm among young API MSM peers.

#### **About Adolescents**

Voisin (2002) studied 171 African-American and 187 Puerto Rican, urban, heterosexually-identified adolescent males and found differences in how young men from these different cultural groups viewed the impact of social support on sexual risk behavior. For the African-American youth, fewer self-reported sexual risk behaviors were associated with perceptions that emotional support from family members was adequate, satisfying, and congruent with personal goals. Among the Puerto Rican youth, however, fewer self-reported sexual risk behaviors were associated with being raised by single mothers whom they felt supported their personal goals; no other associations were significant. In both groups, high emotional support from family members was associated with a decreased likelihood of engaging in peer networks with risky sexual norms. Voison suggests that clinicians link teens with mentors in religious or community organizations if familial support is low. Also, maternal involvement may be key in developing culturally-relevant prevention interventions for Puerto Rican male teens.

Li, Stanton, Feigelman, and Galbraith (2002) randomly assigned 206 of 383 low-income, urban African-American youth between the ages of nine and 15 at the start of the study to an HIV risk-reduction intervention entitled "Focus on Kids." This intervention consisted of eight 90-minute small group sessions focusing on condom use through discussions, games, and multimedia presentations based on social cognitive theory and facilitated by two trained adult leaders, followed by "booster" sessions at planned intervals over the three-year study period. Compared to control group participants, youth who received the intervention reported a higher cumulative rate of condom use over the study period. The authors suggest that "face-to-face, theory-based, small-group interventions, especially if periodic boosters are introduced, may offer increasing cumulative protection from HIV risk, even though at particular points in time more distal from the intervention, the risk behaviors of intervention youth may no longer be significantly lower than that of control youth" (p. 795).

Several recent studies spotlight youth "in the system":

o Dévieux et al. (2002) measured level of impulsivity in a culturally diverse, inner-city sample of 377 substance abusing teens who were incarcerated or in court-ordered treatment, divided the sample on the basis of high and low impulsivity, and found that the former group, when compared to the latter, reported: higher levels of alcohol and marijuana use during the preceding three months; more unprotected sex when high on substances; greater HIV knowledge; a higher perceived susceptibility to HIV, coupled with more HIV-related anxiety; and less favorable sexual attitudes and self-efficacy. Instead of assuming that all alcohol and other drug (AOD)-abusing teens, either in treatment or incarcerated, are highly impulsive, Dévieux and colleagues suggest that "AOD-abusing adolescent offenders should be assessed for levels of impulsivity. Incarcerated youth with high levels of impulsiveness should be provided with more intensified or targeted risk reduction, ... [with] interventions focusing on specific attitudinal and behavioral changes ... for reducing

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The AETC NRC at the François-Xavier Bagnoud Center, University of Medicine & Dentistry of New Jersey, provides education and training resources for the AETC network to support their mission to offer timely, high quality, state-of-the-art information to healthcare professionals working with existing and emerging populations affected by HIV.

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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the risk of HIV and preventing transmission in this subgroup" (pp. 31-32).

o Otto-Salaj, Gore-Felton, McGarvey, and Canterbury (2002) explored the relationship between neuropsychiatric, emotional and cognitive functioning as well as substance use and HIV risk behavior through interviews with 894 incarcerated adolescents averaging 15 years of age. While most study participants reported HIV risk behavior, teens who experienced "sullen" affect and teens who engaged in higher levels of alcohol use were more likely to engage in such behaviors. To reduce HIV risk among delinquent adolescents, the authors recommend that clinicians address emotional distress as well as alcohol use in the context of HIV prevention interventions.

o Auslander et al. (2002) interviewed a convenience sample of 343 young people in foster care and found that those exhibiting borderline and clinical levels of externalizing behaviors (i.e., delinquent and aggressive ["acting out"] behaviors) both engaged in and had the intention to engage in more HIV risk behavior when compared to those with other mental health profiles (e.g., internalizing behaviors [depressed, withdrawn, manifesting somatic complaints]). Additionally, more than one-third of the youth sampled reported a history of sexual abuse. When treating youth who present with both delinquent/aggressive behavior and a sexual abuse history, Auslander and colleagues recommend that clinicians take a comprehensive approach to sexual risk behaviors, combining cognitive-behavioral strategies that have proven effective in HIV prevention with those that have been used to treat sexual abuse.

Krantz, Lynch, and Russell (2002) surveyed 61 HIV-positive and 124 HIV-negative young adults and found that HIV status was not associated, in this sample, with the use of alcohol or drugs or with gang-related behavior during adolescence. Rather, positive status was associated, among females, with early and unprotected intercourse; for males, positive status was associated with early, frequent, and unprotected intercourse with many partners (including male partners), engaging in more risky sexual behav-

iors, having experienced sexual abuse during childhood and adolescence, and abusing cocaine during adolescence. Krantz and colleagues recommend early and specific inquiry regarding sexual activity when working with at-risk preadolescents and adolescents "as both a preventive and a restorative intervention" (p. 33).

Finally, Guo et al. (2002) followed 808 individuals living in high-crime Seattle neighborhoods between the ages of 10 and 21 and found specific forms of substance use during adolescence predicted certain types of risky sexual behavior in young adulthood. More specifically, early onset binge drinking predicted a greater number of sex partners, while late onset binge drinking and use of marijuana predicted a greater number of sex partners and less consistent condom use. Guo and colleagues submit that "interventions [to] prevent the onset of binge-drinking and marijuana use during high school may be of particular utility in preventing later risky sexual behavior" (p. 361).

#### **About Substance Users**

Utilizing a targeted sampling plan, Corsi, Kwiatkowski, and Booth (2002) interviewed 168 injecting drug users (IDUs) at baseline who were subsequently engaged through street outreach to enter a methadone maintenance treatment program. These same individuals were re-interviewed five to nine months later, at which time positive outcomes (e.g., decreases in drug use and drug-use risk behaviors) were associated with the amount of time in treatment and, to a greater extent, being in treatment during the 30 days preceding follow-up assessment. Additionally, first-timers in drug treatment demonstrated notable reductions in injecting behavior at follow-up. Corsi and colleagues suggest that enticing IDUs without prior treatment experience into drug treatment may stem the tide of risk behaviors early on and retaining IDUs in drug treatment may increase the chances that reductions in HIV risk behavior will occur.

