

# 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 11, Issue 1 – Fall 2009

## Biopsychosocial Update

### HIV Prevention News

#### **About Adolescents & Young Adults**

Borowsky, Ireland, and Resnick (2009) “sought to determine the proportion of U.S. youth who anticipate a high likelihood of early mortality and relationships with health status and risk behaviors over time” (p. e81). The investigators

analyzed data from times 1 (1995), 2 (1996), and 3 (2001-2002) of the National Longitudinal Study of Adolescent Health, a nationally representative sample of youth in grades 7 through 12. . . . At time 1, 14.7% of the 20,594 respondents reported at least a 50/50 chance that they would not live to age 35. In adjusted models, illicit drug use, suicide attempt, fight-related injury, police arrest, unsafe sexual activity, and a diagnosis of HIV/AIDS predicted early death perception at time 2, time 3, or both. . . . Conversely, perceived early mortality at time 1 predicted each of these behaviors and outcomes, except illicit drug use, at time 2 or time 3, most strongly a diagnosis of HIV/AIDS . . . in young adulthood. (p. e81)

Borowsky and colleagues observe that

perceived risk for untimely death in adolescents is a powerful marker for involvement in health-

jeopardizing behaviors. The relationship between perceived risk for early death and involvement in risky behavior is a reciprocal one, with judgments of risk influencing behavior and health outcomes as well as behavioral experience affecting perceived risk. Given the significant association of **adolescents’ belief in premature death** with serious health behaviors and outcomes, . . . [clinicians] who work with youth . . . must tackle this unusually common negative view in addressing adolescent morbidity and mortality. . . . [S]creening adolescents for the perception of having a foreshortened life may serve as a useful approach for identifying both a pessimistic explanatory style and involvement in risk behaviors now and in the future. A question about perceived risk for death can be incorporated into a discussion of future school, work, and career plans and goals. This type of screening could provide an indicator of multiple issues that deserve attention and offer an opportunity to intervene to prevent risky behaviors and improve health outcomes. (p. e86)

On the topic of potentially risky behaviors, Lescano et al. (2009) “examined demographic, behavioral, relationship context, attitudinal, substance use, and mental health correlates of recent **heterosexual anal**

**intercourse** among [1,348 at-risk] adolescents and young adults who reported engaging in recent unprotected sex” (p. 1131). The investigators found that “recent heterosexual anal intercourse was reported by 16% of respondents. Females who engaged in anal intercourse were more likely to be living with a sexual partner, to have had 2 or more partners, and to have experienced coerced intercourse. For males, only a sexual orientation other than heterosexual was a significant predictor of engaging in heterosexual anal intercourse” (p. 1131). Lescano and colleagues stress that

open dialogue between providers and their young clients about anal intercourse is important. When asking young people about vaginal intercourse and protection behaviors, clinicians should also be aware of the prevalence of anal intercourse and screen for this behavior. In particular, clinicians should not presume that types of sexual behaviors and partner gender are consistent with defined sexual orientation. Thus, a detailed history of sexual behavior

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and all partner types is required. In addition, power in relationships and trauma from unwanted sexual intercourse are major factors and should be addressed in HIV-prevention interventions. Teaching adolescent girls and young women how to be assertive in sexual relationships – refusing unwanted sexual acts and negotiating for safer sex, whether anal or vaginal – is of the utmost importance. (pp. 1135-1136)

Seth, Raiji, DiClemente, Wingood, and Rose (2009) conducted audio computer-assisted self-interviewing (ACASI) with 715 African American female adolescents between the ages of 15 and 21 years and residing in a large southeastern city in the United States. These young women were also assessed for current sexually transmitted infections (STIs). The investigators found that, in this sample, “the overall prevalence of high levels of **psychological distress** was 44.5%” (p. 291). Further analyses

revealed that adolescents with high psychological distress, relative to those with low psychological distress, were more likely to test positive for a biologically confirmed STI, use condoms inconsistently, not use condoms during their last casual sexual encounter, have sex while high on alcohol or drugs, have male sexual partners with concurrent

female sexual partners, have low condom use self-efficacy, [low] partner sexual communication self-efficacy, [low] refusal self-efficacy and be more fearful of communicating with their partners. (p. 295)

Although these findings are preliminary, they suggest, according to Seth and colleagues, that

screening for psychological distress should be a part of regular health care maintenance and highlights the importance of assessing psychological distress among African-American female adolescents engaging in high-risk sexual behaviour. By coordinating medical care with mental health services, early detection of potential mental and physical health problems will be facilitated. Because psychological resources serve as a protective agent against the effects of these risk factors, there is a need to identify and intervene early rather than dismiss these symptoms as transitory experiences. HIV intervention programs should increasingly be geared towards increasing psychological resources and coping mechanisms to buffer against potential negative consequences of psychological distress. (p. 298)

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

Johnson, Scott-Sheldon, et al. (2009)

examined “the **efficacy of behavioral interventions to reduce HIV for African Americans** among 78 randomized controlled trials [(RCTs)] that sampled at least 50% African Americans (N = 48,585, 81% African American), measured condom use or number of sexual partners, and provided sufficient information to calculate effect sizes” (p. 492). “Studies that fulfilled the selection criteria and were available by June 1, 2006 were included” (p. 493). The investigators determined that, “compared with controls, participants who received an HIV risk reduction intervention improved condom use at short-term, intermediate, and long-term assessments” (p. 492). In fact,

sexual risk reduction interventions were efficacious in increasing condom use over durations as long as 3 years post intervention. . . . Condom use improved more when studies sampled more people living with HIV, more MSM [men who have sex with men], and when intervention content was extensive and contained interpersonal skills training. . . . Under ideal circumstances, intervention success increased at longer intervals after the intervention. In particular, interventions with multiple sessions and more time per session as well as those that achieved high-retention rates exhibited greater efficacy at long intervals. . . . Moreover, the evidence suggests that interventions increase condom use, and for young samples assessed at long-term intervals, interventions succeeded in decreasing the number of partners. . . . Parallel to condom use outcomes, interventions were successful at reducing numbers of sexual partners when they provided sufficient interpersonal skills training. (pp. 496-497)

According to the investigators, “the fact that interpersonal skills training

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– providing content that assists participants to negotiate safer sex – lowered risk both in terms of condom use . . . and in terms of number of partners . . . suggests the importance of a skills training component. Whereas the risk reduction effect on condom use accrued regardless of dose, the effect on number of partners required larger doses of interpersonal skills training ( . . . [e.g., 90 minutes per session])” (p. 498).

Johnson, Scott-Sheldon, and colleagues point out that “these results pertain only to efficacy rather than effectiveness. RCTs are highly controlled to assure strong internal validity, but they usually include conditions that are not ordinarily present in a local community ( . . . [e.g., incentives to return for multiple sessions). . . . Community evaluation trials take what is known from intervention trials and attempt to translate these strategies into policies and organizational plans. Results may vary at the point of translation” (p. 499). Also important, according to the investigators, is acknowledgment that “any attempts to implement a successful intervention among African Americans must address social and structural issues relevant to the community” (p. 499). “Poverty, homelessness, incarceration, limited access to quality health care, lack of medical coverage, and other socioeconomic issues create a context that confers considerable risk for HIV and other STDs [sexually transmitted diseases]” (p. 498).

Continuing the evaluation of data compiled by the Healthy Living Project Team (2007; see the [Summer 2007](#) issue of *mental health AIDS* for details), Rotheram-Borus et al. (2009) examined the efficacy of this “individually delivered, skill-focused, case-management intervention” (p. 1105) “in reducing risky sexual behavior and substance use among adults with HIV infection who were **marginally housed** (i.e.,

homeless at some point over a 37-month period)” (p. 1100). The investigators

had previously conducted a[n RCT] with 936 adults living with HIV infection. In that study, 3 intervention modules of 5 sessions each addressed different goals: reducing risky sexual acts and drug use, improving the quality of life, and adhering to healthful behaviors. Participants were interviewed at baseline and at 5, 10, 15, 20, and 25 months; 746 completed 4 or more assessments. In this study, . . . [the investigators] analyzed sexual behavior and drug use outcomes for the 35% (n = 270 of 767) of participants who were considered marginally housed. (p. 1100)

“Compared with consistently housed adults living with HIV,” Rotheram-Borus and colleagues found, “these marginally housed adults were more likely to be African American or Latino, uninsured, and less educated; to have been in jail; and to have a history of injection drug use” (p. 1105). Nevertheless, “among the marginally housed participants, there were significantly greater reductions in unprotected risky sexual acts, the number of sexual partners of HIV negative or unknown serostatus, alcohol or marijuana use, and hard drug use among the intervention group than among the control group” (p. 1100).

