

mental health AIDS

A Quarterly Update from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) Volume 6, Issue 1 – Fall 2004

Biopsychosocial Update

HIV Prevention News

About Women

Shain et al. (2004) randomly assigned 775 low-income, high-risk, African- and Mexican-American women being treated for a non-viral sexually transmitted disease (STD) to one of three conditions – a control condition; a standard, gender- and culture-specific, three-session, small-group, cognitive-behavioral intervention; or an enhanced intervention (standard intervention, plus the option of attending five monthly support-group sessions) – and followed them over a two-year period. Among the 690 women completing the study, lower adjusted rates of infection with chlamydia and/or gonorrhea were observed for women in *either* intervention arm in comparison with women in the control condition at each evaluation point over the two-year

period. Enhanced intervention participants who opted to attend **support groups** had the lowest adjusted rates of infection (and repeat infections) at both the midpoint and the close of the study. Shain and colleagues conclude that “[r]isk-reduction interventions significantly decreased both single and multiple infective episodes with chlamydia and/or gonorrhea and risky sexual behaviors in the two-year study period. Support-group attendance appeared to contribute additional risk reduction in Year 1” (p. 401). While the low prevalence of HIV in this community made it impossible to evaluate the efficacy of these efforts against seroconversion, the authors reason that “behavioral risk reduction that disrupts heterosexual transmission of bacterial pathogens could also prevent heterosexual transmission of HIV ...” (p. 408).

mental health AIDS is a free, online, quarterly biopsychosocial research update designed to summarize, organize, and facilitate the practical application of the immense and ever-increasing body of peer-reviewed literature on HIV and mental health for front line clinicians.

Entering its sixth year of publication, *mental health AIDS* is now fully sponsored by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA, an agency of the U.S. Department of Health and Human Services) and has moved to the SAMHSA Web site (<http://mentalhealthAIDS.samhsa.gov>).

The format for *mental health AIDS* 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.

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About Adolescents

Based on a review of 24 randomized controlled trials (RCTs) published before 2003 evaluating **sexual risk reduction interventions with adolescents**, Pedlow and Carey (2004) recommend that “developmentally appropriate” interventions:

Use multiple intervention strategies that are compatible with adolescents’ cognitive abilities

Illustrate abstract concepts, such as risk appraisal, with clear, personalized examples

Teach techniques to cope with emotions and feelings associated with practicing risk reduction

Provide multiple opportunities for behavioral skills training

Emphasize sexual communica-

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tion, negotiation, and decision-making skills

Facilitate skills maintenance by providing “booster” sessions

Address peer norms and peer pressure

Include activities to involve parents in the intervention

Provide integrated prevention messages to reduce risk for HIV, STDs, and unintended pregnancy (p. 180)

It should be noted that “the interventions tested in RCTs were more effective in delaying the onset of sexual activity than in promoting abstinence among sexually active youth. Interventions with booster sessions were effective in reducing sexual risk behavior [and] improvements in sexual communication skills and perceived norms for safer sex were associated with reductions in sexual risk outcomes” (p. 172).

As illustrated by Shain et al. (2004) above, **gender and culture** are additional factors considered important by some investigators in planning interventions. With this in mind, DiClemente et al. (2004) randomized 522 sexually-experienced, young African-American women between the ages of 14 and 18 to one of two conditions: four, four-hour group sessions that “empha-

siz[ed] ethnic and gender pride, HIV knowledge, communication, condom use skills, and healthy relationships” (p. 171) or sessions that emphasized exercise and nutrition. Following up at six months and one year post-intervention, the authors found that those receiving the first of these interventions were more likely to use condoms consistently (i.e., during every occasion of vaginal intercourse) and less likely to have acquired a new vaginal sex partner in the preceding 30 days than those in the control condition. DiClemente and colleagues conclude that “[i]nterventions for African American adolescent girls that are gender-tailored and culturally congruent can enhance HIV-preventive behaviors, skills, and mediators and may reduce pregnancy and chlamydia infection” (p. 171).

About Men

Building on their study of gay men (Bancroft et al., 2003), Bancroft et al. (2004) assessed 865 young heterosexual men to examine **the relationship between sexual risk taking** and three aspects of **personality**¹: sexual arousability (as

¹Why study relatively immutable personality characteristics as factors relevant to sexual risk reduction? In part, Bancroft et al. (2003) have this to say:

[P]ersonality characteristics may play a crucial role in designing appropriate one-on-one interventions. Thus, for example, interventions with individuals who have a tendency to take sexual risks when

well as propensities toward its inhibition in the context of risk or threat), negative mood, and sensation seeking. In this heterosexual sample,

[m]en with low inhibition of sexual arousal in the face of risk ... reported more partners with whom they use no condoms and more lifetime “one night stands.” Men who experience increased sexual interest in states of depression ... reported more partners in the past year and more one night stands. ... [D]is-inhibition ... was predictive of whether sexual intercourse had occurred in the past 6 months, and also of the number of sexual partners in the past year. A measure of an intention to practice safer sex was strongly related to measures of sexual arousability and inhibition ... (p. 181)

Bancroft and colleagues conclude that “[b]oth this study and [the] par-

depressed, or who use sex as a form of mood regulator, could initially employ a behavioral analysis of the relation between mood and sexual behavior (e.g., using daily diaries) to confront the individual with this pattern and focus motivation for change, followed by a cognitive-behavioral approach to develop and maintain alternative methods of mood regulation. ... [T]his approach is particularly relevant to ... men who cruise for casual sexual partners. As the negative mood in such men is driving them to go out and look for partners, interventions should focus on redirecting that sequence early, before the contact with a partner is made. The individual who appears to take more risk during the sexual interaction, because of the persistence of sexual arousal in the face of risk, needs to take this aspect of his personality into account when anticipating or planning sexual encounters, and take steps to build safe procedures, such as condom availability, into the sequence. ... The individual who is reluctant to use condoms because of concerns about his erectile function should be guided to use other methods of maintaining erectile function, such as Viagra, rather than avoid condom use. (p. 569)

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allel study of gay men ... reinforced the idea that personality factors, particularly those of more direct relevance to sexuality, are important in understanding [high-risk sexual behavior]" (p. 191) and that "[i]ndividual differences in sexual excitation and inhibition proneness and the relation between mood and sexuality ... should be taken into consideration when designing behavioral intervention" (p. 181).

About Men Who Have Sex with Men

Dutch investigators (Davidovich, de Wit, & Stroebe, 2004) examined the first incident of **unprotected anal intercourse (UAI) occurring within the steady relationships** of 324 gay men in Amsterdam, as well as related cognitions. "Of the men who had UAI with their steady partners, 55% ... did so within the first 3 months of the relationship, and 46% did not discuss having UAI with their partner before it occurred. ... [P]erceiving UAI as a symbol of trust and believing that the partner desired UAI were associated with less condom use but also with a higher likelihood that men established HIV-negative seroconcordance and ... practiced negotiated safety Perceiving UAI as more gratifying was [also] associated with having ... UAI" (p. 304).

As for reducing sexual risk-taking within steady male relationships, Davidovich and colleagues suggest that clinicians utilize beliefs related to trust and to a partner's desire for UAI as leverage to promote negotiated safety.² In those relationships in which negotiated safety cannot be established (e.g., relationships that have only just begun), these beliefs and, in particular, the percep-

² When gay men negotiate safety, it most often means that they ascertain (through HIV testing) that they are both HIV-negative and agree to have UAI only with their steady partner and to use condoms when having sex with casual partners.

From the Block Native Circle

Native Circle, a component of San Francisco's Native American Health Center (NAHC) Family and Child Guidance Clinic, is funded by CMHS/SAMHSA to provide mental health services to Native Americans with HIV/AIDS residing in the San Francisco Bay Area. The program integrates individual, group, and family therapy into a larger, holistic system of care that includes community outreach, HIV/AIDS risk reduction, case management, substance abuse treatment, dental care, and medical services (including alternative and Native American practices). Mental health treatment will often address the stigma associated with being gay/lesbian/bisexual/transgender and/or HIV-positive, as well as multigenerational family dysfunction associated with "cultural genocide," the outcome of forced relocation and forced assimilation of Native peoples into mainstream society.