On the topic of treatment retention, Kang, Deren, and Goldstein (2002) studied 432 men and women who had dropped out of methadone maintenance treatment programs and found high rates of childhood

abuse and neglect (sexual abuse, 36%; physical abuse, 60%; emotional abuse, 57%; physical neglect, 66%; all combined, 25%) among those sampled. Not surprisingly, those who had been abused in childhood had more medical, legal, psychological, and relationship problems in adulthood than those who had not. Importantly, those who had experienced *neglect* in childhood were more likely to be HIV-positive than those who had not, while the experience of *physical* abuse in childhood was associated with multiple sexual partners in adulthood. Kang and colleagues suggest that early intervention for both physically abused and neglected children may help to reduce the risk for HIV infection later in life.

Does social support from sex partners serve the interest of HIV risk reduction? Not always, according to Miller and Neaigus (2002), who interviewed a racially and ethnically diverse sample of 257 non-injecting heroin users whose HIV risk was limited to sexual exposure. They found that three-quarters of those sampled reported unprotected vaginal or anal intercourse in the 30 days preceding their interview and that 27% had sex with partners who were known to be at risk of being infected. Interestingly, the provision of support by a sex partner was associated with unprotected intercourse among the men sampled, while the women were as likely to have unprotected intercourse with a supporting sex partner as with one who did not provide support. Since social support in this study was associated with increased HIV risk in drug-using dyads, Miller and Neaigus caution that, "[b]efore sex risk reduction interventions that are predicated on the benefits of social support are targeted at [drug] users, it is necessary to evaluate whether support masks dependent relationships and possibly coercive social ties; whether support is provided by sex partners who ... are ... at increased risk of being HIV infected; and the perceived obligations associated with the receipt of support" (p. 810).

#### **About Women & Men**

Gore-Felton et al. (2002) assessed a convenience sample of 122 adults living with HIV and found sexual risk behavior to be associated with being male, having a higher

level of education, perceiving support (possibly for continuing unsafe behavior) from one's partner, and using emotion-focused coping strategies to manage one's HIV positivity. Promoting problem-focused coping, which was not associated with risky behavior, may reduce risky sexual behavior. Additionally, "HIV prevention efforts need to ... develop effective negotiation as well as communication strategies that increase safer behavior among couples. However, prior to including partners into prevention and intervention efforts, several issues such as violence, power and economics within the couple relationship need to be well assessed, particularly for men and women with histories of abusive relationships" (p. 720).

Kalichman, Rompa, Luke, and Austin (2002) interviewed 269 men and 114 women living with HIV and found that, among those who engaged in intercourse (vaginal or anal) with serodiscordant partners (regular and casual), the percentage of intercourse occasions during which condoms were utilized – a figure that accounts for overall rates of intercourse – was greater for casual than for regular partners. Interestingly, serostatus disclosure did not appear to play a role in differentiating risk behaviors between regular and casual partners, prompting Kalichman and colleagues to urge the implementation of "HIV transmission risk reduction interventions for HIV serodiscordant couples, particularly for couples in established, regular relationships" (p. 677). Such interventions "will be most effective when placed in a broader context of counselling and support services for managing multiple challenges facing serodiscordant couples including the stress of managing a chronic illness, financial pressures, and coping with HIV-related stigmas. ... [Additionally,] small ... [group interventions are effective in reducing HIV risk behaviours in HIV-uninfected and HIV-positive persons and these same approaches may be adaptable to HIV-serodiscordant couples ..." (pp. 681-682).

On the subject of stigma, Lee, Kochman, and Sikkema (2002) assessed a racially and ethnically diverse sample of 268 people who were living with HIV in either urban areas of Wisconsin or New York City and found that

most had experienced some degree of internalized stigma in connection with their HIV status. Those high in internalized HIV stigma were diagnosed more recently, came from families that were less accepting of HIV, were less likely to have attended an HIV support group, knew fewer people living with HIV, and worried more about transmitting the virus to others. Internalized HIV stigma also contributed to levels of anxiety, depression, and hopelessness (after controlling for other variables). "Given the association ... between [internalized HIV stigma] and concerns about spreading infection, clinicians would do well to raise the issue of communication in relationships and explore possible barriers to safer sex practices with their HIV-positive clients" (p. 318).

In Sweden, Svenson, Östergren, Merlo, and Råstam (2002) obtained 493 completed questionnaires from a random sample of university students and found that consistent condom use was higher among students with strong intentions to implement the use of condoms, more support for condom use among peers, and greater ability to manage their behavior. To generate prepared or "autopilot" responses to sexual situations for the purpose of freeing up cognitive resources, thus allowing for greater self-monitoring and self-regulation in the context of such encounters, the authors recommend that clinicians rehearse responses to a variety of sexual risk situations with adolescent and young adult clients, help in the development and learning of "scripts," promote mental rehearsal, buff up negotiation skills, and engage in other interactive social cognitive exercises.

Thompson, Kyle, Swan, Thomas, and Vrungos (2002) randomly assigned 128 college students to one of two conditions: a single, one-hour intervention designed to undermine self-perceived invulnerability to HIV infection or watching a video on HIV protection strategies.

Based on research indicating that failure experiences undermine illusory control, this study used a failure experience intervention to reduce unrealistic optimism regarding personal risk for HIV and to increase condom use. One com-

ponent was a task which required participants to judge the HIV status of individuals based on pictures and sexual biographic information. This was a difficult task and [most] experienced a failure that should undermine their sense of invulnerability. The second component was a reminder of past failures to consistently protect oneself [and] a public endorsement of the necessity for consistent protection against HIV. The intervention was found to increase perceptions of personal risk for HIV, intentions to use condoms, and actual condom use. (p. 511)

As these findings suggest that individuals can be motivated to increase condom use by experiencing failure in their protective strategies, Thompson and colleagues suggest that clinicians plan interventions that circum-

<p><b>Tool Box</b></p> <p><b>Books &amp; Articles</b></p>
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Antinori, A., Ammassari, A., & Wu, A.W. (Eds.). (2002). Proceedings of the 1<sup>st</sup> workshop on HAART adherence: State-of-the-art. *Journal of Acquired Immune Deficiency Syndromes*, 37(Suppl. 3), S95-S169. These 16 papers, updated from their original presentation in Rome in 2001, summarize what is known about antiretroviral adherence among people living with HIV.