In their conclusion, Rotheram-Borus and colleagues observe that,

although a program with 15 sessions sounds intensive, changing daily routines is difficult. The cognitive, affective, and behavioral skills taught in the Healthy Living Project are the same across modules. Participants were taught skills to apply in the situations targeted in the module: maintaining health and interact-

ing with health providers, reducing the numbers of risky sexual acts and the amount of drug use, and improving mental health. Because of the repeated application of problem-solving approaches to diverse content areas, participants were prepared to apply these skills in future situations. (p. 1106)

### **About Men Who Have Sex With Men**

In their continuing analysis of data from the multisite, multiyear EXPLORE Study,<sup>1</sup> Mimiaga et al. (2009) examined “the longitudinal association between CSA [**childhood sexual abuse**] and HIV infection, unprotected anal sex, and serodiscordant unprotected anal sex, as well as mediators of these relationships among a large sample of HIV-uninfected MSM” (p. 340). Among 4,295 study participants, the investigators found that 39.7% reported a history of CSA. Moreover, participants with a history of CSA were more likely to engage in unprotected anal sex as well as serodiscordant unprotected anal sex. In turn, Mimiaga and colleagues observed “a predictive relationship between a history of CSA and higher rates of HIV infection among HIV-uninfected MSM, when controlling for study arm, study site, age at enrollment, education, and race/ethnicity. This finding extends previous research that has documented higher rates of CSA among HIV-infected MSM by identifying CSA as a risk factor for HIV infection in an HIV-uninfected sample of MSM” (p. 343). Moreover, the investigators discerned that “among participants reporting CSA, the EXPLORE intervention had no effect in reducing HIV infection rates. . . .

<sup>1</sup> “The EXPLORE Study was a behavioral intervention trial conducted in 6 U.S. cities over 48 months with HIV infection as the primary efficacy outcome” (Mimiaga et al., 2009, p. 340). For more information about this study, see Chesney et al. (2003), summarized in the [Summer 2003](#) issue of *mental health AIDS*.

[T]hese findings provide good initial evidence that the presence of CSA history in MSM interferes with their ability to derive benefit from traditional HIV prevention interventions" (p. 344).

Attempting to understand this lack of response among MSM with histories of CSA, Mimiaga and colleagues observe that,

in this study, depression was significantly more prevalent among MSM with a history of CSA relative to those without. In addition, MSM with a history of CSA versus those without were more likely to use illicit substances and alcohol. . . . The coexistent untreated depression and increased substance use that are often associated with sexual risk-taking behavior in this population need to be addressed in future HIV prevention interventions to decrease further infection, acquisition, or transmission of HIV and other STIs.

Notably, individuals with a history of CSA compared with those without reported (1) lower self-efficacy for adopting safer sex behaviors, (2) poorer communication skills regarding safer sex, and (3) lower social norms that favor safer sex. . . . [In short, t]he cognitive and behavioral consequences of CSA can affect many of the psychosocial variables that have been used to explain HIV risk taking. . . . CSA and the resulting negative emotions and negative beliefs about oneself, for example, can interfere with self-efficacy, perceived social norms about sexual risk taking, and the perceived costs and benefits of condom use and norms and attitudes. (pp. 344-346)

The investigators further reason that the EXPLORE intervention, which

included some skills building but was predicated on participants' perceptions that they could change their behavior, might not have been robust enough to change patterns of internalized anger, depression, and lack of self-efficacy that may have been long standing in the participants who experienced CSA. . . . Future behavioral interventions for this group of at-risk MSM may need to incorporate counseling and skills building that address the traumatic memories and coping strategies that ensue after young men are abused, given the high prevalence of these childhood experiences and their role in potentiating sexual risk-taking behavior. (p. 346)

Wilton et al. (2009) "evaluated the efficacy of *Many Men, Many Voices* (3MV), a small-group HIV/STI prevention intervention developed by Black MSM-serving community-based organizations and a university-based HIV/STI prevention and training program" (p. 532). "3MV is a **small group intervention that addresses behavioral and social determinants and other factors influencing the HIV/STI risk and protective behaviors of Black MSM.** . . . A unique component of 3MV is the development of menus of behavior change options for HIV/STI prevention rather than a singular emphasis on condom use that is common in other HIV prevention interventions for MSM" (p. 535).<sup>2</sup>

<sup>2</sup> "Session 1 (*The Culture of Black MSM*) helped participants recognize how racism and homophobia are related to sexual and substance use risk behaviors. Session 2 (*STI/HIV Prevention for Black MSM*) described the roles of 'Tops' and 'Bottoms' as they relate to sexual relationship dynamics and the risk of STI and HIV transmission. Session 3 (*STI/HIV Risk Assessment and Prevention Options*) helped participants personalize their own risk by building a menu of behavioral options (e.g., abstinence, mutual monogamy between two HIV seronegative partners, consistent condom use) to reduce HIV/STI transmission risk.

"The study sample included 338 Black MSM of HIV-negative or unknown HIV serostatus residing in New York City. Participants were randomly assigned to the 3MV intervention condition ( $n = 164$ ) or wait-list comparison condition ( $n = 174$ )"

Session 4 (*Intentions to Act & Capacity for Change*) enhanced participants' intentions to change their own risky behaviors, and guided them toward safer sex behaviors. During Session 5 (*Relationship issues: Partner selection, Communication & Negotiation*), participants recognized power and control dynamics in their relationships, and were encouraged to select and implement a relationship-focused risk reduction behavior change option with their partner(s).

## Tool Box

### Books & Articles

Arnold, E.M., & Rotheram-Borus, M.J. (2009). Comparisons of prevention programs for homeless youth. *Prevention Science, 10*(1), 76-86.

"There are six HIV prevention programs for homeless youth whose efficacy has been or is currently being evaluated: STRIVE, the Community Reinforcement Approach, Strengths-Based Case Management, Ecologically-Based Family Therapy, Street Smart, and AESOP (street outreach access to resources). . . . A comparison of . . . [these] programs . . . identifies the robust components of each and suggests which programs providers may choose to replicate" (p. 76).

Bauermeister, J.A., Tross, S., & Ehrhardt, A.A. (2009). A review of HIV/AIDS system-level interventions. *AIDS & Behavior, 13*(3), 430-448.

"System-level interventions refer to programs aiming to improve the functioning of an agency as well as the delivery of its services to the community. . . . We reviewed studies focusing on system-level interventions . . . [and found that m]ost . . . studies focused on strengthening agency infrastructure, while other studies included collaborative partnerships and technical assistance programs. Our findings suggest that system-level interventions are promising in strengthening HIV/AIDS prevention and treatment efforts. Based on our findings, we propose recommenda-

(p. 532). Data were collected at baseline, 3 months, and 6 months post-intervention. According to Wilton and colleagues, "relative to comparison participants, 3MV participants reported significantly greater reductions in any unprotected anal inter-

Session 6 (*Social Support & Problem Solving to Maintain Change*) involved participants role-playing communication and negotiation strategies, provided peer support to promote problem solving, and identified effective risk-reduction strategies if relapse should occur. Information about the 3MV intervention is available from the Center for Health and Behavioral Training (<http://www.urmc.rochester.edu/chbt/>)" (Wilton et al., 2009, pp. 535-536).

tions for future work in developing and evaluating system-level interventions" (p. 430).

Brogan, K., & Lux, J. (2009). Management of common psychiatric conditions in the HIV-positive population. *Current HIV/AIDS Reports*, 6(2), 108-115.

This article comprises "a discussion of treatment considerations derived from recent literature, as well as a consideration of judgments that clinicians may make in the absence of available data. The use of antidepressants, stimulants, mood stabilizers, and antipsychotics is discussed, as are precautions that must be taken with the HIV population when using these medications, not only because of side effect vulnerability, but because of significant drug-drug interactions" (p. 108).

Davies, S.L., Horton, T.V., Williams, A.G., Martin, M.Y., & Stewart, K.E. (2009). MOMS: Formative evaluation and subsequent intervention for mothers living with HIV. *AIDS Care*, 21(5), 552-560.

"The Making Our Mothers Stronger (MOMS) Project is a randomized controlled behavioral trial, comparing a [six-session, group] stress-reduction and social support intervention (Healthy MOMS) to a parenting skills intervention (Parenting Skills for MOMS) for mothers living with HIV. Outcomes include maternal mental and physical health, parenting behaviors, and children's behavior. To ensure that these interventions were tai-

course [(UAI)] with casual male partners; a trend for consistent condom use during receptive anal intercourse with casual male partners; and significantly greater reductions in the number of male sex partners and greater increases in HIV testing. This study is the first randomized trial to demonstrate the efficacy of an HIV/STI prevention intervention for Black MSM" (p. 532).