Native Circle incorporates the beliefs, traditions, and rituals of various tribal groups into its psychotherapy model, centered on the premise that "disease" represents a need for re-balancing, which can be achieved through participation in ritual (e.g., the use of "talking circles" as a form of group therapy; the burning of ceremonial herbs to assist in the healing process; traditional "sweats," used to teach relaxation techniques and stress reduction). While this perspective is not imposed on clients, the invitation to take part in such activities remains open.

The Principal Investigator is Ethan Nebelkopf, PhD; the Clinical Director is Nelson Jim, MA. For more information, please call 415/621-4371 x 533 or go to: <http://www.nativehealth.org/>.

— *Compiled by the MHHSC Program
Coordinating Center*

tion that UAI is more gratifying may, indeed, function as barriers to safer sex. Moreover, the rapid initiation of risk behavior within steady relationships suggests that clinicians must intervene early with couples

and could, by logical extension, target single gay men in an effort to promote safer sex within future steady relationships.

In a related study, Dudley, Rostosky, Korfhage, and Zimmerman (2004) surveyed 154 young men who have sex with men (MSM; ages 13 to 21) in five mid-sized, Midwestern U.S. cities and found that, in addition to number of reported anal sex partners and relationship status (i.e., having a dating partner), **impulsive decision making** was positively associated with the self-reported frequency of UAI. Dudley and colleagues urge clinicians to teach young, impulsive decision-makers "to carry condoms with them at all times, to keep condoms stored in a place where they are most likely to have sexual intercourse (next to the bed), and to proactively identify and avoid situations that are likely to lead to unprotected sex. Other psychoeducational interventions ... include increasing awareness of impulsive tendencies, overrehearsing responses to sexual pressure, and overrehearsing decision-making steps" (p. 336).

Contributing to the ongoing investigation of **the role of alcohol in unsafe sexual behavior**, Vanable et al. (2004) analyzed event-level data from a three-city sample of 1,712 HIV-negative MSM and discerned that, in encounters that involved a primary partner, rates of UAI did not vary in accordance with the use of alcohol. In fact,

[a]cross the entire sample, [UAI] was just as likely for nondrinking events as for events that included alcohol consumption. However, alcohol use prior to sex was strongly related to unsafe sex for **encounters involving nonprimary partners.** Indeed, among participants who reported consuming four or more drinks prior to a recent

sexual encounter with a nonprimary partner, rates of [UAI] were nearly three times those reported by men who did not drink or who reported consuming less than four drinks. ... Results also indicate that alcohol use relates to sexual risk taking in a dose-response fashion: For events involving a nonprimary partner, rates of unsafe sex were elevated only for events involving heavier alcohol use (four or more drinks). Taken together, findings highlight the importance of the social context for sexual activity, both in determining whether alcohol is consumed at all and with regard to whether alcohol consumption (and level of intoxication) is related to sexual risk taking. (p. 530)

Vanable and colleagues reason that "alcohol use may be related to increased sexual risk primarily in situations involving desirable behaviors that are most strongly proscribed or avoided under sober conditions" (p. 530; see also Parsons et al., 2004a, 2004b below). With regard to intervention, they recommend strengthening "self-management strategies for reducing alcohol use and improving safer sex negotiation skills for encounters involving new or nonprimary partners" (p. 531).

Deepening this focus on the context of alcohol use, Parsons et al. (2004b) interviewed 48 gay and bisexual men living with HIV who were diagnosed with **alcohol use disorders** (81% men of color) for the purpose of describing "the role participants assigned to alcohol before or during sexual activity. ... The time at which men drank, for how long, where, why, and to what extent was related to the role they assigned to alcohol. Moreover, the role alcohol played in the sexual activity structure impacted its role in sexual risk behavior" (p. 168).

Parsons and colleagues observe that

[a]lcohol does not play a direct or dominant role in the sexual risk behaviors for the HIV-positive MSM in [this] sample. Rather, the intoxication is one aspect of a sexual script, which includes particular settings, partners, and sexual behaviors. The sexual scripts themselves are somewhat automatic and become more so under the influence of alcohol. Alcohol acts on these scripts by decreasing self-monitoring and increasing the reliance on default scripts, which are driven by environmental stimuli and situational cues ... The default scripts that participants used could be seen as routine, spontaneous (alcohol enabled), or taboo. (pp. 168-169)

Within this same sample, Parsons et al. (2004a) delved further into interviews with those men **engaging in "stigmatized" sexual practices** (i.e., enacting a taboo sexual script) **while using alcohol**.

For these men, alcohol facilitated engagement in behaviors that elicited shame or guilt based on internalized social norms and proscriptions. For some men, alcohol and sex became so coupled that they did not or could not engage in sexual activity when they were sober.

For bisexual men, alcohol enabled them to have sex with other men while temporarily postponing a reconciliation of their behavior with their sexual identity. Alcohol also facilitated atypical sexual behaviors for men who experienced anxiety around anal receptive sex. Alcohol played a role in the violation of sexual parameters for those ... who were in monogamous relationships. Finally, of-

ten due to its role in enabling stigmatized sexual behaviors, alcohol played a role in unsafe sex for some participants. (p. 1050)

With regard to interventions, Parsons and colleagues observe that

[b]ehavioral interventions designed to reduce the HIV sexual risk practices of HIV-seropositive MSM who abuse alcohol should consider the implications of sexual scripts and their role in sexual experiences. Cognitive or motivational interventions may be useful in helping HIV-positive MSM to understand their sexual scripts and the role that alcohol plays in scripting their sexual activities. Such approaches, which are designed to facilitate cognitive restructuring, amplify discrepancy, and increase self-monitoring, may benefit men through enabling script modifications. (Parsons et al., 2004b, p. 171)

Enriching this focus on contextual factors associated with unsafe sex, Díaz, Ayala, and Bein (2004) used data drawn from a probability sample of 912 Latino gay men in three U.S. cities to identify ways in which **social discrimination** (i.e., homophobia and racism) **and financial hardship** may be linked to risky sexual behavior:

First, individuals' experiences of social oppression on account of race/ethnicity, class, and sexual orientation are strongly correlated to sexual practices that place individuals at risk for HIV transmission. Second, ... social oppression and psychological distress predict participation in sexual situations of risk. Third, social oppression affects sexual risk by increasing the likelihood that individuals participate in situations that make it difficult to practice safer sex. Men who

were more discriminated [against] and psychologically distressed were more likely to participate in sexual situations under the influence of drugs or alcohol, to engage in sex ... to alleviate anxiety and stress, and to be with partners who resisted condom use, among others. Participation in these "difficult" situations mediates the impact of social oppression on risky sexual behavior. (p. 265)

Simply stated, these findings, in combination with earlier work, "suggest that discrimination increases isolation, undermines a sense of self-worth, and produces psychological distress. Those who are oppressed and distressed, in turn, participate more often in sexual situations in which risk behavior is likely to occur" (p. 265).

Among the interventions suggested by these findings, the authors encourage clinicians to help Latino gay men "discover and understand that the risk for HIV is not simply an individual characteristic related to some kind of personal or moral deficiency. Rather, HIV education and prevention must be focused on the fact that 'risk' is often a property of situations or the product of personal and contextual factors interact making it difficult to practice safer sex" (p. 266).

Continuing with this theme, Williams, Wyatt, Resell, Peterson, and Asuan-O'Brien (2004) conducted four focus groups involving 23 men (five gay-identifying African-American men, seven non-gay-identifying African-American men, five gay-identifying Mexican/Mexican-American men, and six non-gay-identifying Mexican/Mexican-American men) living with HIV, all of whom reported a history of sexual abuse, in an effort to better understand **sexual risk among MSM of color**.