Bok, M. (2002). A review of attitudes, social policy and educational materials on adolescent sexuality and HIV prevention. *Journal of HIV/AIDS Prevention & Education for Adolescents & Children*, 5(1-2), 45-60. Bok highlights the importance of targeting HIV prevention strategies to different population groups of adolescents.

Burkemper, E.M. (2002). Family therapists' ethical decision-making processes in two duty-to-warn situations. *Journal of Marital & Family Therapy*, 28(2), 203-211. Burkemper presents an exploratory study regarding ethical decision-making processes among marriage and family therapists in Missouri that includes a duty-to-warn scenario involving the potential sexual transmission of HIV.

Cartwright, D., & Cassidy, M. (2002). Working with HIV/AIDS sufferers: "When good enough is not enough." *American Journal of Psychotherapy*, 56(2), 149-166. "In this article we want to explore what the analytically oriented therapist has to offer in the

vent denial and increase HIV risk perceptions to increase condom use.

### About Women

Logan, Cole, and Leukefeld (2002) conducted a meta-analysis involving 30 studies on HIV-prevention interventions targeting adult heterosexual women that were published between 1991 and 2000 and concluded that the interventions under review had little impact on sexual risk behavior (i.e., self-reported condom use and number of sexual partners) and only minimally addressed social factors (e.g., social and cultural norms, social status, incarceration history) and contextual factors (e.g., connection and relationships, victimization, substance abuse, mental health problems, sex exchange, sexually transmitted diseases [STDs]) that contribute to HIV risk for women. The authors posit that "women's

responses to HIV interventions are complex and determined by multiple, interacting factors" (p. 873).

This complexity is highlighted in a recent study by Ickovics et al. (2002), who interviewed 162 HIV-negative, heterosexually-active women (54% white, 33% African-American, 13% Latina) and found that, while social class was both directly and indirectly associated with HIV risk behavior, race and ethnicity were not. More specifically, lower-income women reported higher levels of stress and riskier sexual partners than higher-income women, who assumed risk through their greater likelihood of having unprotected intercourse, though most often with a steady partner. While *both* groups of women were at risk, Ickovics and colleagues observe that "women with higher income may need to be counseled about

the risks of unprotected intercourse, even in the context of a 'committed' relationship, [while] women with lower income [may need to be counseled about] the selection of sexual partners at high risk for HIV" (p. 347).

Utilizing a new measure, the Sexual Relationship Power Scale (SRPS), Pulerwitz, Amaro, De Jong, Gortmaker, and Rudd (2002) explored the condom negotiation skills of 388, mostly Latina, women receiving care at a community health center. They found that women claiming high levels of relationship power were five times more likely to report consistent use of condoms when compared to women claiming low levels of power. Since relationship power appears to play a significant role in the decision to engage in safer sexual practices, clinicians should direct prevention messages to the partner with higher power in

treatment of individuals who seek help in dealing with the consequences of HIV/AIDS" (p. 149).

Chesney, M.A., & Antoni, M.H. (Eds.). (2002). *Innovative approaches to health psychology: Prevention and treatment lessons from AIDS*. Washington, DC: American Psychological Association.

This volume describes advances in behavioral health care that have emerged from nearly two decades of experience addressing HIV-related medical concerns (e.g., sleep disturbance, chronic pain, nonadherence to complex medical regimens), subpopulations at risk for infection or already infected (e.g., teens, African-American women, gay men, IDUs), and intervention targets (e.g., the individual, families, small groups, and communities). These innovations may also have wider application in the prevention and treatment fields.

Corless, I.B. (Ed.). (2002). Examining the impact of September 11, 2001 on HIV/AIDS care. *Journal of the Association of Nurses in AIDS Care*, 13(5), 11-68.

In this special issue *JANAC*, "we examine the impact of 9/11 on HIV/AIDS, not the virus, but the hosts, care providers, community, and society" (p. 11).

Duncan, C., Miller, D.M., Borskey, E.J., Fomby, B., Dawson, P., & Davis, L. (2002). Barriers to safer sex practices among African American college students. *Journal of the National Medical Association*, 94(11), 944-951.

Duncan and colleagues offer recommendations on the development of HIV prevention pro-

grams for African Americans attending college.

Ginsburg, K.R., Winn, R.J., Rudy, B.J., Crawford, J., Zhao, H., & Schwartz, D.F. (2002). How to reach sexual minority youth in the health care setting: The teens offer guidance. *Journal of Adolescent Health*, 31(5), 407-416.

Lesbian/gay/bisexual/transgendered and questioning youth specify what factors help them to feel safe (or unsafe) when receiving health care.

Hijazi, L., Nandwani, R., & Kell, P. (2002). Medical management of sexual difficulties in HIV-positive individuals. *International Journal of STD & AIDS*, 13(9), 587-592.

Hijazi, Nandwani, and Kell review causes, available treatments, and issues specific to sexual dysfunction in HIV-positive persons.

McGrath, P.L., Levenkron, J.C., Knox, K.L., Scahill, M.P., Berkhoudt, K.S., & Coury-Doniger, P.A. (2002). The development, reliability, and validity of a rating scale of stage-based behavioral counseling for STD/HIV prevention. *Journal of Public Health Management & Practice*, 8(6), 54-61.

"[T]he SBC Scale is a reliable and valid instrument to measure Stage-based Behavioral Counseling skills and can be used by ... STD/HIV prevention program[s] for ... quality assurance, the implementation and maintenance of [a] behavioral counseling intervention, and as an instructional and evaluation methodology for training [new] providers" (p. 61).