In Sydney, Australia, Zablotska et al. (2009) explored the concept of "seroguessing" (serosorting based on the assumption of HIV seroconcordance) and casual [UAI] (UAIC) associated

lored to the needs of HIV+ mothers, extensive formative work was conducted with members of the intended audience and relevant service providers. . . . Initial anecdotal responses from participants suggest that the Healthy MOMS intervention addresses several salient issues for the growing population of HIV+ mothers who can benefit from long-term support in adapting to this chronic disease" (p. 552).

Ferrando, S.J. (2009). Psychopharmacologic treatment of patients with HIV/AIDS. *Current Psychiatry Reports*, 11(3), 235-242.

"This paper reviews the literature on psychopharmacologic treatments of key psychiatric disorders in HIV/AIDS as well as differential diagnosis and drug-drug interactions" (p. 235).

Fisher, J.D., & Smith, L. (2009). Secondary prevention of HIV infection: The current state of prevention for positives. *Current Opinion in HIV & AIDS*, 4(4), 279-287.

Fisher and Smith "provide a state-of-the-science review of the literature on secondary prevention of HIV infection or 'prevention for positives' (PfP) interventions" (p. 279).

Gonzalez, J.S., Hendriksen, E.S., Collins, E.M., Durán, R.E., & Safren, S.A. (2009). Latinos and HIV/AIDS: Examining factors related to disparity and identifying opportunities for psychosocial intervention research [Review]. *AIDS & Behavior*, 13(3), 582-602.

"Latinos living with HIV are a rapidly growing group, are more severely im-

with **seroguessing**" (p. 501) among two cohorts: one that enrolled 729 HIV-positive gay men and another that enrolled 1,427 HIV-negative gay men. Zablotska and colleagues found that "HIV-positive men knew partners were seroconcordant in 54% and assumed it in 13% of sex encounters (42[%] and 17% among HIV-negative men). Among HIV-positive men, the likelihood of UAIC was higher when a partner's status was known . . . and assumed seroconcordant *because of seroguessing* . . . compared with unknown. Among HIV-negative men, the likelihood of UAIC was also higher when a partner's

pacted by HIV than whites, and confront unique challenges in coping with HIV/AIDS. A body of research suggests that depression, substance abuse, treatment adherence, health literacy, and access to healthcare may be fruitful targets for intervention research in this population. Though limited, the current literature suggests that psychosocial interventions that target these factors could help reduce HIV/AIDS disparities between Latinos and whites and could have important public health value" (p. 582).

Halkitis, P.N. (2009). *Methamphetamine addiction: Biological foundations, psychological factors, and social consequences*. Washington, DC: American Psychological Association. From the publisher: "*Methamphetamine Addiction* presents a biopsychosocial perspective on this drug addiction, taking into account the biochemistry of the drug, the predispositions and behavioral patterns of the individual user, and the effects of the drug on the immediate and wider social environments of these drug users. . . . Two contributed chapters, one from a physician and the other from a counseling psychologist, provide details on working compassionately and effectively with methamphetamine users in healthcare settings."

Hatcher, S.S., Toldson, I.A., Godette, D.C., & Richardson, J.B., Jr. (2009). Mental health, substance abuse, and HIV disparities in correctional settings: Practice and policy implications

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for African Americans [Commentary]. *Journal of Health Care for the Poor & Underserved*, 20(2A), 6-16.

"This paper has three sections: (1) mental health; (2) substance abuse; and (3) HIV/AIDS. Each section summarizes current treatment issues unique to correctional settings, and provides recommendations for enhancing programs and policy to meet the needs of Black people who have been arrested, detained, incarcerated, paroled, or released. Further, we make recommendations for how interdisciplinary researchers and health care/treatment providers can engage in science-guided advocacy to address these issues and reduce related disparities experienced by people of African ancestry" (p. 6).

Hoffman, A.C., Starks, V.L., & Gritz, E.R. (Eds.). (2009). The impact of cigarette smoking on HIV/AIDS [Supplement]. *AIDS Education & Prevention*, 21 (Suppl. A), 1-121.

"This special supplement . . . features original, peer-reviewed works by invited authors. . . . [B]iomedical and health-related outcome data are presented, including interactions of smoking with the course and progression of HIV and mortality outcomes, and the

impact of smoking on HAART [highly active antiretroviral therapy] effectiveness. Mediating factors that have the potential to affect medication adherence in HIV-positive smokers are also highlighted. Finally, the topic of smoking cessation interventions for HIV-positive smokers is addressed . . . , including rationale, behavioral and psychological characteristics, and cessation strategies. The importance of stimulating and supporting additional research in this area is underscored" (p. 2).

Lewis, J.E., Miguez-Burbano, M.-J., & Malow, R.M. (2009). HIV risk behavior among college students in the United States. *College Student Journal*, 43(2 Part B), 475-491.

"This article updates our 1997 review that examined the literature on HIV risk behavior among college students. . . . As reported in our original review, the majority of students continue to have multiple sex partners, use condoms inconsistently during intercourse, and have a tendency to combine alcohol and/or other drugs with their sexual experiences. They remain very knowledgeable about the virus and routes of basic transmission, but that does not impact condom use. Communication among partners about safer sex con-

tinues to be limited. . . . Enhancing self efficacy should be an important focus for intervention strategies among students, given consistent evidence for its impact on lowering risk for HIV transmission. Additional evidence-based recommendations for strategies to prevent the spread of HIV within the college population are provided" (p. 475).

Norman, L.R., Basso, M., Kumar, A., & Malow, R. (2009). Neuropsychological consequences of HIV and substance abuse: A literature review and implications for treatment and future research. *Current Drug Abuse Reviews*, 2(2), 143-156.

"This review provides an overview of the neuropsychology of HIV and substance abuse and the extant research that has examined the effects of both HIV disease and substance use on neuropsychological functioning and implications for treatment and future research" (p. 143).

Norton, W.E., Amico, K.R., Cornman, D.H., Fisher, W.A., & Fisher, J.D. (2009). An agenda for advancing the science of implementation of evidence-based HIV prevention interventions. *AIDS & Behavior*, 13(3), 424-429.

status was known . . . and assumed seroconcordant . . . compared with unknown" (p. 501). Moreover, "whether men directly discussed serostatus with their . . . partners or seroguesed did not seem to affect the decision to engage in UAI" (p. 505).

In their discussion, Zablotska and colleagues reinforce an observation also made by Sheon and Lee (2009; see the [Summer 2009](#) issue of *mental health AIDS*):

The consequences of seroguessing may be of more importance for HIV-negative men. For them, HIV serostatus disclosure itself has a different meaning than for HIV-positive men. HIV-negative test results are not absolute; a false HIV-negative result remains possible if the test was done in

[the] seroconversion window. Furthermore, HIV-negative serostatus after testing is uncertain if men have engaged in risk practices since their last HIV test. . . . Seroguessing adds additional uncertainty about the possible risk. As a result, some of the risk reduction afforded by HIV-negative serosorting may be reversed by a high degree of seroguessing. . . .

For men engaging in anal intercourse, condom use still remains the best method of HIV prevention, but when condoms are not used, recommendations should encourage direct HIV disclosure and active risk reduction as opposed to seroguessing and passive risk taking. Policies and programs encouraging disclosure should address

issues of stigma and discrimination due to HIV serostatus and build skills in HIV discussion among both HIV-positive and HIV-negative people. . . . Education and prevention programs should address the fact that HIV-negative men who engage in UAI due to assumptions of seroconcordance may be at high risk of HIV infection. (pp. 505, 508)

With regard to disclosure, Serovich, Reed, Graftsky, and Andrist (2009) analyzed "pilot data from a newly developed **disclosure intervention** and associated measures specifically tailored for disclosure to casual sexual partners. Treatment consisted of a four-session, theoretically driven intervention focusing on the costs and benefits of disclosure"

"The objective of the current paper is to highlight select and initial areas of research that are critically needed to advance the state-of-the-science of implementation of HIV prevention interventions in our broader efforts to curb the epidemic worldwide" (p. 424).

Paul, R.H., Sacktor, N.C., Valcour, V., & Tashima, K.T. (Eds.). (2009). *HIV and the brain: New challenges in the modern era*. Totowa, NJ: Humana Press. From the publisher: "Written by a panel of leading experts," this volume "offers a clear picture of brain impairment associated with the virus with particular focus on three emerging areas including different genetic strains of the virus throughout the world, interactions between advanced age and HIV, and the impact of HIV on the brain in the context of chronic, long-term treatment with . . . HAART." The book "provides a comprehensive review of both basic science and clinical implications in these important areas."