The data were organized into a matrix of seven domains to assist in developing interventions. The domain were: "(a) sex with men, (b) sex with women, (c) the importance of family including having children, (d) gender roles and social expectations, (e) sex or 'partying' with drugs and alcohol, (f) church and religion, and (g) living with HIV" (p. 272).³ Williams and colleagues observe that this investigation

described many of the issues and conflicts ... for MSM of color and highlighted the need to better understand what it means to be African American or Latino, gay, male, and to live with HIV and a history of sexual abuse. ... The seven domains identified in these focus groups should be prioritized to help men address the conflicts and challenges they reported. The primary focus should be the importance of personal identifications and acceptance as an African American or Latino [MSM]. Once the socio-cultural and gender conflicts are addressed, the second area of focus should be on the behaviors and experiences that may influence these men's sexuality, namely, their HIV status, past and current abuse, and resultant sexual risk-taking practices that increase current HIV-related risks. Future interventions should also include sociocultural, religious, and alternative resources to minimize social isolation and rejection. These factors must be considered as basic to behavior change because they build on personal strengths while helping men to redefine themselves as critical members of their ethnic, cultural, and religious communities. The health and well-being of [MSM] is as es-

³ The richness of this data set cannot be easily summarized; readers are referred to the original text for an expanded discussion of these seven domains.

sential to them as it is to the people who care about and depend on them. (p. 283)

Finally, the EXPLORE Study Team (2004) reported on its multisite RCT testing the efficacy of a **behavioral intervention designed to prevent HIV infection** in a sample of 4,295 MSM at high risk for infection and living in six U.S. cities. Study participants received either ten intensive, one-to-one counseling sessions, followed by quarterly, client-centered maintenance sessions, or twice-yearly standard, voluntary HIV counseling. All participants were assessed behaviorally and tested for HIV every six months over the four years of the study. The team found that the rate of receptive UAI with serodiscordant or unknown-status partners was 20.5% lower in the intervention group in comparison with the standard condition group over the course of the study. They also found that fewer men in the experimental group became infected with HIV during the study period in comparison with men in the standard condition (115 vs. 144; 18.2% lower in the intervention group, attenuated to 15.7% when adjusting for baseline covariates), although this difference was *not* statistically significant; moreover, the effect appeared to be more favorable during the first 12-18 months of follow-up than later. Nevertheless, the investigators suggest that "a behavioural intervention can prevent HIV infection, not just reduce the frequency of self-reported risk behaviours. Further analyses of [the] data are under way with the aim of generating hypotheses to help develop more effective behavioural interventions" (p. 47).

About Substance Users

Over a six-month period, Longshore, Stein, and Conner (2004) followed 294 HIV-negative injecting drug users (IDUs) receiving drug

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Tool Box

Resources

Books & Articles:

Aidala, A., Havens, J., Mellins, C.A., Dodds, S., Whetten, K., Martin, D., Gillis, L., & Ko, P. (2004). Development and validation of the Client Diagnostic Questionnaire (CDQ): A mental health screening tool for use in HIV/AIDS service settings. *Psychology, Health & Medicine*, 9(3), 362-379.

The CDQ is "a brief diagnostic screening tool designed for use by non-mental health professionals and designed specifically to assess the range of psychiatric disorders known to be prevalent among persons infected with HIV or at high risk of infection: depression, anxiety, PTSD, substance abuse. ... The CDQ can be used by providers in a range of service settings to identify persons in need of formal mental health assessment and treatment, to more effectively target scarce mental health resources, and to reduce the negative impact of unrecognized disorder on the health and well-being of individuals in their care" (p. 362).

Blasini, I., Chantry, C., Cruz, C., Ortiz, L., Salabarría, I., Scalley, N., Matos, B., Febo, I., & Díaz, C. (2004). Disclosure model for pediatric patients living with HIV in Puerto Rico: Design, implementation, and evaluation. *Journal of Developmental & Behavioral Pediatrics*, 25(3), 181-189.

The authors describe a "developmentally appropriate," five-component disclosure procedure for HIV-infected youth that "(1) allow[s] the staff to feel competent and comfortable with delivering disclosure information; (2) equip[s] families with new knowledge and skills to mobilize them from secrecy, to readiness, and to the final disclosure phase; and (3) provid[es] pre- and post-disclosure assessment and intervention to the youth, allowing continuity of care and leading to optimal emotional support" (p. 188).

Laurence, J. (Ed.). (2004). *Medication adherence in HIV/AIDS*. Larchmont, NY: Mary Ann Liebert.

This volume "deals with the barriers to medication adherence and thoroughly addresses the scope of this problem as it affects various segments of the population, including adolescents, mi-

norities, and drug users. ... [I]t also addresses proposed solutions for overcoming this critical challenge."

Mallinson, R.K. (2004). Perceptions of HIV/AIDS by deaf gay men. *Journal of the Association of Nurses in AIDS Care*, 15(4), 27-36.

In this exploratory pilot study, Mallinson observes that "[d]eaf gay men represent a subpopulation of the gay male community at particularly high risk for HIV/AIDS due to numerous barriers including language, stigma, and inequitable access to health services" (p. 27) and offers recommendations for culturally sensitive care.

Mitchell, C.G., & Linsk, N.L. (2004). A multidimensional conceptual framework for understanding HIV/AIDS as a chronic long-term illness. *Social Work*, 49(3), 469-477.

"This article provides a conceptual framework for understanding HIV in the multiple contexts of the client's culture, strengths, life course, and biomedical progression ... [and] concludes with a discussion of HIV prevention and treatment adherence as key focal points for social workers and their clients" (p. 469).

Morrison-Beedy, D., & Nelson, L.E. (2004). HIV prevention interventions in adolescent girls: What is the state of the science? *Worldviews on Evidence-Based Nursing*, 1(3), 165-175.

"A systematic review was undertaken to identify and critique the most scientifically rigorous HIV prevention interventions identified in the literature that focused on adolescent girls. ... [The authors conclude that c]linically relevant components of successful interventions include the combination of providing information and behavioral skills training, as well as enhancing motivation to reduce risk within these interventions" (p. 165).

Remple V.P., Hilton, B.A., Ratner, P.A., & Burdge, D.R. (2004). Psychometric assessment of the Multidimensional Quality of Life Questionnaire for Persons with HIV/AIDS (MQOL-HIV) in a sample of HIV-infected women. *Quality of Life Research*, 13(5), 947-957.

Remple and colleagues conducted a psychometric assessment of the MQOL-HIV, a 40-item scale consisting of 10 dimensions, in a sample of women

living with HIV and conclude that "[a]lthough some revision may make the scale more content-valid for HIV-infected women, given due care in the interpretation of results, the MQOL-HIV can be used with female populations in its current form" (p. 947).

Sherman, A.C., Mosier, J., Leszcz, M., Burlingame, G.M., Ulman, K.H., Cleary, T., Simonton, S., Latif, U., Hazelton, L., & Strauss, B. (2004). Group interventions for patients with cancer and HIV disease: Part III. Moderating variables and mechanisms of action. *International Journal of Group Psychotherapy*, 54(3), 347-387.

"Parts I and II of this review examined the efficacy of different interventions for individuals at different phases of illness, ranging from primary prevention to late-stage disease, in both psychosocial and biological domains. The current paper examines some of the factors other than phase of illness that might influence group treatment effects (e.g., intervention parameters, participant characteristics), and explores mechanisms of action" (p. 348).

Treisman, G.J., & Angelino, A.F. (2004). *The psychiatry of AIDS: A guide to diagnosis and treatment*. Baltimore: Johns Hopkins University Press.

Treisman and Angelino describe "the relationship between psychiatric disorders and HIV/AIDS and [demonstrate] the ways in which effective recognition and treatment of mental disorders can increase a patient's ability to obtain better treatment, improve compliance with medical regimens, and reduce incidents of high-risk behavior. ... Containing the most up-to-date information on diagnosis, prognosis, and treatment, this book ... uses case studies to show HIV/AIDS professionals how psychiatric interventions benefit the patient, the medical team, and society as a whole."