Miller, R.L., & Kelly, J.G. (Eds.). (2002). Community-level approaches to preventing HIV. *Journal of Primary Prevention*, 23(2), 151-257.

In this Special Section of the Winter 2002 issue of this journal, current themes in the prevention of HIV through community-level intervention are highlighted.

Noar, S.M., Morokoff, P.J., & Harlow, L.L. (2002). Condom negotiation in heterosexually active men and women: Development and validation of a Condom Influence Strategy Questionnaire. *Psychology & Health*, 17(6), 711-735.

The authors report on the development and initial validation of the CISQ, which measures six influence strategies (direct request, seduction, withholding sex, relationship conceptualizing, risk information, deception) utilized to negotiate the use of condoms with a main sexual partner.

Sterk, C.E. (2002). The Health Intervention Project: HIV risk reduction among African American women drug users. *Public Health Reports*, 117(Suppl. 1), S88-S95.

This project offered female African-American crack cocaine users individually-tailored interventions framed within a racial, ethnic, social, and cultural context.

Strug, D.L., Grube, B.A., & Beckerman, N.L. (2002). Challenges and changing roles in HIV/AIDS social work: Implications for training and education. *Social Work in Health Care*, 35(4), 1-19.

The authors describe how the practice of social work has evolved over the course of this epidemic and the preparation required to address newer challenges in this important field.

--Compiled by Abraham Feingold, Psy.D.

the sexual relationship *as well as the partner with lower relationship power*, since addressing messages to the latter alone will likely prove ineffective.

Similarly, Seage et al. (2002) had 1,647 women at high risk for HIV in six U.S. cities describe their most recent protected and unprotected sexual encounters. "Compared with their most recent protected sexual encounter, women were more likely to have an unprotected sexual encounter with a steady male partner older than 40 years of age who drank or used drugs within 2 hours of the encounter. These results strongly suggest that a successful HIV prevention intervention for women should have an impact on male partners and particularly focus on drug and alcohol use by that partner" (p. 436).

## HIV Assessment News

### Psychiatric Assessment

Evans et al. (2002) studied 63 HIV-positive and 30 HIV-negative women, none of whom was abusing substances at the time of the study, and found that 16% in the former group suffered from major depression, compared to 10% in the latter group. This rate of depression in HIV-positive women is about twice that reported among HIV-positive men. Moreover, these investigators found an association between depression in the women who were living with HIV and alterations in two components of cellular immunity: natural killer cells and CD8 T lymphocytes. Findings "suggest that depression may decrease natural killer cell activity and may lead to an increase in activated CD8 T lymphocytes and viral load" (p. 1757). For reasons such as these, depression may be associated with more rapid HIV disease progression.

## HIV Treatment News

### Medical Care

Skowron et al. (2002) conducted a 48-week study involving 11 antiretroviral-naïve adults who were prescribed a *once-daily, four-drug* regimen of adefovir (Preveon®), lamivudine (3TC or Epivir®), didanosine (ddI or Videx®), and efavirenz (EFV or Sustiva®) and found that this nine-pill regimen was generally well-tolerated (with the exception of adefovir-related nephrotoxicity, which was

resolved without complications through discontinuation of that medication).<sup>2,3</sup> This quadruple-drug regimen resulted in better virological suppression than triple-drug combinations, with more than 90% of subjects achieving a viral load of < 50 copies/mL by the end of the study period. The researchers surmised that adherence may have played a role in this result, although the overall adherence rate of 85% was lower than that necessary to achieve such viral suppression with three-drug regimens. Participants attributed their relatively high levels of adherence to low pill burden and convenient dosing. The authors conclude that "once-daily quadruple-drug therapy with adefovir, lamivudine, didanosine, and efavirenz provides pronounced and durable suppression of HIV-1 RNA and elevation of CD4 cell counts over the course of 48 weeks, with generally good tolerability and adherence" (p. 1028).

Wilson et al. (2002) assessed the inpatient and outpatient care experiences of a nationally representative sample of adults receiving HIV medical care in 1996 (1,074 provided ratings of an inpatient stay, 2,204 of an outpatient visit, and 818 of both) and found that inpatients consistently reported more problems and provided lower global ratings of their care than did outpatients. The only patient characteristic consistently associated with having a poorer experience with care was mental health. While the authors suggest that most problems with care, particularly for inpatients, can and should be addressed by better communication between provider and client (e.g., pain control), "for both inpatient and outpatient care, special attention should be paid to the diagnosis and treatment of mental disorders in person with HIV" (p. 1158).

### Psychiatric/Psychological/ Psychosocial/Spiritual Care Neuropsychiatric Impairment

Neuenburg et al. (2002) performed autopsies

<sup>2</sup>Adefovir is no longer being studied as an HIV medication. Tenofovir (Viread®), a related once-daily nucleotide reverse transcriptase inhibitor not associated with nephrotoxicity, has recently been approved for this indication.

<sup>3</sup>EFV is now available in a 600 mg. tablet, replacing three 200 mg. capsules and potentially fostering even greater adherence by further reducing pill burden.

on 436 HIV-positive individuals who died between 1985 and 1999 and found that, while improvements in antiretroviral therapy reduced overall mortality as well as the prevalence of opportunistic infections of the central nervous system, the incidence of mild and moderate HIV encephalopathy *increased* during this same period (although, importantly *severe* encephalopathy was not diagnosed during the era of highly active antiretroviral therapy [HAART]). "[O]ur findings suggest that HAART prolongs life by restoring immune responses to non-HIV-1 pathogens, but does not prevent direct HIV-1-related pathology in the brain" (p. 176).

### Alternative Medicine

Risa et al. (2002) studied 118 individuals receiving medical services (including HAART) through the VA and found that 38% of this sample made use of alternative treatments, with 56% undertaking alternative treatment following the initiation of HAART. Alternative treatment users were more likely to be white than African-American or Latino (although *new* users were more likely to be African-American), *less* satisfied with emotional support, experiencing *greater* psychological stress, yet more likely to make use of problem-focused coping. In 40% of these cases, physicians were not aware that alternative treatments were being used, percentages found to be even higher among herbal therapy users (67%) and dietary supplement users (100%). Importantly, use of alternative treatments did not appear to reduce adherence to HAART. Given the greater likelihood of psychological distress and dissatisfaction with emotional support noted in this sample, clinicians should consider working to increase psychological well-being and enhance emotional support among alternative treatment users.