Robinson-Papp, J., Elliott, K.J., & Simpson, D.M. (2009). HIV-related neurocognitive impairment in the HAART era. *Current HIV/AIDS Reports*, 6(3), 146-152. "In this review, we address the nature of HIV-related neurocognitive impair-

ment in the HAART era, including its etiology, pathology, appropriate diagnostic tools for clinical practice and research, and rational treatment approaches" (p. 146).

Rotheram-Borus, M.J., Ingram, B.L., Swendeman, D., & Flannery, D. (2009). Common principles embedded in effective adolescent HIV prevention programs. *AIDS & Behavior*, 13(3), 387-398.

"Each interpersonally delivered, evidence-based (EB) program for HIV prevention shares common features that aim to shift HIV risk behaviors. We used qualitative research methods to examine manuals from five EB programs for adolescents and identified 10 core principles embedded in each program's activities. Principles reflect the stated goals and anticipated lessons in an activity. The principles were: *Believe in your own worth and your right to a happy future; Commit to change; Distinguish fact from myth; Plan ahead and be prepared; Practice self-control; Know pleasurable alternatives to high risk activities; Negotiate verbally, not nonverbally; Evaluate options and consequences; Show concern for others; Choose to limit your own freedom; and Act to help others protect themselves*. Focusing on common features

rather than the unique properties of each EB program may allow community providers to have more flexibility and ownership in adapting EB programs, and may also facilitate development of new EB program[s]" (p. 387).

Rotheram-Borus, M.J., Swendeman, D., Flannery, D., Rice, E., Adamson, D.M., & Ingram, B. (2009). Common factors in effective HIV prevention programs. *AIDS & Behavior*, 13(3), 399-408.

"We propose a set of common factors in [EB] interventions (EBI) for HIV prevention, which cut across theoretical models of behavior change. Three existing literatures support this agenda: (1) Common factors in psychotherapy; (2) core elements from the Centers for Disease Control and Prevention EBIs; and (3) component analyses of EBI. To stimulate discussion among prevention researchers, we propose a set of common factors at the highest level of abstraction that describe what all effective programs do: (1) establish a framework to understand behavior change; (2) convey issue-specific and population-specific information necessary for healthy actions; (3) build cognitive, affective, and

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(p. 207).<sup>3</sup> In the study, 77 MSM living with HIV "were randomized into one of three conditions (wait-list control, facilitator only, and computer and facilitator)" (p. 207). Serovich and colleagues report that

group comparisons at baseline, postintervention, and 3-month postintervention suggested that only participants in the facilitator-

<sup>3</sup> "Session 1 of this intervention included an introduction to the project, goal setting, an assessment of disclosure strategies or tactics utilized, and disclosure triggers (e.g., partner age or attractiveness). Session 2 focused on the costs and benefits of disclosing and exercises designed to minimize costs and maximize benefits. Session 3 focused on the evaluation and testing of different strategies for disclosing as well as strategies for managing reactions. Session 4 was a continuation of the session 3 activities with an additional focus on learning more strategies and rehearsal" (Serovich et al., 2009, p. 210).

only group experienced decreases in scores on all three disclosure subscales. Effect sizes for these score reductions were large for the disclosure behavior scale, moderate for disclosure attitudes, and small for disclosure intentions. Similar effects of treatment were not observed in the computer-and-facilitator group. The facilitator-only group also reported decreased frequencies of unprotected sex (anal, oral, and vaginal) over time, and mean frequencies among wait-list and computer-and-facilitator groups increased. Further research is needed to ascertain what components of the intervention delivered maximum benefits. (p. 216)

Serovich and colleagues conclude that "facilitated administration of the

pilot intervention was effective in reducing mean scores on the HIV disclosure behavior and attitude scales and that these reductions were both statistically and practically significant" (p. 207).

In an exploratory study, Semple, Zians, Strathdee, and Patterson (2009) looked into the phenomenon of **sexual marathons**, "defined as prolonged sexual activity over hours and even days" (p. 583) among a convenience sample of 341 methamphetamine- (meth) using MSM who were living with HIV. Semple and colleagues found that 84% of the men in this sample "reported engaging in marathon sex while high on [meth]" (p. 583), "and that risk behaviors, including unprotected anal and oral sex, were common among sexual marathon partici-

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behavioral self-management skills; (4) address environmental barriers to implementing health behaviors; and (5) provide tools to develop ongoing social and community support for healthy actions. A focus on common factors will enhance research on new HIV prevention interventions, encourage collaboration among researchers, provide guidelines for adapting EBI, and simplify and speed the adoption of EBI for providers” (p. 399).

Senn, T.E., & Carey, M.P. (2009). HIV testing among individuals with a severe mental illness: Review, suggestions for research, and clinical implications [Review article]. *Psychological Medicine*, 39(3), 355-363. “The goals of this review are: to summarize knowledge about HIV testing prevalence, correlates, and interventions among individuals with [a severe mental illness]; to identify research needs; and to discuss clinical implications of the studies reviewed” (p. 355).

Stone, V., Ojikutu, B., Rawlings, M.K., & Smith, K.Y. (Eds.). (2009). *HIV/AIDS in U.S. communities of color*. New York: Springer.

From the preface: “The goal of this book is to provide a comprehensive guide to the HIV/AIDS epidemic among U.S. racial/[ethnic] minorities, including prevention strategies and clinical management of those living with HIV/AIDS. We hope to provide expert perspectives on how to approach the care of diverse minority populations with HIV/AIDS, many of whom may have other life challenges and often several other clinical conditions – ranging from Hepatitis C to depression or pregnancy. . . . We hope that this resource will lead to better understanding of the needs of racial/ethnic minorities with HIV/AIDS and ultimately improved HIV care and outcomes in U.S. communities of color” (n.p.).

Sullivan, E.V. (Ed.). (2009). Special section of *Neuropsychology Review* on HIV/neuroAIDS. *Neuropsychology Review*, 19(2), 143-249.

“This special section of *Neuropsychology Review* . . . lends an historical . . . and world perspective . . . on the evolution of the infection as affecting the

[central nervous system] . . . , its relevance to cognitive neuropsychology . . . , and the influence of neuropsychological [(NP)] impairment on activities of daily life. . . . The effects of comorbidities on [NP] functioning are detailed . . . as are sex differences in expression of [NP] deficits and comorbidities affecting the course of HIV infection. . . . Each paper is rich in its review and provides synthetic considerations for an understanding of the behavioral neuroscience of the disease” (p. 143).

Wenzel, S.L., D’Amico, E.J., Barnes, D., & Gilbert, M.L. (2009). A pilot of a tripartite prevention program for homeless young women in the transition to adulthood. *Women’s Health Issues*, 19(3), 193-201.

“Among young women who are impoverished and homeless, the transition to adulthood (ages 18-25) is associated with alcohol and drug use, risky sexual activity, and increased risk of being victimized by intimate partner violence. . . . ‘The Power of YOU,’ a program using motivational interviewing (MI), was designed to address these problems.<sup>1</sup> . . . Results from this pilot suggest that ‘The Power of YOU’ may hold promise in helping homeless young women in the transition to adulthood make healthier choices and plan for high-risk situations, and that the nonconfrontational, nonjudgmental approach of MI appeared appropriate for this population” (p. 193).

Werkmeister Rozas, L., & Smith, E. (2009). Being on this boat: The provision of culturally competent mental health services to people living with HIV/AIDS. *Journal of HIV/AIDS & Social Services*, 8(2), 166-187.

“This article reports on an evaluation study of a mental health program for people living with HIV/AIDS. Findings suggest that social service agencies need to be responsive to all aspects of a client’s identity. Implications for practice with this multidimensional population are also discussed” (p. 166).

— Compiled by  
Abraham Feingold, Psy.D.

<sup>1</sup> This intervention model was introduced in the [Summer 2009](#) issue of *mental health AIDS*.