Internet Resources:

The July issue of HRSA CARE *Action* identifies factors that increase HIV risk for adolescent girls and young women and describes responsive strategies and programs. The newsletter may be found at: <ftp://ftp.hrsa.gov/hab/july2004.pdf>.

— Compiled by
Abraham Feingold, Psy.D.

(Biopsychosocial Update--continued from Page 5)
treatment and found that the intention to reduce risk as well as continuous participation in treatment were associated with a reduction in **injection risk behavior**. In addition, greater self-efficacy, less risk behavior at baseline, less perceived susceptibility to infection with HIV, and *greater* fear of AIDS were also associated with the intention to reduce risk. The authors suggest that

HIV risk intervention in drug treatment settings should focus on raising the client's intention or conscious commitment to risk reduction while also imparting skills and confidence for risk reduction. ... Strategies to address intentions and self-efficacy include exercises to promote the cognitive "accessibility" ... of risk reduction skills as well as intentions and goal-setting exercises ... in which a person declares both the acquisition of specific skills and the adoption of specific commitments as his/her intervention objectives. (pp. 362-363)

Longshore and colleagues further submit that it is "crucial to assess the client's perceived susceptibility based on his/her own behavior and, even more important, to see whether perceived susceptibility contributes to ongoing risk behavior by inducing unrealistic optimism regarding infection risk ... or through debilitating pessimism regarding that risk. Interventions may be considerably more effective if tailored to the client's perceived susceptibility in this way" (p. 363).

With regard to "fear appeals," which are generally thought to *undermine* risk reduction, such appeals, in the view of these authors,

can have favorable effects if closely paired with information on how to avoid risk ... [and may]

be productive *in a treatment context* [italics added]. However, treatment-based intervention efforts should ... be careful not to "turn up the volume too high" ... when delivering information on the risk of behaviors in which clients are known to have engaged, should carefully gauge each client's emotional response to threat-related material, and should include content designed to overcome possible denial or other defensive responses to fear ... (p. 364)

Turning to sexual risk, French investigators (Vincent et al., 2004) studied 192 IDUs receiving highly active antiretroviral therapy (HAART) who reported one or more experiences of sexual behavior with an "occasional" partner over a seven-year period and found (when controlling for co-factors such as injecting drug status, number of partners, and frequency of sexual intercourse) that unprotected sex was associated with the presence of three or more non-lipodystrophy **HAART-related side effects**. "Our study ... suggests that HIV patients' perception of HAART-related side effects may be of importance beyond that of strict clinical relevance. Clinicians should allow for patient's self-perceived side effects when counselling on secondary prevention. This study also indicates that injection prevention should not be dissociated from the management of HAART toxicity when addressing sexual risk taking issues among HIV-infected IDU[s]" (p. 1324).

About Women & Men

Crepaz, Hart, and Marks (2004) conducted *three* meta-analyses of English-language studies published between January 1996 to August 2003, along with other information sources from the same period, to determine if 1) being treated with HAART (21 findings), 2) having an undetectable viral load (13 findings),

or 3) holding **specific beliefs about HAART and viral load** (18 findings) are associated with increases in the likelihood of having unprotected sex. They found that

the prevalence of unprotected sexual intercourse was not significantly higher in the group of HIV-positive persons receive HAART (vs not receiving HAART) or in the group of HIV-positive persons with undetectable (vs detectable) viral load. Unprotected sex was, however, associated with people's beliefs about HAART and viral load. Regardless of their HIV serostatus, the likelihood of unprotected sex was higher in people who agreed that receiving HAART or having an undetectable viral load protects against transmitting HIV or that the availability of HAART reduces their concerns about having unsafe sex. (p. 234)

The authors urge that

HIV and [STD] patients should receive prevention messages emphasizing that having an undetectable viral load does not eliminate the possibility of transmitting HIV nor does it mean that an infected person is "cured" of the virus. Even HIV-positive patients who are engaging in safer sex should hear these messages to reinforce their safer-sex practices. Similar messages are also needed for a broader audience because beliefs about HAART and viral load held by those who are HIV-negative and whose serostatus is unknown were significantly associated with their sexual risk behaviors. (p. 235)

Regarding prevention counseling, Bolu et al. (2004) conducted a subset analysis of data from Project RESPECT, a multisite RCT that

compared the capacity of three clinic-based interventions to increase condom use and prevent HIV/STD infection. A total of 4,328 men and women were randomized to one of the three interventions (HIV education [the control condition], brief prevention counseling, or enhanced prevention counseling) and followed for 12 months. After 12 months, participants receiving *either* form of **interactive, risk-reduction counseling** had fewer STDs than participants receiving educational messages. The authors conclude that "HIV/STD prevention counseling (brief or enhanced counseling) resulted in fewer STDs than educational messages for all subgroups of STD clinic clients, including high-risk groups such as adolescents and persons with STDs at enrollment" (p. 469).

Finally, what is the **potential for HIV transmission** to partners of those already infected and engaging in high-risk behavior? Weinhardt et al. (2004) interviewed an ethnically- and geographically-diverse convenience sample of 3723 people living with HIV in four U.S. cities – 1918 MSM, 978 women, and 827 heterosexual men. Less than 25% of the latter two groups recalled two or more sexual partners during the three-month reporting period, while multiple partners were recalled by 59% of the MSM studied. Although most acts of unprotected intercourse (vaginal or anal) were reported to have occurred with seroconcordant partners, unprotected sex with a known or possibly serodiscordant partner was reported by about 13% of heterosexual men, 16% of MSM, and 19% of women, even as the majority indicated that they had disclosed their serostatus to all unprotected partners. It also bears noting that, of the 304 individuals who injected drugs during the three-month reporting period, 18% shared their injection equipment with others.

Weinhardt and colleagues estimated that 30.4 *new* infections (79.9% of these in the context of sexual activity with MSM) could be expected to have occurred among sex partners of those participating in this study during the three-month reporting period. They conclude that "[by integrating prevention with medical and social care services, it will be possible for persons with HIV infection to live longer and healthier lives and to avoid behaviors that could result in virus transmission to others and their own exposure to additional [STDs] and treatment-resistant strains of HIV" (p. 1065).

HIV Assessment News Psychiatric Assessment

In a study of diagnostic classifications and service utilization patterns

observed among persons of color living with HIV and receiving "culturally responsive" mental health services integrated into an urban HIV primary care clinic, Budin, Boslaugh, Beckett, and Winiarski (2004) found that 80 (86%) of 93 persons referred for psychiatric consultation presented for at least one encounter and the average number of encounters was 4.2. Psychotropic medications were more often prescribed to Hispanics (when compared with African Americans) and people living with HIV (when compared with people living with AIDS). The 25.5% of this sample with six or more visits ("high utilizers") consumed 67.3% of services offered. In terms of diagnosis, "[t]he frequency of Substance Use Disorders [38.7% of sample], Major Depres-

(Continued from Page 1)

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 three types of sidebars:

- o Building Blocks, focusing on news from CMHS/SAMHSA and other governmental sources;
- o Tool Boxes, containing practical information and resources for the provider of HIV-related prevention, assessment, and/or treatment services; and
- o From the Block, highlighting the work of the CMHS/SAMHSA Minority AIDS Initiative Mental Health HIV Services Collaborative (MHSC) Program.¹

Longstanding readers will notice an enlarged typeface to improve readability as well as increased use of bold-faced type to facilitate the efforts of scanners who read selectively. In addition to its traditional PDF format, *mental health AIDS* is now also offered in an HTML format to support those who prefer to read directly from the computer screen.