### Adherence to Treatment

Ferguson et al. (2002) assessed antiretroviral adherence and perceived barriers utilizing the HIV-specific Patient Medication Adherence Questionnaire (PMAQ) in a sample of 149 whites and African Americans receiving HIV care in Alabama and found that, while there were no overall differences in adherence or perceived barriers based on race or gender, specific barriers

ers did vary based on demographics and were associated with reductions in adherence. "Caucasian participants were more likely to report that they were taking more medications than desired and that medication was inconvenient. African American participants were more likely to report problems with storing medications, not taking medications when they felt well, and being more embarrassed about refilling and taking medications. Women were more likely to report forgetting to refill medications and not understanding how to take medications properly" (p. 614). While the authors suggest that these results might inform the development of more demographically-tailored adherence interventions, they caution that, "[r]ather than relying on demographic predictors, which may be only an indirect marker of adherence, evaluations of adherence should examine the psychological and social barriers to positive adherence outcomes in individual patients" (p. 607).

Miller, Huffman, Weidmer, and Hays (2002) conducted four focus groups (two in English, two in Spanish) involving 30 people living with HIV and surveyed an additional 31 individuals to assess preferences regarding the potency, number of pills, side effects (e.g., fatigue, nausea, diarrhea), and the inconvenience of various antiretroviral regimens. "[I]n our population, patients are willing to compromise items that may impact quality of life (i.e. increased side-effects, inconvenience, and pill burden) to have a potent antiretroviral regimen. Patients also prefer regimens with fewer side-effects to those with less inconvenience. Pill burden was found to be of relatively low importance for patients" (p. 598). Based on these data, Miller and colleagues suggest that the potency of an antiretroviral regimen should be given uppermost consideration in the selection process. Regimen tolerability and minimal inconvenience, based on lifestyle "fit," should be considered secondarily, with final consideration given to pill burden. Since such generalities may not extrapolate to all people living with HIV, Miller and colleagues stress, as did Ferguson and colleagues, that dialogue between provider and client is essential to optimize regimen acceptability and adherence, since preferences will vary from client to client.

Canadian investigators (Heath, Singer, O'Shaughnessy, Montaner, & Hogg, 2002) surveyed 638 individuals receiving antiretrovirals and found that most reported antiretroviral-related side effects during the preceding year, with an average of 12 symptoms caused by or believed to be related to medications and generally one symptom that was thought to be "severe." Importantly, 11% of survey respondents admitted that they selectively skipped medications or took a "drug holiday" that was not recommended by their physicians in an effort to reduce side effect symptoms. Intentional nonadherence was associated with having a poorer response to therapy, with lower educational status, and with "having one or more symptoms classified as severe as well as the number of objective action-requiring symptoms reported" (p. 215; e.g., rash, blood in the urine, vomiting, diarrhea). Study participants did, however, also intentionally skip or alter medication dosages or unilaterally discontinue medications for a period of time in response to non-life-threatening side effects, including disfiguring (and potentially stigmatizing) lipodystrophy-associated symptoms. Heath and colleagues observe that intentional antiretroviral nonadherence commonly occurs when side effects emerge and, in fact, was likely underestimated in this study.

Our results indicate that intentional non-adherence occurs in relation to symptoms regardless of their strict clinical importance. Moreover, the actual presence of symptoms and their true relationship to antiretroviral use may be of less relevance than the patient's perceptions. ... In many practices and clinics, a symptom checklist administered by clinical staff would help to identify any emerging possible side effects and serve to open a physician-patient dialogue regarding these symptoms, their causes, and possible treatments. This approach may be of particular relevance for patients who may have low literacy levels, those who may be otherwise marginalized, or those not experiencing virologically successful treatment, as these individuals may be at increased risk of intentional nonadherence. ... Commitment to, and the suc-

cess of, long-term antiretroviral therapy requires a fine balance between encouraging patients to maintain efficacious therapy and being alert to the implications of symptoms related to medication use for social and emotional well-being and adherence. (p. 216)

In this country, Wilson, Hutchinson, and Holzemer (2002) interviewed an ethnically diverse sample of 66 people living with HIV in the San Francisco Bay area to gain a better understanding about how these individuals sort through the interaction of illness symptoms, side effects induced by antiretrovirals, and the choice to adhere to medication regimens when experiencing distress. Given the complexity of these interactions, Wilson and colleagues reached the conclusion that adherence choices were made on a dose-by-dose basis. They emphasize that, to optimize adherence, clinicians can help clients to differentiate, whenever possible, side effects of medication from symptoms of HIV disease itself.

Howard et al. (2002) followed a racially diverse, HAART-experienced sample of 161 women living with HIV over a six-month period and found, though the use of Medication Event Monitoring System (MEMS) caps, that antiretroviral adherence varied over time (e.g., averaging 64% in Month 1 and 45% in Month 6). Among the factors associated with lower rates of adherence were hospitalization as well as the initiation of a new HAART regimen during the study period. Howard and colleagues conclude that "assessment of adherence should be an ongoing process, and may be especially important during periods of illness or when a patient starts a new regimen" (p. 2180).

#### Serostatus Disclosure

Mellins et al. (2002) interviewed 128 mothers living with HIV (58% African-American, 35% Latina; 70% single parents) and found that antiretroviral nonadherence was associated with the presence of a psychiatric or substance abuse disorder and with parenting stress, while missing medical appointments was associated with less disclosure of HIV status to children and being a single parent. Mellins and colleagues note that these findings underscore the need for

## Tool Box

### The Promises & Pitfalls of STIs: A Primer for Mental Health Professionals

While practice guidelines currently recommend that antiretroviral therapy, once begun, continue uninterrupted (Panel on Clinical Practices for Treatment of HIV Infection, 2002), research continues on "structured," "strategic," or "supervised" treatment interruptions (STIs). During STIs, all antiretrovirals are discontinued under intensive medical supervision for a discrete period of time; concurrently, prophylactic therapies are continued or initiated to prevent opportunistic infections. When the interruption is concluded, the same highly active antiretroviral therapy (HAART) regimen or a new combination of antiretrovirals is reinstated.