(Biopsychosocial Update -- continued from Page 7)

pants” (p. 587). In addition, “men who engaged in marathon sex used significantly more illicit drugs, were more likely to use sildenafil (Viagra®) and amyl nitrates [‘poppers’], and scored higher on a sexual compulsivity scale compared to men who did not engage in marathon sex. In multivariate analyses, use of sildenafil in the past two months was significantly correlated with participation in sexual marathons” (p. 583). According to the investigators,

the high prevalence of sexual marathons among HIV-positive [meth] users suggests the need to address this activity in safer-sex counseling programs. Because of the potentially life-threatening consequences of HIV transmission, it is imperative that HIV-positive individuals who engage in sexual marathons use condoms properly and consistently with their HIV-negative and serostatus-unknown partners. HIV-positive individuals who engage in sexual marathons also need to be educated regarding the risks associated with prolonged sexual activity, including the increased likelihood of tearing delicate oral and rectal tissue and the increased risk of “condom failure” due to prolonged friction. (pp. 587-588)

Expanding on the “three categories of psychosocial and behavioral factors that distinguished between men who engaged and those who did not engage in sexual marathons: reasons for [meth] use; use of other drugs in addition to [meth], including sexually enhancing drugs; and sexual compulsivity” (p. 588), Semple and colleagues offer this additional advice to clinicians:

Current motivations for [meth] use, primarily sexually-oriented motivations, differentiated individuals who engaged in marathon



sex from their counterparts who did not. This finding suggests that clinicians should explore with their clients the possible connections between motivations for [meth] use and risky marathon sex. Motivational Interviewing [(MI)] is one clinical approach that can help individuals gain insight into the psychological and physiological processes that motivate risk behaviors. . . . Establishing a link between motivations for [meth] use and risky sex in the context of sexual marathons is a first step toward positive behavior change (e.g., condom use) and safer sex behavior goals.

MSM who participated in sexual marathons also used a significantly larger number of illicit drugs and were more likely to report using sildenafil and amyl nitrates in the past two months as compared to men who did not participate in sexual marathons. Similar to [meth], sildenafil and amyl nitrates . . . have been associated with enhanced sexual experience, prolonged sexual performance, and unprotected insertive and receptive anal sex. . . . Counselors working in prevention and intervention programs should clarify with their clients the extent to which sexually enhancing drugs promote or facilitate high risk sexual behaviors during sexual marathons. Counselors should also ascertain whether clients who engage in sexual marathons are polydrug users and, if they are, seek to increase clients' insight into the ways in which sexually-enhancing drugs might be promoting or facilitating the clients' choices of specific sexual behavior roles.

Sexual compulsivity was another characteristic associated with participation in marathon sex. Although some research suggests that pharmacological treat-

ment of impulsivity might help to reduce or abate drug use and sexually compulsive behaviors . . . , the current standard of treatment for impulsive behavior is psychological counseling. Cognitive behavioral therapy (CBT) strategies are often used to help individuals identify and correct cognitions that contribute to impulsive behavior. CBT also teaches coping strategies that help individuals to manage or self-regulate impulsive risk-taking behaviors. (p. 588)

### **About Women**

"Women with histories of incarceration show high levels of risk for HIV and intimate partner violence (IPV)" (p. 509), according to Weir et al. (2009). These investigators conducted an "[RCT] with women at risk for HIV who had **recent criminal justice system involvement (n = 530)**" and "evaluated two interventions based on **[MI] to reduce either HIV risk or HIV and IPV risk**" (p. 509). In brief,

MI is both directive in that the interventionist guides conversation with the participant toward specific topics, and client-centered in that the client's experiences, views, and reluctance or readiness to change are central topics of discussion. Interventionists employ feedback to help participants notice the discrepancy between participants' current actions and actions participants wish to take. Interventionists offer empathic listening to participants while supporting their self-efficacy and assisting them in resolving their ambivalence regarding current behaviors and regarding behavior change. (p. 510)

Weir and colleagues remind us that MI "and its brief adaptations, often described as Motivational Enhancement (ME), have been demonstrated to facilitate HIV preventive behavior

in a number of studies" (p. 510). The investigators suggest that

because of its focus on the resolution of ambivalence, the MI framework may also hold value in working with women who experience partner violence. Clients in an MI approach are invited to identify the potential costs and benefits of various courses of action, including costs and benefits of maintaining their current status quo. Clients are asked non-judgmentally how ready they are to move toward new courses of action, reasons for their readiness, and reasons for their reluctance. . . . Typically women in violent relationships . . . describe their relationships in ambivalent terms; for example, they express two-sidedness toward leaving their relationship or remaining in it. . . . Feelings of anxiety and attributions of self-blame may also coexist with women's thoughts of leaving violent relationships. . . . It is reasonable to expect, then, that an effective intervention framework for women facing partner violence could be an approach such as MI which supports women to identify and resolve mixed feelings about these relationships. Additionally, the client-centered nature of MI means that interventionists call clients' attention to the successful steps clients take toward their own well-being. This is intended to facilitate a sense of self-efficacy among clients. . . . Thus it is reasonable to expect an MI-based approach could help women facing partner violence to feel more capable of protecting themselves. To date, however, there are no reported findings of randomized trials to test the effectiveness of MI-based interventions for the prevention of partner violence. (pp. 510-511)

As noted above, in this RCT, the

investigators test two interventions based on MI. "The first intervention entails ME for HIV risk reduction and for addressing life stability issues. The second intervention entails ME for HIV risk reduction, for the reduction of exposures to IPV, and for addressing life stability issues. This study compares the effects of these two interventions on HIV sex risk behaviors, HIV drug risk behaviors, and IPV, compared to the standard HIV counseling and testing services offered by a local county health department" (p. 511).

Of interest is the fact that the interventionists who implemented the ME groups in this study were not trained counselors, but rather community health specialists "hired partly on the basis of their competence as reflective listeners as observed during an interview role-play and their experience working with marginalized populations of women" (p. 512).

"Baseline and 3, 6, and 9-month follow-up assessments measured unprotected intercourse, needle sharing, and IPV" (p. 509) among study participants. In these assessments, Weir and colleagues found that "the intervention groups had significant decreases in unprotected intercourse and needle sharing, and significantly greater reductions in the odds and incidence rates of unprotected intercourse compared to the control group. No significant differences were found in changes in IPV over time between the HIV and IPV group and the control group" (p. 509). The investigators conclude that this study "provides strong evidence that interventions based on MI can be efficacious in reducing unprotected intercourse, and some evidence that such interventions may be efficacious in reducing needle sharing. Additional studies are needed to explore the long-term impact of such interventions and to explore the utility of briefer interventions employing a[n] ME framework" (p. 520).

## **HIV Assessment News**

### ***Psychiatric Assessment***

Martinez, Hosek, and Carleton (2009) screened "HIV-positive youth between the ages of 13 to 24 consecutively enrolled in an adolescent and young adult HIV clinic between 1998-2006 ( $n = 174$ ), . . . for **mental health disorders and violence**, using the Client Diagnostic Questionnaire (CDQ).<sup>4</sup> All youth subsequently had diagnostic interviews conducted by psychologists" (p. 469). The sample was "comprised of mostly African American and Latino youth" (p. 473). According to the investigators, the CDQ and diagnostic interviews revealed the following:

Violence reported by youth occurred in several forms: physical assault/abuse (24% in childhood; 19% as adolescents), sexual abuse/assault (28% in childhood; 15% as adolescents), dating violence (i.e., physical abuse by sexual partner) (18%), and family violence (44%). Females . . . [in this sample were more likely to have experienced] sexual abuse [than males]. . . . Psychological disorders included: major depressive disorders (15%), generalized anxiety disorder (17%);

<sup>4</sup> "The CDQ is a brief assessment tool designed to identify clients who may have mental health needs. It is a modification of the PRIME-MD, an instrument developed for screening mental health disorders in primary care settings. The CDQ screens for lifetime experience[s] . . . with violence (witnessing and experiencing violence, inclusive of family violence and sexual abuse), depression, anxiety disorder, including PTSD, and psychosis, as well as alcohol or drug abuse or dependence. The CDQ was developed for persons living with HIV or at high risk of infection. The screening tool has been used in a variety of service sites including medical clinics, multi service community organizations, and homeless shelters. Screenings take 15-20 minutes to complete. . . . Use of the CDQ provides a baseline assessment of mental health functioning and indicates which clients need additional mental health services, either further assessment or direct referral for treatment by a clinician" (Martinez et al., 2009, pp. 470-471).

posttraumatic stress disorder ([PTSD] 28%); alcohol abuse disorder (19%); and substance abuse disorder[, primarily cannabis abuse] (31%). (p. 469)

Further analysis revealed that

physical assault in childhood was significantly associated with meeting criteria for major depressive disorder . . . and PTSD. . . . Physical assault in adolescence/young adulthood was significantly associated with a diagnosis of panic disorder . . . and PTSD. . . . [A]ll findings remained significant when correcting for multiple analyses, with the exception of the finding [described below] linking witnessing family violence to major depression.