I provide a wealth of information in this update for SAMHSA's diverse constituency. 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

¹ 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, 20 community-based organizations are expanding their current service capacity to reach and provide coordinated mental health services to individuals with a diagnosed mental illness who are also HIV-positive.

sive Disorder [24.5%], Panic Disorder with Agoraphobia [11.3%], and Personality Disorders [13.2%] suggests that clinicians need to have a high index of suspicion for these conditions in **HIV-positive persons of color in the urban primary care setting**" (p. 376).

Blaney et al. (2004) analyzed data from interviews with 307 pregnant women living with HIV (71% African-American or black Caribbean, 20% Latino) and found that

[d]epressive symptomatology was considerable, despite excluding somatic items ... to avoid confounding from prenatal or HIV-related physical symptoms [and that] psychosocial factors significantly predicted the level of prenatal depressive symptoms beyond the effects of demographic and health-related factors. Perceived stress, social isolation, and disengagement coping [(i.e., giving up)] were associated with greater depression, positive partner support with lower depression. These findings demonstrate that psychosocial and behavioral factors amenable to clinical intervention are associated with **prenatal depression among women of color with HIV**. Routine screening to identify those currently depressed or at risk for depression should be integrated into prenatal HIV-care settings to target issues most needing intervention. (p. 405)

Florence et al. (2004) surveyed 166 women living with HIV in seven European countries and found that 25% reported moderate to severe **female sexual dysfunction (FSD)**. No single sexual disorder predominated in this sample, nor was dysfunction associated with any particular antiretroviral or antiretroviral combination. Rather, psychological distress (i.e., depression, irritability,

and anxiety) was the sole risk factor associated with sexual dysfunction in this sample. Furthermore, reductions in sexual functioning were reported to have occurred since the time of HIV diagnosis, but not since initiating antiretroviral treatment. While this study was not representative of all women living with HIV disease, the authors nevertheless conclude that "FSD is frequent among HIV-positive women. Antiretroviral treatments do not seem to play an important role in this syndrome, which is probably mainly driven by psychological factors. Sexual function of HIV-positive women should be regularly investigated in daily clinical practice by standardized and validated tools"⁴ (p. 556).

HIV Treatment News

Medical Care

On August 2, 2004, the U.S. Food and Drug Administration (FDA) announced the approval of two **fixed-dose combination (FDC) antiretroviral drug products** (i.e., two medications – in these cases, two nucleoside reverse transcriptase inhibitors [NRTIs] – in one pill) designed to simplify dosing regimens when treating adults with HIV infection:

o Epzicom™, composed of abacavir (ABC or Ziagen®) and lamivudine (3TC or Epivir®); and

o Truvada™, composed of tenofovir (TDF or Viread®) and emtricitabine (FTC or Emtriva™).

Each of these FDCs need only be taken once daily in conjunction with other antiretrovirals from different classes (i.e., non-nucleoside reverse transcriptase inhibitors [NNRTIs] or protease inhibitors [PIs]) (FDA, 2004a).

⁴ The instrument used in this study was the Female Sexual Function Index (FSFI; Rosen et al., 2000).

On August 3, 2004, the FDA approved Sculptra, a biodegradable, biocompatible, injectable synthetic filler to correct **facial lipoatrophy** (wasting), a condition that occurs in the context of HIV disease and its treatment. "Analysis indicated that the product significantly improved facial appearance, and was safe for restoration and/or correction of shape and contour deficiencies resulting from facial fat loss in patients with HIV/AIDS. ... After an initial treatment series, repeat treatments may be needed to maintain the correction. ... The studies also demonstrated significant improvement in quality of life, and measures of anxiety and depression, conditions which can be associated with lipoatrophy" (FDA, 2004b).

Though use of questionnaires, investigators in France (Spire et al., 2004) identified 327 people living with HIV who had experience with **efavirenz** (EFV or Sustiva®): 175 who took EFV for at least six months and 152 (46%) who discontinued its use between two and 10 months after initiation (median = 4 months). Discontinuation was independently associated with the following factors: being female, being unemployed, having a steady sexual partner, and having a history of multiple depressive episodes. Spire and colleagues urge clinicians to be mindful of "the neuropsychiatric risks of EFV during the first year, especially among patients with a history of multiple depressive episodes" (p. 558).

Psychiatric/Psychological/ Psychosocial/Spiritual Care Psychopharmacology

Rabkin, Wagner, McElhiney, Rabkin, and Lin (2004) conducted an eight-week, randomized, double-blind, placebo-controlled trial comparing the effects of **fluoxetine** (Prozac®; up to 60 mg/day), **testosterone** (up to 400 mg. injected intramuscularly on a biweekly ba-

sis), and a double placebo on symptoms of **depression and/or fatigue** in 123 men living with HIV/AIDS and diagnosed with a DSM-IV depressive disorder.

In intention-to-treat analyses, mood response rates were 54%, 47%, and 44% for fluoxetine, testosterone, and placebo, respectively. Among [the 90] completers, mood response rates were 70%, 57%, and 53%, respectively; in neither analysis were differences between treatments statistically significant. In contrast, testosterone was superior to fluoxetine and placebo for completers regarding fatigue. In intention-to-treat analysis, response rates were 39%, 56%, and 42% for fluoxetine, testosterone, and placebo, respectively, and for study completers, 41%, 63%, and 52%, respectively ... (p. 379)

Rabkin and colleagues conclude that, "[w]hile over 50% of patients treated with testosterone reported improved mood, this rate was not statistically superior to placebo. Thus, ... findings do not support prescription of testosterone as a first-line treatment for depressive disorders in HIV-positive men. However, if validated in additional studies, testosterone may be a useful option for medically ill men experiencing significant fatigue as well as depression" (p. 385).

Access to Care

Taylor, Burnam, Sherbourne, Andersen, and Cunningham (2004) conducted additional evaluation in 1997-1998 on a group of 1,489 individuals within a nationally representative sample of 2,864 adults receiving HIV medical care in 1996 and found that 70% of this sample was in need of mental health services based on a diagnosis of a nonsubstance use mental disorder and/or self-perceived need for men-

tal health services. During the preceding six-month period, 30% of these individuals received *no* mental health services, 16% received such services from their HIV primary care provider alone, and 54% received such services from a mental health specialist. Importantly, when compared to individuals with a mental disorder who did not perceive a need for mental health services, individuals who perceived such a need were more likely to receive mental health care in some form, and more often from a mental health specialist than an HIV primary care provider. Controlling for the severity of psychiatric symptoms, those seeing a specialist rather than a primary care provider were more likely to receive psychotropic medications and psychiatric hospitalization, as well as more mental health visits. "These findings emphasize **the high level of need for mental health services among person with HIV nationally**. ... Medical providers should be educated on the mental health needs and treatment of person with HIV" (p. 162).

Adherence to Treatment

Reynolds et al. (2004) surveyed a diverse sample of 980 antiretroviral-naïve individuals (82% male, 47% white) regarding their **adherence beliefs and self-efficacy** (i.e., the ability to take antiretrovirals as directed).

A greater belief in one's ability to adhere to antiretroviral therapy and confidence in the benefits of antiretroviral therapy were associated with higher quality of life and health functioning. More highly educated and younger individuals were more confident about the benefits of antiretroviral therapy and their ability to adhere. When age, gender, race, and education were controlled, greater role functioning, better perceptions of one's health, and lower stress

remained the strongest predictors of one's beliefs about antiretroviral therapy effectiveness and adherence. Social support also proved to be an important explanatory variable in the subset of participants who rated their support from family and friends. In the subset of individuals experienced with medications other than antiretrovirals, depressive symptoms were the strongest correlate of low adherence. (pp. 147-148)

While these associations were modest, "personal and situational factors, such as depressive symptoms, perceived stress, and lower education, were associated with less certainty about the potential for antiretroviral therapy effectiveness and one's perceived ability to adhere to therapy" (p. 148), suggesting the importance of "baseline screening for adherence predictors and focused interventions to address modifiable factors placing persons at high risk for poor adherence prior to antiretroviral treatment initiation" (pp. 141-142).