Discontinuing HAART for any length of time invokes a number of risks, but may also offer several benefits. Potential risks include a drop in CD4 cell count and renewed concern about the development of opportunistic infections, dramatic increases in viral load, the emergence of drug-resistant strains of virus, and the re-seeding of viral reservoirs within the body. On the other hand, by decreasing drug burden and toxicity,<sup>1</sup> STIs offer the potential for improvements in quality of life for people living with HIV (Walmsley & Loutfy, 2002).

#### Divergent "Whys?" of STIs

The goals of STIs vary, depending upon the current status of the recipient. In the case of an acute HIV infection (during which the immune system is relatively intact and the individual can achieve prolonged suppression of HIV with antiretrovirals), researchers believe that early and intermittent treatment protects CD4 cells from destruction, allowing them to continue to summon killer T-cells to destroy HIV-infected cells, thereby suppressing viral load and, in essence, "teaching" the immune system to fight HIV without the continual use

<sup>1</sup>As an example, in one recent preliminary study (Dybul et al., 2001), investigators followed 10 individuals on daily HAART with low viral loads and high CD4 counts and had them begin cycling their HAART regimen in a seven days on/seven days off pattern over a period of up to 68 weeks. Virus levels not only remained suppressed on this short-cycle intermittent treatment schedule, but *cholesterol levels dropped by 22% on average, and triglyceride levels by 51%*. Should these findings bear out in larger studies, the toxicity of these medications might be lowered and the cost of treatment could be cut in half for many people living with HIV.

open discussion between clinicians and clients regarding preferences related to HIV status disclosure to family members and strategies for disclosure or maintaining the privacy of treatment as well as the need to integrate mental health and substance

of medications (Rosenberg et al., 2000).

With chronic HIV infection, in which the individual has achieved prolonged suppression of HIV with antiretrovirals that were initiated long after seroconversion, the goal would be to reduce drug toxicity or to provide respite from continual use of HAART without jeopardizing viral suppression when treatment is resumed.

Finally, when an individual experiences virologic failure on HAART and salvage therapy is being considered (i.e., the initiation of new classes of drugs, the recycling of older drugs, or other strategies intended to slow the progression of HIV in individuals who are fully or partially resistant to the current roster of antiretrovirals), STIs may improve virologic response to salvage therapy by allowing time for drug-sensitive virus to develop or reemerge and for drug-resistant virus to diminish (Walmsley & Loutfy, 2002).

#### Recent Reports Offer Mixed Results

Chen et al. (2002) conducted a retrospective analysis involving 75 chronically HIV-infected individuals who discontinued HAART, largely as a consequence of virologic failure, for a period of at least 30 days and found that "the majority of our patients in virologic failure who underwent a temporary [treatment interruption] recovered 90% of their baseline CD4<sup>+</sup> cell counts and returned to within 2-fold of their baseline [viral load] when HAART was resumed" (p. 909). Chen and colleagues were unable to identify factors predictive of either success or failure when interrupting HAART and are not yet recommending its incorporation into routine clinical practice, but conclude that, when closely supervised, temporary interruptions of antiretroviral treatment are "relatively safe."

By contrast, Schweighardt et al. (2002) found that "repeated abrupt termination and resumption of certain antiretroviral drug regimens during STI therapy may lead to the development of drug resistance in chronically HIV-infected individuals" (p. 2342).

While Chen and colleagues could not identify reasons for success, investigators in Spain (García et al., 2002) attempted to differentiate baseline factors that might predict a favorable outcome following STI. From three pilot studies involving a total of 44 early-stage, chronic

abuse treatment into medical services for women living with HIV to increase both access and adherence to antiretrovirals.

Lee and Rotheram-Borus (2002) followed a racially and ethnically diverse cohort of

HIV-infected patients, García and colleagues concluded that "preserved memory response in CD4 T cells is the most important factor in obtaining virological response after STI. This finding could be useful in ... select[ing] those patients with a higher probability of response" (p. 1764).

Again, in contrast to the results of Chen and colleagues, investigators in Switzerland (Oxenius et al., 2002) conducted a prospective study of sequential STIs involving 97 individuals with chronic HIV infection and found that, while viral load was slightly lower following repeated STIs, the difference was quite small. Moreover, while CD4 levels increased during STIs, they stayed at elevated levels only when pretreatment viral load was low. "These findings demonstrate that STI initiated during chronic HIV-1 infection is generally unable to significantly alter the individual preexisting equilibrium between cellular immunity and viral replication nor is it able to significantly lower the set-point [viral load]. This result is in contrast to STI initiated during primary infection where a certain degree of modulation of the ensuing set-point [viral load] has been observed" (p. 13752).

On this latter point, Tebas et al. (2002) studied 72 people living with HIV who had achieved a viral load of < 500 copies/mL for a minimum of three months and subsequently discontinued HAART (with close physician monitoring) for at least 12 weeks. While admittedly a preliminary, "best-case scenario" for STI, the authors argue that "discontinuation of antiretroviral therapy during successful virologic suppression is clinically safe for the majority of patients, provided that the CD4<sup>+</sup> T cell counts remain > 200 cells/mm<sup>3</sup>. The major predictor of the slope of CD4<sup>+</sup> T cell decay is the number of CD4<sup>+</sup> T cells gained while receiving therapy, suggesting that it may be possible in many patients to determine the interval during which therapy can be safely interrupted" (pp. 853-854). Since treatment interruptions can foster the development of drug-resistant viral strains, however, Tebas and colleagues urge the coupling of intermittent therapy with enhanced education regarding risk reduction.