Childhood sexual assault before age 12 was not predictive of having a particular [psychiatric] diagnosis. However, . . . experiencing sexual assault before or after age 12 was significantly associated with at least one of the diagnoses screened for in this study (major depressive disorder, anxiety disorder, panic disorder, psychotic disorder, PTSD, alcohol or drug abuse . . .). Specifically, sexual victimization as an adolescent or young adult was associated with a diagnosis of PTSD. . . . Witnessing family violence was significantly associated with a diagnosis of major depressive disorder . . ., generalized anxiety disorder . . ., PTSD . . ., and drug abuse . . ., but not with alcohol abuse. No violent exposure type was associated with the development of a psychotic disorder. (p. 472)

Yet "the more violent events a youth experienced, the more likely were youth to have major depressive disorder and psychotic disorder" (p. 473).

Martinez and colleagues conclude that "failure to provide screening, assessment and treatment of mental health symptoms, make[s] HIV [primary care] treatment difficult, especially when considering the problems that HIV-positive youth have with adherence to medical appointments and with antiretroviral regimens." Moreover, the high rates of physical and sexual abuse among this cohort "highlight the association between abuse and risks for HIV. . . . From a secondary prevention perspective, addressing these issues as part of a comprehensive interdisciplinary treatment plan may reduce rates of reinfection and acquisition of resistant strains of HIV, [and] thereby enhance more optimal treatment outcomes and quality of life for HIV-positive youth" (p. 473).

Tsao and Soto (2009) "examined the prevalence and correlates of **pain** in 162 HIV-positive persons diagnosed with mood and/or anxiety disorders and substance use disorders" (p. 307). The investigators found that "HIV-positive persons with diagnosed mood/anxiety and substance use disorders reported substantially higher levels of pain than the general population and HIV-positive persons without these comorbid conditions" (p. 307). Tsao and Soto point out that these

differences in reported pain were substantial and clinically meaningful. The key correlates of increased pain in the current sample were the presence of mood disorder, older age, and CD4 counts below 200. Of note, the presence of mood disorder accounted for the largest share of unique variance associated with pain, suggesting that mood disorders may be a key marker for pain among triply diagnosed HIV-positive individuals. The current findings support the need for an enhanced focus on the identification and treatment of pain

among HIV-positive persons. (p. 311)<sup>5</sup>

## **HIV Treatment News**

### **Medical Care**

"On July 8, 2009, FDA [U.S. Food and Drug Administration] granted approval to ISENTRESS (**raltegravir**), for the treatment of HIV-1 infection in treatment-naïve patients. The recommended dose for treatment-naïve adult patients is ISENTRESS 400 mg twice daily, with or without food" (FDA, 2009). As described in the [Winter 2008](#) issue of *mental health AIDS*, raltegravir was first approved by the FDA in 2007 "for use in combination with other antiretroviral agents in the treatment of antiretroviral-experienced adults with drug-resistant strains of HIV" (FDA, 2007).

### **Psychiatric/Psychological/ Psychosocial/Spiritual Care**

#### **Adherence to Treatment**

Dutch investigators (Vervoort, Grypdonck, de Grauwe, Hoepelman, & Borleffs, 2009) interviewed 30 Caucasian men and women receiving HIV care in Belgium or the Netherlands "to explore and clarify the **underlying processes which lead to (non)-adherence behavior** in patients treated with highly active antiretroviral therapy (HAART)" (p. 431). The investigators found that adherence

is mainly influenced by the experience of being HIV positive. Acceptance or non-acceptance of HIV leads to one of two basic stances toward adherence: "being determined to be adherent" or "medication is subordinate to other priorities in life". This stance determines the commitment to therapy and influences how patients cope with adherence. Patients who are determined to be

<sup>5</sup> For more information on the treatment of pain among persons living with HIV, see the **Tool Box** in [this issue](#) of *mental health AIDS* entitled "Psychotherapy Select: The Science of Matching Clients to Treatment."

adherent find solutions to adherence problems. Patients who are not determined to be adherent solve problems only if the solution does not compromise important aspects of their lives. (p. 431)

Vervoort and colleagues suggest that

the basic stance should be examined before HAART is started. . . . In acceptors, it is meaningful to start preparing for treatment and adherence early. For all patients the choice of medication needs to be based on what fits best into their lifestyle. The acceptors need practical advice on how to behave in specific situations when obstacles occur. Both patients and providers should be aware that routine can have both positive and negative effects.

For non-acceptors, if medically possible, the focus should be on helping the patient to accept the place of the disease in life before starting HAART. If this is not possible or if the role of HIV in life remains unaccepted, attention should be focused on minimizing interference and increasing skills to minimize conflicts. Patients should be prepared to deal with situations that threaten adherence. It can be helpful to anticipate . . . problematic situations. Proactive coping . . . using "if then" questions can be helpful. . . .

The regimen has to be discussed on a regular basis to detect adjustments and information should be repeated. (p. 437)

Spanish investigators (Fumaz et al., 2009) "evaluated the prevalence of **menstrual disorders** [i.e., irregular cycles and/or amenorrhea] in HIV-1-infected women and explored the association between such disorders and adherence to antiretroviral therapy [(ART)], sexual functioning,

and depressive symptoms in a group of [107] HIV-1-infected women aged younger than 46 years and on [ART]" (p. 463). Fumaz and colleagues found that "menstrual disorders were present in one third of the HIV-infected women . . . surveyed. . . . The women with menstrual disorders had lower levels of treatment adherence, reported a decline in their sexual interest and were dissatisfied with their sexual functioning. More than half of the women with menstrual disorders attributed these abnormalities to the use of [ART] and most women with this belief had inadequate adherence to [ART]" (p. 466). Notably, "depressive symptoms were not observed" (p. 463) among the women surveyed. The investigators suggest that "patients' beliefs about antiretroviral medication and about other health disorders that may appear alongside infection should be explored before establishing strategies of intervention in clinical practice, particularly when adherence is seen to be lacking" (p. 467).

Through AIDS service organizations in New York and Ohio, Johnson, Heckman, Hansen, Kochman, and Sikkema (2009) recruited 244 adults living with HIV who were 50 or more years of age and conducted ACASI and a neuropsychological (NP) battery. The investigators found that NP functioning and antiretroviral adherence were not associated. Instead, results "supported a stress and coping model, with negative affect mediating the effects of social support and maladaptive coping on ART adherence" (p. 541). On the basis of these findings, Johnson, Heckman, and colleagues conclude that

interventions aimed at improving adherence in HIV-infected older adults are more likely to be successful if social support, adaptive coping strategies, and affect are enhanced. This study underscores the importance of social support in influencing health be-

haviors and health outcomes, and supports the use of group interventions focused on coping enhancement and alleviating psychological distress. . . . Additionally, study results suggest that healthcare providers should regularly assess affect and encourage patients to seek social support. For example, online or telephone-based support groups may provide isolated or stigmatized older adults with opportunities to interact with HIV-seropositive peers who face the unique challenges of aging with HIV. (pp. 548-549)

#### Service Engagement, Retention, & Utilization

Kupprat, Dayton, Guschlbauer, and Halkitis (2009) conducted "a retrospective, longitudinal analysis of case management and medical charts . . . to evaluate **utilization of support group, mental health, and substance abuse treatment services among [46] HIV-positive women in New York City**" (p. 874). The investigators analyzed 4,134 case management and supportive service transactions and found that 70% of study participants "utilized support groups over the two-year study period. In contrast, only 35% utilized mental health services (therapy) and of those identified as using substances, only 48% utilized substance abuse treatment services" (p. 874). Kupprat and colleagues observe a "high prevalence of mental illness (63%,  $n = 29$ ) and substance use (54%,  $n = 25$ ) in the sample" and suggest that these "low utilization rates highlight unmet needs for service" (p. 874).

Of particular interest is the finding of "significant differences . . . in utilization of mental health and substance abuse treatment services, with those who received services at a medical model agency (integrated care) being more likely to receive both types of treatment. In contrast, participants

attending support groups in non-medical model agencies (77.8%,  $n = 7$ ) were significantly more likely to be retained in group (i.e., attend 11 or more sessions) than those at medical model agencies (39.1%,  $n = 9$ )" (p. 874). "Based on the higher utilization rates of support groups among seropositive women," the investigators reason that "these groups could be a vehicle for establishing rapport between mental health professionals and group members to bridge the utilization gap and reduce the stigma associated with therapy and substance abuse treatment services" (p. 874). To that end, Kupprat and colleagues suggest that service providers could develop standards for group leaders

that included: (1) being a licensed mental health professional; and (2) having baseline HIV/AIDS knowledge. While there are cost implications for staffing groups with licensed therapist[s] versus peers, the benefits may include: (1) inclusion of therapeutic practices in support groups; (2) increased exposure to both the mental health professional and therapeutic process; and (3) reduced stigma of receiving therapy. This latter issue is particular[ly] important for racial and ethnic groups . . . who[,] because of their culture, may be reluctant to receive tradition[al] therapy.