Analyzing data from 1,889 antiretroviral users participating in a survey involving a nationally representative sample of 2,864 adults receiving HIV medical care in 1996, Tucker et al. (2004) found that, "[i]n general, **HIV-positive patients with mental health or substance use problems** ... tended to report poorer adherence to [antiretrovirals] compared with patients without these problems. Associations with nonadherence were particularly strong among patients with multiple problems, whether it was drug use combined with heavy drinking or psychiatric problems combined with substance use" (pp. 367-368).

Turning to specific adherence barriers, the authors found that "[d]ifficulty getting medication was a significant mediator for the heavy

drinking group, and poor fit with lifestyle was a significant mediator for the drug use and heavy drinking group. ... Given that we controlled for indicators of socioeconomic status in all analyses ..., our findings suggest that the access problems

... are primarily due to the time and effort it takes patients with mental health and substance use problems to get their medications” (p. 368).

Although these barriers do not, in and of themselves, fully account for

nonadherence among those with mental health and substance abuse problems, Tucker and colleagues offer several recommendations to clinicians working to improve antiretroviral adherence in this population, including: 1) screening

Building Block

Research as Our Guide

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.

– Vision Statement, New Freedom Commission on Mental Health (*Executive Summary*, 2003, p. 1).

Responding to a charge “to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers, can implement” (p. 2), the President’s New Freedom Commission on Mental Health issued its final report in July 2003 entitled, ***Achieving the Promise: Transforming Mental Health Care in America***.

The Commission identified the following six goals as the foundation for transforming mental health care in America:

- Goal 1 – Americans understand that mental health is essential to overall health.
- Goal 2 – Mental health care is consumer and family driven.
- Goal 3 – Disparities in mental health services are eliminated.
- Goal 4 – Early mental health screening, assessment, and referral to services are common practice.
- Goal 5 – Excellent mental health care is delivered and research is accelerated.
- Goal 6 – Technology is used to access mental health care and information.

Each identified goal was accompanied by specific recommendations to facilitate this transformation.

In confluence with recommendations made by the Commission, and in recognition of the strategic relocation of this research update to the SAMHSA Web site, it bears noting that *mental healthAIDS* is contributing to this transformation by:

- o Presenting the most current mental health research on one of the world’s most pressing physical health problems [Goal 1];
- o Providing research information that might be accessed and utilized by consumers as well as providers in developing individualized plans of care [Goal 2];
- o Highlighting developments in the provision of culturally competent mental health care for people living with HIV [Goal 3];
- o Bringing current research information to even the most remote geographic settings through online access to this resource [Goal 3];
- o Emphasizing screening and integrated treatment strategies for those who are ultimately “triple-diagnosed” (i.e., presenting with HIV infection, mental disorder[s], and substance use disorder[s]) [Goal 4];
- o Disseminating, in a user-friendly format, research findings that reflect emerging best practices and form the building blocks for evidence-based, state-of-the-art medications and psychotherapies for use in providing care to adults, children, and families at risk for or living with HIV [Goal 5]; and
- o Making this wealth of information easily accessible to all through quarterly postings of *mental healthAIDS* on the Internet [Goal 6].

Readers – clinicians and consumers alike – are invited to carefully consider the findings reported in *mental healthAIDS* and how they might apply to work with people at risk for or living with HIV. With research as our guide, we can, together, envision a future when everyone with *HIV infection and a mental illness* will recover, a future when all *HIV infections and mental illnesses* can be prevented or cured, a future when all *HIV infections and mental illnesses* are detected early, and a future when everyone with *HIV infection and a mental illness* at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.

– Abraham Feingold, Psy.D., Editor

Reference

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Executive summary*. Rockville, MD: DHHS Pub. No. SMA-03-3831.

for and addressing underlying mental health and substance use problems; 2) focusing greater attention on helping clients – even those engaged in HIV primary care – obtain their medications (an issue rarely addressed in interventions), perhaps even arranging for the delivery of medications to ensure their availability; and 3) helping clients to better integrate treatment regimens into their daily routines.

Results from this study also suggest several strategies that are unlikely to be effective in reducing nonadherence [in this population]. Rates of nonadherence did not increase as patients' attitudes toward [antiretrovirals] became more negative; thus, there is no evidence from this study that efforts to identify patients with negative attitudes and modify these attitudes will have a significant impact on nonadherence. Our results further indicate that simply having a discussion with one's health care provider about how to remember to take [antiretrovirals] is insufficient to avoid nonadherence. However, it is possible that ongoing discussions with a health care provider that adequately address the patient's specific adherence problems may be beneficial, as should providing the patient with devices such as timers and alarms to help them remember to take their medication. (p. 368)

Continuing with this topic, Kempainen et al. (2004) interviewed 46 individuals living with both HIV and severe mental illness (SMI) and receiving day care services in Northern California and found, among other things, that persons with **bipolar disorder** reported greater difficulty with antiretroviral adherence due to their psychiatric symptoms than those with other psychiatric diagnoses. With regard to interven-

tion, "findings suggest that interventions traditionally used for improving compliance to psychiatric medications, such as behavioral skills training and memory enhancement interventions, may be effectively adapted to improve compliance to HIV therapies. For example, compliance interventions should help persons with SMI find ways of incorporating HIV medications into consistent daily routines or offer strategies for managing distractions that contribute to patterns of non-compliance" (p. 403).

Utilizing a 14-item, comprehensive measure of the "**routinization**" of daily behavior with 51 drug users living with HIV, Wagner and Ryan (2004) found that the extent to which daily activities are routinized and structured can be predictive of medication adherence.

Five activities that are a typical part of daily life for many patients and that were found to be associated with adherence included eating breakfast, watching a favorite television program, attending regularly scheduled meetings, sleeping overnight at home, [all associated with higher adherence,] and having friends over to visit [associated with lower adherence]. ... The composite score that combined these five activities, and represented the extent to which a patient's daily routine incorporated these specific behaviors, was highly correlated with adherence. (p. 390)

Wagner and Ryan conclude that "[t]he individual items of this scale as well as the 5-item composite measure ... can ... be used to predict adherence and inform strategies to enhance adherence via recommended changes in the patient's daily routine" (p. 392).

Klitzman et al. (2004) interviewed

142 adults living with HIV (52 MSM, 44 IDU men, 56 women) in four U.S. cities regarding **the interface of HAART use and HIV disclosure**. They found that

HIV disclosure and adherence to HAART can shape each other in several important ways. On the one hand, HAART can 'out' individuals, leading to efforts to disguise medications or alter treatment regimens, in turn potentially affecting adherence. The physiological effects of these medications – both good and bad – can also shape disclosure. Side effects can serve as a proxy for disclosure, and beneficial effects can make it easier to delay or avoid divulging one's status. Disclosure can also facilitate initiation and maintenance of treatment. Yet at times, the interplay between disclosure and adherence reveals a conflict of goals. The desire to stay healthy and fight HIV (by taking medications) may conflict with a desire to maintain privacy about one's HIV status (by not taking the medications around other people). Disclosure may also be a key variable in obtaining or mediating social support, which can be important in adherence. (p. 637)

The authors urge further investigation of this important interface.

Finally, Stone, Jordan, Tolson, Miller, and Pilon (2004) surveyed a convenience sample of 299 highly treatment-experienced HAART recipients regarding barriers to adherence and found that pill count, dosing frequency, and adverse side effects were perceived to have the greatest potential impact on adherence. In terms of actual regimens, study participants predicted that adherence would be "highest for a twice-daily (BID) regimen with 2 pills daily, no dietary restrictions, and 1

prescription and copayment and lowest for a BID regimen with 13 pills daily, food requirements, and 3 prescriptions and copayments” (p. 808). Interestingly, while once-daily (QD) dosing regimens were preferred, *they did not score better than other proposed regimens*. Based on this exploratory study, Stone and colleagues suggest that “[t]he **main principles for simplification of HAART** ... include the following: the fewer pills in a regimen the better, and 2 or fewer is the ideal; dosing frequency should be minimized, and once a day is the ideal; the requirement that pills be taken on an empty stomach or with food is a deterrent to adherence, and no dietary restrictions is the ideal; the fewer prescriptions, refills, copayments, and medicine bottles the better, and 1 prescription, refill, copayment, and bottle is the ideal” (p. 814).