#### Impact on Adherence & Quality of Life

Walmsley and Loutfy (2002) observe that STIs have the potential to increase or decrease

301 New York City parents living with HIV and their 395 adolescent children over a five-year period to explore the process of parental disclosure of HIV status and its aftermath. They found that mothers tended to disclose earlier than fathers and did so



antiretroviral adherence when HAART is reintroduced following a treatment interruption. "Patients may approach reinitiation of therapy with better adherence if relieved of [the] toxicity and fatigue of HAART, and if they recognize the risks of an STI with rising viral load and declining CD4 count off therapy. In contrast, adherence can be negatively affected by an STI if treatment reinitiation is associated with the recurrence of acute adverse events such as nausea, vomiting, diarrhea, or other toxicity" (Walmsley & Loutfy, 2002, p. 101). Poor adherence to HAART can lead to virologic failure and the development of drug resistance.

From a psychological perspective, STIs may engender stress related to the potential rebound in viral load or substantial decline in CD4 cell count as well as increased medical monitoring while the treatment is interrupted. Conversely, temporary relief from drug burden and toxicity may improve outlook and emotional state (Walmsley & Loutfy, 2002).

In a small, prospective study examining the psychological impact of STIs (Tuldrá et al., 2001), 12 people in Spain living with HIV were followed over four STI cycles and compared to 12 matched others whose treatment was not interrupted. All participants were stable on HAART for a minimum of two years and STIs, not exceeding 30 days, were followed by 12 weeks of HAART before the next interruption. Recipients of STI were interviewed at the time of interruption, two weeks later, and one week following the re-introduction of HAART; it was at this last time point that control subjects were also interviewed.

The authors discerned some psychological benefits from receiving STIs. In comparisons with control subjects, an improvement in quality of life was observed during two STI cycles, and trended in this direction during the other two cycles. At the time of the first interruption, individuals reported an improvement in health status, perhaps related to the resolution of side effects while off medications, and greater adherence upon treatment resumption, although this latter finding was not noted following subsequent interruptions. While there was no overall increase in quality of life while off treatment, a decrease in quality of life was reported by those who experienced an STI and then

more often to daughters than to sons. While parents were more likely to disclose to older children than to younger children, they were likely to disclose to all children of all ages over time. While disclosure was common, Lee and Rotheram-Borus also found disclo-

resumed treatment for the first time. While the authors expressed concern about potential adherence problems when HAART is resumed, difficulties with scheduling and food requirements did not translate into reported missed doses. Tuldrá and colleagues conclude that, "[a]lthough some disturbances appear at the resumption of therapy, no definitive problems are found that preclude such therapeutic approaches from a psychological perspective. However, a close follow-up of patients during interruption periods is advisable to avoid difficulties reported at treatment resumption presenting a risk to patients' health" (p. 1904).

#### Reality Check

Of course, a recent case study on HIV "superinfection" (i.e., infection by a second strain of HIV; Altfeld et al., 2002) in an individual who was in the midst of an STI has raised new questions and concerns about this controversial approach to treatment. As Walmsley and Loutfy (2002) fairly observe,

The structured treatment interruption strategy remains in a state of equipoise, and until the relative benefits and risks can be fully measured in randomized clinical trials, the use of STIs should be considered experimental and not part of routine practice. For many patients, the potential for a treatment interruption, structured or not, is often considered beneficial, primarily to decrease the burden and toxicity associated with continuous therapy. Patients need to be counselled on the potential risks and benefits of such an approach before it is recommended in clinical management. (p. 95)

The bottom line? While these findings are provocative and worthy of further exploration, people living with HIV are cautioned not to interrupt antiretroviral treatment unless they are doing so under close medical supervision.

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that these outcomes can persist for a lengthy period of time. "[T]he medical setting offers a venue for providing support regarding decisions about whether, when and how [parents] disclose their serostatus to their children. ... In particular, as more

than one-third of parents disclose very soon after their HIV diagnosis, post-test counseling with seropositive parents should encourage a delay in disclosure until the parent deals with [his or her] own feelings of anger, fear or depression ... [Parents then have] an opportunity to plan their disclosure and not to use the disclosure to get support for themselves from their child" (p. 2206).

What about the process and aftermath of disclosing to a child his or her HIV-positive status? In a preliminary investigation, Lester et al. (2002) studied 51 children who were perinatally infected with HIV and found that earlier disclosure to the child of his/her HIV status was associated with a higher IQ in the child, greater family expressiveness, and residence in a community educated about HIV disease. Disclosure was also associated with a higher level of recent stressful life events affecting the child, although the direction of this association was unclear. Importantly, "[t]hese data [also] suggest that diagnostic disclosure may not necessarily minimize emotional distress, indicating the need for further evaluation of the appropriate timing and type of disclosure for pediatric HIV" (p. 309). The authors recommend: 1) a comprehensive developmental assessment of HIV-infected children for the purpose of planning the timing and process of the diagnostic disclosure; 2) assessment of family communication style to identify families needing greater support in the disclosure process; 3) anticipation of community responses in advance of disclosure; and 4) evaluation of ongoing stressors in the life of the child.

#### Pain Management

Based on self-report measures completed by 145 persistent pain sufferers living with HIV, Smith, Egert, Winkel, and Jacobsen (2002) conclude that those who merited a likely diagnosis of posttraumatic stress disorder (PTSD; 53.8% of this sample) also experienced higher pain intensity as well as greater pain-related interference in mood and daily activities (e.g., working, sleeping, walking) when compared with those who did not likely merit a PTSD diagnosis. Smith and colleagues recommend that clinicians consider assessing HIV clients for PTSD symptoms and offering those with a high

symptom burden cognitive-behavioral treatments (e.g., cognitive therapy, systematic desensitization, relaxation training) proven effective in reducing PTSD symptomatology. "By modifying both the quantity and quality of PTSD symptom expression, such intervention strategies may also prove effective in reducing the intensity and functional impact of pain symptoms" (p. 15).

#### Care for Caregivers

Murphy, Marelich, Dello Stritto, Swendeman, and Witkin (2002) interviewed 135 mothers – largely HIV asymptomatic and prescribed antiretrovirals – whose children were HIV-negative and between the ages of six and 11 and found these women, as a group, to be moderately depressed. Depression was associated with poorer family cohesion, poorer family sociability, and mothers less able to perform "typical" tasks, with greater responsibility placed on children for household chores. "The current findings suggest that if mothers' disease continues to progress and affect parental skills during the time the children are transitioning to early and middle adolescence that the children may themselves be vulnerable to engaging in earlier risk behaviour. ... More efforts need to be concentrated in assessing the impact of mothers' health status on parenting skills, and providing family services as necessary" (p. 642).