With non-medical model agencies excelling at retaining clients in support group[s] and medical model agencies better linking clients to therapy and substance abuse treatment services, perhaps . . . a collaboration would allow for sharing of best practices. Providing seamless support group, therapy, [and] substance abuse treatment in addition to integrating HIV-prevention messages and practices into physical and mental health

screenings and treatment can be a form of both primary and secondary HIV prevention for women. (p. 879)

In another small study involving peer providers, Naar-King, Outlaw, Green-Jones, Wright, and Parsons (2009) “utilized . . . **MI . . . to improve youth retention in [HIV] primary [and reproductive health] care** and compared the fidelity and outcomes of **peer outreach workers (POW)** to **masters level staff (MLS)**” (p. 868). The investigators randomized 87 youth living with HIV (YLH), predominantly African American and between the ages of 16 and 29 years, to receive two sessions of MI from either a POW or MLS. Audio-taped sessions, 37 in all, were coded for fidelity, with the finding that “POW had higher fidelity on two . . . scales, and did not differ from MLS on [the] remaining three scales. While both groups improved the regularity of primary care appointments, the effect size for POW on retention in care and intervention dose was larger than that of MLS. The results suggest that POW can provide MI with quality comparable to MLS with adequate training and supervision” (p. 868). Naar-King and colleagues conclude that

this pilot study presented preliminary evidence that not only can peer staff be trained to show equivalent competency and outcomes, but that in the context of MI to promote engagement of youth in care, POW may provide better services. Although this pilot study was not powered to find significant differences, . . . POW showed significantly higher fidelity on two . . . behavior counts and a moderate effect on retention in care compared to the MLS condition. With only two therapists per condition, extreme cases may strongly affect results. . . . However, the data demonstrate that outreach workers may

be trained to provide MI with adequate fidelity to a marginalized population with documented poor retention in health care. . . .

These data suggest that MI may be useful to engage marginalized populations in primary and reproductive health care as both groups improved their retention in care as evidenced by fewer gaps in care following intervention. However, studies comparing MI to an attention control are necessary. . . .

There are immediate implications for those settings where outreach workers are already providing . . . services such as in HIV counseling and testing, STI screening, breast cancer screening, and substance abuse pre-treatment services. Integrating MI into these services may further promote behavior change. As outreach workers and other community health workers are expected to provide evidence-based services in the public health domains, adopted models of behavior change counseling must include quality assurance protocols such as specified training, ongoing coaching, and fidelity monitoring to ensure quality service delivery. (pp. 871-872)

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

Returning to data compiled by the Healthy Living Project, the RCT involving a 15-session, individually delivered, cognitive-behavioral intervention “designed primarily to reduce HIV transmission risk behavior” (p. 556; reintroduced in [this issue of mental health AIDS](#)), Carrico et al. (2009) analyzed data from the full, diverse sample of 936 adults living with HIV infection to identify treatment effects on **psychosocial adjustment**. Of the 15 intervention sessions, five

that dealt with executing effective coping responses were delivered between baseline and the 5 months post-randomization. Additional assessments were completed through 25 months post-randomization. Despite previously documented reductions in HIV transmission risk, no intervention-related changes in psychosocial adjustment were observed across the 25-month investigation period. In addition, there were no intervention effects on psychosocial adjustment among individuals who presented with mild to moderate depressive symptoms. More intensive mental health interventions may be necessary to improve psychosocial adjustment among HIV-positive individuals. (p. 555)

Fekete, Geaghan, and Druley (2009) “examined associations between the receipt of **positive and negative health-related social control** (i.e., influence) from a primary network member, affective and behavioural reactions (i.e., behaviour change) to social control, and psychosocial well-being in a cross-sectional study of 91 HIV+ men living with HIV” (p. 501). According to the investigators, “compared to control that is exerted using negative strategies (e.g., pressuring, criticising), control that is exerted using positive strategies (e.g., persuading, encouraging) is more effective in changing health behaviours without arousing negative affect. . . . Positive control strategies have been associated with positive affective reactions, behaviour change and feelings of appreciation, whereas negative control strategies have been associated with negative affective reactions and resistance to changing behaviours” (p. 502).

In their study, Fekete and colleagues found that “when men received social control that was encouraging and motivating, they engaged in more

## Tool Box

### Psychotherapy Select: The Science of Matching Clients to Treatment

The careful screening and selection of suitable candidates for therapy is a critical task for psychotherapists, according to Ogrodniczuk, Joyce, and Piper (2009), who contend that

with thorough assessment and appropriate placement, there is a better match between a patient's capacities or strengths and the demands of the specific treatment. Thus, it is expected that the likelihood of missed sessions and premature termination will be reduced, and the probability of a favorable outcome will be increased.

. . . The selection procedure results in a decision as to whether the patient is offered psychotherapy or not, and if so, the type of therapy and format. . . . Ideally, psychotherapists should have some guidelines and criteria for the selection of patients that are supported by research evidence. (p. 427)

In this **Tool Box**, a new instrument for identifying individuals who are "ready" for therapy is introduced. The discussion then centers on research findings that can help to promote productive matches between clinicians and clients. These findings also can help clinicians to select the type of therapy that holds the greatest promise for a positive clinical outcome. The **Tool Box** concludes with a focus on the development of an HIV-related pain management intervention and client characteristics associated with beneficial results.

self-care behaviours, more active coping efforts and experienced fewer depressive symptoms. In contrast, receiving control that was critical or intrusive was associated with fewer self-care behaviours and more depressive symptoms. In addition, . . . men's negative affective reactions and behaviour change in response to receiving control accounted for the relationship be-

### Ready (or Not)

Among the "general selection criteria (i.e., selection criteria that may be relevant to several types of psychotherapy or patient populations . . . [and] must be present or met in order for psychotherapy to be a viable option for treating a patient's problem)," Ogrodniczuk and colleagues focus their investigation on individuals' "readiness" for psychotherapy. Readiness "refers to a patient being psychologically prepared to undertake the tasks associated with engaging in, and utilizing the provisions (the therapeutic alliance, the therapist's interventions) of psychotherapy." Importantly, Ogrodniczuk and colleagues "perceive readiness for psychotherapy as distinct from the stages of change . . . that are described by the Transtheoretical Model of Change" (p. 427).<sup>1</sup>

To address the absence of a widely accepted instrument for use by clini-

<sup>1</sup> "According to the transtheoretical model, behavioral changes occur in a series of discrete states. Regardless of treatment participation, and in relation to virtually any problem behavior, the states include precontemplation (not thinking about change), contemplation (thinking about change), action (behavioral change), and maintenance (maintaining change). . . . The stages of change have . . . been interpreted as a person's readiness for change. It is assumed that ascending through the stages reflects a greater 'readiness' to change a particular behavior. Readiness to change thus refers to preparedness to change a particular problematic behavior (e.g., smoking). This differs from our conceptualization of readiness for psychotherapy, which refers to preparedness to engage in a specific activity, regardless of the problem that a person has. Thus, we do not believe they are synonymous constructs. A person may have a high level of preparedness to change a certain behavior, but be ill-prepared to engage in psychotherapy as a means to change that behavior" (Ogrodniczuk et al., 2009, pp. 427-428).

tween different types of control strategies and men's health" (p. 510). Additionally, the investigators found that

behaviour change in response to social control may differ in men who are depressed and men who are not depressed. Men who received negative social control engaged in more behaviour

change only if they were not at risk for being clinically depressed. . . . It could be that men who were not depressed did not interpret negative control efforts as being overly intrusive, and thus did not experience resistance to changing their behaviours. In contrast, when men were depressed and their primary supporter criticised or nagged them about changing

Factor 1, Disinterest, reflects lack of interest or desire for psychotherapy, thus representing a negative indicator of readiness. This conclusion is supported by the negative correlations between Disinterest and the 3 other factors. . . . Factor 2, Perseverance, reflects willingness to work in therapy. . . . [T]hose with a willingness to meet the demands of therapy, make reasonable sacrifices, and generally demonstrate resolve are likely to be more committed to attend sessions and collaborate with the therapist, ultimately leading to greater benefit from psychotherapy. Factor 3, Openness, represents willingness to discuss personal matters with a therapist. It may also reflect a person's capacity for trust. Revealing what are often painful feelings and experiences represents one of the most critical tasks for patients in psychotherapy. Psychotherapy, a talk therapy, simply cannot succeed if . . . [people are] unwilling to talk about their problems. Factor 4, Distress, represents concern about one's problems. Level of distress is the characteristic of readiness most frequently described in the literature. . . . Most authors contend that a person

must experience a certain degree of suffering before he or she can commit to psychotherapy. Some authors, however, caution that too much distress can impede a person's ability to engage in the activities of psychotherapy. . . . Given the positive correlations that Distress had with Perseverance and Openness, . . . [Ogrodniczuk and colleagues] believe that it represents a positive indicator of readiness. Collectively, these factors appear to reflect a person's psychological state of being ready to commit to, meet the demands of, and engage in the tasks of psychotherapy. (p. 431)