Stress Management

Utilizing a sample of 90, largely African-American, women receiving HAART, Weaver et al. (2004) investigated the relationship between HIV-specific coping strategies and quality of life. They found that cognitive coping strategies (e.g., positive reframing) were associated with a higher quality of life, denial with a lower quality of life, and that both of these relationships were mediated by **perceived stress**. Interestingly, religious coping was unrelated to quality of life in this sample. Given that the use of particular coping mechanisms can raise or lower perceptions of stress, and “because perceived life stressfulness was significantly related to [quality of life], it is plausible that interventions such as cognitive-behavioral stress management (CBSM) that broadly target life stress may be successful in improving quality of life” (p. 182).

People manage stress in many ways – some healthy, some not. Reynolds, Neidig, and Wewers (2004) conducted two focus groups

with convenience samples of seven current and six former male smokers living with HIV and noted that respondents believed that **cigarette smoking** offered a variety of benefits to those who are living with HIV. Participants reported that smoking was emotionally comforting when feeling upset, depressed, under stress, or socially isolated. Moreover, they discounted the health risks of smoking, believing that these short-term emotional benefits outweighed short-term risks and reasoned that they would die before suffering the long-term health consequences of smoking.

With regard to intervention⁵, the authors reason that

[s]moking-cessation treatment may be most effective if it is suggested with a low-pressure approach and introduced near the time of HIV diagnosis when individuals are most receptive to making health behavior changes. Smoking-cessation strategies that integrate individualized counseling addressing belief systems with pharmacotherapy (including treatment for depression as indicated) would appear to have the greatest potential for success. Participants in this study clearly indicated that cigarette smoking was used to modify negative mood states. ... Thus, the possibility of an underlying mood disorder should be considered when initiating smoking-cessation treatment. (pp. 44-45)

Coping, Social Support, & Quality of Life

In London, Bor, du Plessis, and Russell (2004) interviewed 48, pre-

⁵ “The U.S. Public Health Service report *Treating tobacco use and dependence: A clinical practice guideline* has been updated to incorporate evidence of the efficacy of seven different smoking-cessation pharmacotherapies ...” (p. 45). Go to: <http://www.surgeongeneral.gov/tobacco/>

dominantly white, British-born, gay men and 40 of their caregivers (generally partners and friends) and noted that the interviews “demonstrate a circular or recursive relationship in **patterns of support**. Each person appears to take cues from the other in responding to one another. If one is seen to be coping well, this affects how others cope, and vice versa” (p. 186). Bor and colleagues recommend that “[t]herapists ... should first learn from the patient who he or she defines as ‘family’. They should also enquire about the impact of disclosure of illness on all care-givers as well as subsequent reactions and unexpressed feelings associated with this” (p. 167). “In the final analysis, whether [working with] a family, couple or individual, it is most useful to explore in therapy themes about coping, support, resilience and fears associated with abandonment” (p. 186).

Brashers, Neidig, and Goldsmith (2004) conducted six focus groups involving 29 men (all but one gay-identified) and four women to examine how social support makes the **management of uncertainty** regarding health, identity, and relationships easier or more difficult for people living with HIV or AIDS. They found that social support can facilitate uncertainty management by: “(a) assisting with information seeking and avoiding, (b) providing instrumental support, (c) facilitating skill development, (d) giving acceptance or validation, (e) allowing ventilation, and (f) encouraging perspective shifts” (p. 305). Supportive others were also found to impede uncertainty management through “a lack of coordination in uncertainty management assistance, the addition of relational uncertainty to illness uncertainty, and the burden of others’ uncertainty management” (p. 305). To manage the costs and complications of support from others, respondents

Tool Box

Positive & Positive: A Winning Combination?

Gonzalez et al. (2004) studied a convenience sample of 61 men who have sex with men and 29 low-income, primarily ethnic minority women receiving highly active antiretroviral therapy (HAART) and found that better medication adherence was associated with greater perceived social support and with **positive states of mind** (PSOM)¹, while higher depression scores were associated with nonadherence. The study showed as well that “PSOM was ... a significant mediator of the relationship between social support and medication adherence. Moreover, the relationship of PSOM to medication adherence was independent of depression, suggesting that PSOM represents more than the absence of depression ... [, and] that social support is related to medication adherence more through positive psychological processes than through negative ones” (p. 417).

How would this mechanism operate? Gonzalez and colleagues reason that “social support, through the stability, predictability, and control that it provides, may facilitate increases in PSOM in the support receiver. These positive factors may provide psychological resources to help HIV+ individuals cope successfully with the stressful aspects of taking HIV medication and may increase motivation to take medication as prescribed. These findings may be useful in the development of intervention strategies aimed at improving medication adherence among HIV+ individuals” (p. 417).

¹ “As a construct, PSOM is related to positive mood but is conceptually broader as it also includes one’s ability to attain and appreciate positive experiences related to general well-being” (Gonzalez et al., 2004, p. 414).

“develop[ed] an active or self-advocating orientation, refram[ed] supportive interactions, withdr[few] from nonproductive social situations, selectively allow[ed] others to be support persons, and maintain[ed] boundaries” (p. 305).

With these findings in mind,

The Big O

While PSOM is a psychological “state” and therefore subject to change, a related positive psychological “trait” is optimism. According to Strassle, McKee, and Plant (1999), optimism “has been found to be negatively correlated with depression, anxiety, anger, perception of daily hassles, physical symptoms, and job burnout, and positively correlated with life satisfaction, positive physical and mental health, lower frequencies of mental disorder, and self-esteem ...” (pp. 191-192). With so **many health advantages associated with**

optimism, “the ability to induce optimism in pessimistic individuals could have powerful implications for the mental and physical functioning of people managing the ongoing stress of a chronic illness” (Mann, 2001, p. 26).

In contemplating this prospect, it must be noted that there are two major theoretical models of optimism in the field: *explanatory style* optimism, which attributes negative events to external factors and relegates them to particular times or particular circumstances, and *dispositional* optimism, characterized

Cognitive-Behavioral Techniques Designed to Increase Optimism

(From Riskind, Sarampote, & Mercier [1996], as summarized by Pretzer & Walsh [2001])

o **Identify and modify dysfunctional “optimism-suppressing” beliefs** – “[A]n individual who holds a belief such as ‘I don’t deserve positive things or good outcomes’ or ‘Happiness, positive thinking, and optimism are illusions’ will be more prone to engage in optimistic thinking if the therapist can help him or her adopt an alternative view that supports optimism” (pp. 334-335).

o **Positive visualization** – “In this technique, the therapist asks the client to choose a problematic situation and to visually rehearse attaining a positive outcome. The client is instructed to imagine the outcome he or she would like to achieve rather than visualizing the outcome he or she expects and to visualize the specific steps needed to achieve these results. The visualization can specifically target the challenges the client would be likely to encounter in real life” (p. 335).

Two variations on this technique:

o **“Story board” technique** – “[T]he client is instructed to visualize a series of discrete scenes that lead to a desired outcome” (p. 335).

o **“Invulnerability training” technique** – “[T]he client ... visualize[s] feeling good about how he or she handled the situation when things do *not* turn out the way the client hoped they would” (p. 335).