Joslin and Harrison (2002) conducted an exploratory study involving 20 older adults who had assumed parenting responsibilities for children and adolescents affected or orphaned by HIV disease. They found chronic health conditions as well as poor self-reported health among these surrogate parents; nearly three-quarters also reported having insufficient time to address these health issues. Josling and Harrison contend that supportive services, designed to improve self-care among caregivers as well as their utilization of health services, are clearly needed for these "hidden patients."

Australia investigators (Pakenham, Dadds, & Lennon, 2002) randomly assigned 36 HIV caregivers and their care recipients to one of three conditions: a dyadic psychosocial intervention, an intervention for the caregiver alone, or a wait list control group; in-

tervention strategies were eclectic and attuned to target problems. All study participants were interviewed and completed self-administered questionnaires prior to treatment, eight weeks later, and (for intervention recipients), four months after that. Among the 29 dyads completing the study, caregivers and care recipients participating in the dyadic intervention showed greater improvement on a variety of psychosocial measures (including dyadic adjustment and some target problems) than participants in the other two groups; most treatment gains held up at four-month follow-up. "Findings suggest that psychosocial intervention at the dyadic level provides both care-recipient and caregiver with greater benefits compared with providing psychosocial assistance to the caregiver alone" (p. 747).

#### Coping, Social Support, & Quality of Life

In Spain, Blanch et al. (2002) interviewed 150 consecutive clinic attendees taking HAART for more than one year and found that 56% met clinical criteria for lipodystrophy syndrome. These individuals tended to be older, on antiretrovirals for a longer period of time, and reporting poorer physical health than those not affected by lipodystrophy. While lipodystrophy, in and of itself, did not appear to influence overall quality of life, gay men as well as study participants receiving psychiatric treatment (i.e., methadone, tranquilizers, or antidepressants) who had lipodystrophy demonstrated greater impairment in a quality of life measure subscales associated with physical capacity (i.e., day-to-day physical and intellectual functioning), psychological functioning (i.e., coping with stressful life events), and negative mood (i.e., anxiety and depression) than those without lipodystrophy. The authors suggest that clinicians pay particular attention to quality of life in gay men as well as men and women with psychiatric disorders who experience lipodystrophy.

On this same subject, Lenert, Feddersen, Sturley, and Lee (2002) surveyed 75 people living with HIV – largely well-educated, white men – and found that *many were willing to trade off years of life to avoid lipodystrophy*. The authors encourage clinicians to gain "a detailed understanding of how a [client] values the specific risks to quality of life inher-

ent in proposed treatments ..." (p. 231) and explore trade-offs clients would be willing to make between length of life and quality of life when working together to arrive at an optimal approach to treatment.

Utilizing a sample of 84 individuals who were initiating, changing, or having difficulty with a HAART regimen, Safran, Radomsky, Otto, and Salomon (2002) found that satisfaction with social support, adaptive coping, and a reduced level of punishment beliefs related to having HIV were associated with psychological well-being. Since these psychosocial factors are responsive to intervention, "a clinician may [promote a higher] quality of life by addressing ... social support, positive coping with illness, and punishment-related beliefs associated with HIV and its treatment. ... Psychoeducation or referral to cognitive behavior therapy, which actively targets adaptive coping strategies, may be useful to achieve these ends. ... [I]nterventions targeting dysfunctional attitudes and problem-solving deficits hold promise of both increasing functioning and decreasing depression" (p. 483).

Lagana et al. (2002) surveyed a diverse sample of 120 people living with HIV (69 men, 51 women) and found that emotional control (i.e., inhibited expression of anxiety, depression, or anger), chronic pain, and use of antidepressants were all associated with the presence of depressive symptomatology. "These findings underscore the need to treat the pain of HIV-positive individuals and to help them express their negative emotions, as both factors are associated with depressive symptomatology. If emotional control and depressive symptoms are in fact interrelated, then psychosocial treatment encouraging emotional expression of negative mood states may be an effective rehabilitation effort aimed at enhancing the psychological adjustment of HIV-positive individuals" (pp. 410-411).

In Canada, Côté and Pepler (2002) randomized 59 male inpatients with advanced HIV disease to one of three conditions: a brief cognitive coping skills intervention, a brief intervention focused on emotional expression ("venting"), or a waiting list. They found that the two nursing interventions produced

reported decreases in distress and reduced negative affect immediately following the first of three consecutive, daily 20-30 minute sessions (i.e., on Day 1), although neither intervention generated positive affect, nor did either intervention engender a sustained decrease in negative affect following the decrease reported on Day 1. Additionally, while the cognitive intervention was associated with reductions in both anxiety and intrusive ideation about HIV in pre-post session comparisons, emotional expression was, in this study, associated with increases in anxiety. Citing the value of brief interventions designed to produce only short-term effects, Côté and Pepler conclude that "the cognitive coping skills nursing intervention is effective in helping to regulate the emotional responses of HIV-positive individuals to advanced disease" (p. 237).

#### Coping & Quality of Death

Pierson, Curtis, and Patrick (2002) interviewed 35 adults (largely white gay men) with advanced AIDS regarding their views on what constitutes a "good" death, as contrasted with what constitutes a "bad" death. Within this one sample, researchers identified 15 domains differentiating a "good" from a "bad" death (e.g., dying process, location of death) and, within these domains, 38 sub-categorical preferences (e.g., some preferred death while sleeping, while others desired to remain alert and aware of approaching death; some wanted to die at home, others in a hospital or hospice), suggesting that there is great variability in how individuals view quality in the dying process. Pierson and colleagues urge clinicians to inquire about the specific factors constituting a good or a bad death from each client's perspective so that preferences may, to the greatest extent possible, be realized.

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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.cdcnpi.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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