“Riskind and his colleagues propose that when positive visualizations of these types are repeated across a variety of situations and different areas of life, there may be a point at which the effects of the visualizations generalize and have beneficial effects that are not confined to the specific situations visualized” (pp. 335-336).

o **“Silver lining” technique** – “[A] simple process in which the client is assigned the task of taking a negative experience and identifying one genuinely positive element in it. The client’s task is not simply to mouth positive platitudes but to identify genuinely positive aspects of the experience” (p. 336).

o **“Pump priming” technique** – “[B]y having individuals intentionally attend to experiences relevant to a schema they wish to encourage, to intentionally repeat relevant self-statements, or to visualize relevant stimuli, it may be possible to increase spontaneous attention to positive experiences ...” (p. 336).

Brashers and colleagues offer the following ideas about clinical intervention for both seekers *and* providers of support:

Given that supportive communication had the potential for positive and negative effects, ... [s]upport seekers and support

providers need to be aware that the successful management of uncertainty and stress involves coordination of complex goals and actions. Support providers can be taught about the broad range of behaviors that can facilitate uncertainty management, including such things as collabo-

by a general expectation of positive outcomes (Tomakowsky, Lumley, Markowitz, & Frank, 2001). "At this point, we know very little about how to either increase dispositional optimism, or decrease dispositional pessimism – and certainly many dispositional theorists would be pessimistic about change at this level" (Norem & Chang, 2001, p. 350). Nevertheless, some investigators have begun to explore ways of altering how people think about the future in an effort to modify this seemingly stable personality trait of dispositional optimism (Mann, 2001; see also sidebar).

Too Much of Good Thing?

Mann (2001) randomly assigned a racially- and ethnically-diverse sample of 40 low-income women living with HIV/AIDS and taking combination therapy to one of two conditions: writing about a "positive" future or not writing at all. Participants in the writing condition were instructed to write for a minimum of ten minutes twice weekly over a four-week period. These women received the following instructions:

You should write about a future in which you only have to take one pill each day for your HIV. When you sit down to write in the journal, I want you to think very hard about that future. What will that future be like? In what ways will that time be different than now? Think very hard about that future time, which is probably not so very far off. And then write about that time. Every day you can write about different aspect of that time. Or you can even repeat things if you need to. The important thing is that when you sit down for your ten minutes of writing, you should think for a little while about that time, so that it is clear in your head and fresh in your mind. And then write. (p. 27)

rating in information gathering and encouraging self-advocacy skill development. Support seekers can be taught strategies for managing dilemmas of social support, including how to select support providers and how to frame support situations. (p. 327)

Among the women who scored *low* on a measure of optimism², the writing intervention was associated with an *increase* in optimism, a trend toward increased medication adherence (based on self-report), and a reduction in distress from medication side effects in comparisons made with women who did not write. Importantly, **the opposite effects were found among women who scored high on the optimism measure prior to writing about a positive future.** Thus, Mann concludes that "dispositional optimism can be altered in a small but meaningful way" (p. 31) and that "a future-oriented writing intervention may be a promising technique to increase medication adherence and decrease symptom distress in pessimistic individuals [italics added]" (p. 26).

Not So Fast

Continued research on increasing optimism is clearly required. In the meantime, interventions must be conducted thoughtfully and, as Mann's research illustrates, assessment of baseline optimism, as well as a host of other variables, is critical.

Norem and Chang (2001) identify several key contexts to consider in understanding how optimism and pessimism serve the individual and contribute to emotional and behavioral outcomes. These include: the *type* of optimism/pessimism; their interface with other aspects of personality; the outcome variables being considered; and the specific interpersonal, social, cultural, and developmental contexts that serve as background for thoughts, feelings,

² The Life Orientation Test (LOT; Scheier & Carver, 1985) was used to assess dispositional optimism in the form of generalized positive outcome expectancies. A 1994 revision of this instrument may be found at: http://www.psy.miami.edu/faculty/ccarver/scLOT_R.html.

Rotheram-Borus, Lee, Lin, and Lester (2004) published findings from six years of an RCT originally involving 307 parents (largely single, Latino or African-American drug users, either active or in recovery) living with AIDS and their adolescent children (423 in all), assigned to either an intensive cognitive-be-

havioral coping skills intervention consisting of three modules (24 sessions; see: <http://chipts.ucla.edu>) or standard care. Over this period, slightly more than half (51.5%) of the parents died. Even with this loss, adolescents receiving the intervention, compared to those who did not, were: more likely to be em-

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behavioral coping skills intervention consisting of three modules (24 sessions; see: <http://chipts.ucla.edu>) or standard care. Over this period, slightly more than half (51.5%) of the parents died. Even with this loss, adolescents receiving the intervention, compared to those who did not, were: more likely to be em-

ployed or attending school, to report better conflict resolution and problem-solving skills in romantic relationships, to expect to have a partner with a good job, and to expect to be parenting in the context of a marriage; and less likely to be on welfare or to report psychosomatic symptoms. "Our data demonstrate the need to address the psychosocial challenges influencing parents with HIV and their adolescent children. Adolescents who were randomized to receive an intervention demonstrated better adjustment 6 years later at work, in school, and in their interpersonal relationships. The intervention provides a model for future psychosocial interventions to improve the outcome for young people affected by HIV" (p. 747).

Turning to affected children, Lightfoot and Rotheram-Borus (2004) examined **formal and informal custody planning** by 253 New York City parents living with HIV/AIDS (largely African-American and Latino mothers) for their 594 children and found that formal custody planning was more likely among parents using a positive action coping style, although parents whose coping strategies included "passive" problem solving, depressive withdrawal, social support-seeking, or a spiritual focus also engaged in formal custody planning. Those with higher parental self-esteem were more likely to engage in such planning, and emotional distress and substance use were not significantly related to planning. Although planning was more common among those with younger children, about half the parents had no formal custody plan in place at the time of assessment. Lightfoot and Rotheram-Borus conclude that, while parents "are informally planning for the custody of their children, this study suggests that interventions designed to facilitate the formation of a formal custody plan should ... [be imple-

mented and] focus on building proactive problem-solving skills. For example, helping parents break a problem into smaller pieces and evaluate its pros and cons would be important" (p. 467).

Lastly, Cook et al. (2004) followed

From the Block
Housing Works
<p>Founded in June 1990, Housing Works is presently the nation's largest community-based AIDS service organization. Housing Works' continuum of care consists of: prevention services, including New York City's largest community-based, intensive case management program and the Second Life Job Training program, New York State's first and most successful job training and placement program for homeless people living with HIV/AIDS; healthcare services, including three licensed AIDS Adult Day Health Care Programs [ADHCs] serving an average of 200 clients daily and two Congregate Residences, co-located with day programs, with 68 units of supportive housing; off-site housing development; advocacy and public policy services; and social ventures development, including four highly successful Housing Works Thrift Shops.</p> <p>CMHS/SAMHSA funding is permitting Housing Works to develop an Evening Mental Health Services Program in four locations to complement and extend its daytime Enhanced Mental Health Services Program, the latter funded through a Ryan White CARE Act Title II grant. Services include psychosocial evaluation, comprehensive psychological assessment, psychiatric consultation and medication evaluation/management, individual and group counseling, crisis intervention, and medication adherence services for individuals living with HIV/AIDS.</p> <p>The Principal Investigator is Errol Chin-Loy, BSN, MSN; the Project Director/Clinical Director is Jill Clockadale, CSW. For more information, please call 212/645-8111 x 201 or go to: http://www.housingworks.org/.</p> <p style="text-align: right;">— Compiled by the MHSC Program Coordinating Center</p>

1,716 women living with HIV on a semiannual basis at six sites over a seven-year period and found, when controlling for all other factors (i.e., use of antiretrovirals and adherence, substance abuse, mental health treatment, clinical indicators, and demographics), that death from AIDS was more likely among women who experienced **chronic depressive symptoms** and that such symptoms were more severe during the terminal phase of illness. Importantly, *use of mental health services was associated with a reduction in mortality*. Cook and colleagues conclude that "treatment for depression is a critically important component of comprehensive care for HIV-seropositive women, especially those with end-stage disease" (p. 1133).

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Tool Box

A Note on Content

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

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