The investigators also arrived at "a total Readiness score[, which] may be derived from these factors using the following formula: [Perseverance + Openness + Distress] - Disinterest" (p. 430). Ogrodniczuk and colleagues stress, however, that clinicians must not

lose sight of the central importance of the components of readiness. While 2 people may have the same overall readiness score, it is possible that their component scores differ markedly. This is particularly important when faced with a patient who has a low degree of readiness. To facilitate readiness for this person (e.g., through pretherapy preparation), . . . [clinicians] need to know what is contributing to this person's lack of readiness. The component scores would be critical in . . . this task. Thus, the factor scores, not an overall score, were of primary interest . . . when examining the psychometric properties of the scale. (p. 431)

their health behaviours, they experienced reactance and failed to engage in any sort of behaviour change. . . . [T]hese results provide more support for the need to identify those most at risk for developing clinical depression, as they may not interpret social interactions in the same way as individuals who are not at risk for being depressed. (p. 511)

Continuing this focus on psychometric properties, Ogrodniczuk and colleagues "found evidence for the convergent validity of the scale, as there were significant, meaningful associations with patients' treatment preferences and self-determination. . . . [There was also] evidence supporting the discriminant validity of the scale. There was minimal association with theoretically distinct constructs such as age, sex, previous psychiatric treatment, social desirability, general psychiatric distress, and internal locus of control" (p. 431).

Finally, the investigators stress that "patients identified as 'not ready' for psychotherapy should not necessarily be considered inappropriate for psychotherapy. Rather, pretherapy preparation interventions may be used to enhance their readiness for psychotherapy. The RPI could be used to evaluate the effectiveness of pretherapy preparation interventions" (p. 432).

#### **What Makes a Matchless Match?**

Once general selection criteria are satisfied, a client must be matched with a treater and with a treatment approach. Van Manen et al. (2008) observe that:

treatment selection in clinical practice is a poorly understood, often largely implicit decision process . . . [and that] effectiveness of treatment would likely substantially benefit from evidence-based treatment selection strategies. Currently, there is only a modest evidence base for these strategies (Links & Stockwell, 2001; Vervaeke & Emmelkamp, 1998). In fact, several studies have indicated that treatment selection is instead (partly)

Fekete and colleagues conclude that "social control may be effective in promoting healthier behaviours only when it does not simultaneously arouse negative affect" (p. 511). "Positive strategies such as encouragement and persuasion appear to be preferable to negative strategies such as pressure and coercion because they elicit desired changes in behaviour without arousing nega-

guided by non-evidence-based factors such as the availability of treatment facilities . . . , personal experience and strong belief (or faith . . . ), and sociodemographic variables (e.g., employment status, health insurance status . . . ). This situation likely results in an inefficient usage of the available resources. Furthermore, treatment selection based on these rationales can be noneffective or even harmful (Beutler, 2000). (p. 711)

A decade earlier, Vervaeke and Emmelkamp (1998) reached the same conclusion, noting that psychotherapy research has yielded "few prescriptions for treatment selection backed by cumulative evidence," the simple fact being that "treatment selection as such is seldom the topic of study. Further, guidelines for the practitioner concerning treatment selection have rarely been formulated. . . . As a consequence, in daily practice the practitioner's favorite treatment (or the treatment that is favored by most of the team members) is still frequently applied irrespective of the problem that presents or the specific patient who requests psychological treatment" (p. 50).

In an attempt to remedy this omission, Vervaeke and Emmelkamp summarize research findings to offer clinicians the following guidelines for treatment selection:

A match between patient and therapist on the following dimensions should be considered to enhance treatment effectiveness. Autonomous patients treated by non-directive therapists profit less

*(Tool Box is continued on Page 16)*

tive affect. This combination of more behaviour change and fewer negative affective reactions is likely to be associated with better health behaviours and psychosocial well-being, which may ultimately prevent disease progression and increase longevity in HIV+ individuals" (pp. 512-513). With regard to psychosocial interventions, findings from this study suggest that

teaching individuals how to positively appraise involvement from their network members or how to cope with social control interactions that are intrusive or overbearing may alleviate some of the negative affect experienced after receiving negative social control. Moreover, if individuals with HIV learn how to solicit the type of involvement they desire from their social network, they may ultimately receive more positive and less negative control. Psychosocial interventions have yet to address the issue of social control; however, cognitive behavioural stress management interventions that address the

importance of improving interactions with social network members have found that increases in social support are associated with better coping skills and less distress in [men living with HIV]. (pp. 511-512)

Finally, as Dodd et al. (2009) point out,

previous research has shown that depression and depressive symptoms are associated with negative health outcomes for individuals with HIV infection. However, very little research has investigated the possible relationship between depressive symp-

toms and HIV-specific disease processes in women. This is a significant gap in the literature because the relationship between depression and specific HIV disease outcomes may help to explain the associations that have already been demonstrated between depression and more global outcomes, such as HIV progression and mortality. By identifying the specific disease processes that may underlie the previously demonstrated link between depression and HIV progression and mortality, specific screening and interventions can be tailored to provide the most effective and compre-

*(Tool Box -- continued from Page 15)*

from therapy than when treated by directive therapists. Matching on interpersonal compatible styles between therapist and client (similar levels of friendliness and contrasting levels of dominance) may also enhance outcome. Furthermore, matching on cognitive style and locus of blame seems to enhance continuation. Finally, gender similarity of patient and therapist may enhance therapeutic change among female clients[,] especially among . . . [those who have experienced sexual assault].

With respect to the attitude during treatment selection the following suggestions can be made: (a) the attitude has to be directed at facilitating the therapeutic alliance which includes explicit attention to possible difficulties in the therapeutic interaction [already in evidence] during the first encounter . . . , a thematic . . . focus on the here-and-now, a challenging and rather distant – then intimate – attitude . . . , and a negotiation[-]based intervention strategy based on expectations and preferences of both – the patient and therapist – directed toward agreement on the therapeutic tasks and goals, and (b) the attitude has to include an openness for discussion with the patient concerning potential problems . . . [engaging] in a relationship with a therapist.

With respect to the choice of therapeutic technical intervention, in general, it can be recommended that treatments that have been proven to be effective for certain disorders are to be preferred above treatments that are supposed to be effective too, but for which controlled studies to support such claims are lacking. . . . In the case of most anxiety disorders and severe forms of depression, CBT [cognitive-behavioral therapy] is without any doubt the most proper treatment.

In some patients, however, a more differentiated approach is required. Although, in general, patients with mild to moderate depression are treated equally effective[ly] by means of imipramine [an antidepressant] and clinical management, CBT[,] and IPT [interpersonal therapy], the following nuances are noteworthy. CBT leads to better results in patients with less disturbed cognitive dysfunctions, patients who are rather avoid[ant,] . . . and patients who do not have an explicit request with respect to improving their interpersonal functioning. IPT is more indicated when the level of social functioning is rather high, and patients are willing to focus on interpersonal functioning. In case of additional marital distress, marital therapy is to be preferred to individual

[CBT]. Finally, high levels of perfectionism make . . . treatment of depression in general more difficult.

The choice for manualized CBT becomes less obvious when problems become more complex and diffuse. Experiential forms of psychotherapy may be taken into consideration when patients are more open, and show interest in inner experience and are rather internalizers. No clear predictors for suitability for psychodynamic therapy have been found until now.<sup>2</sup> For problems for which research data are not yet available, treatment selection decisions can only be based on prior experience and clinical intuition.

<sup>2</sup> Since the publication of Vervaeke and Emmelkamp's guidelines in 1998, research has been published on client characteristics associated with success in psychodynamic interventions. As an example, Valbak (2004) reviewed 41 English-language "empirical studies on outpatients' pretherapy suitability for psychoanalytic psychotherapy" and found that "seventy-five per cent of the studies concerned brief dynamic psychotherapy. . . . Most promising variables with the highest correlations with good outcome were: 'good quality of object relations', 'psychological mindedness' and 'motivation for change'" (p. 164). For more information on time-limited dynamic psychotherapy, see the **Tool Box** in the **Fall 2008** issue of *mental health AIDS* entitled "Cut to the 'Quick': Brief Psychodynamic Treatment for Persons Living with HIV/AIDS."



hensive treatments for HIV+ women. (pp. 185-186)

Within this frame of reference, Dodd and colleagues continued the study of cervical neoplasia (precancerous cell growth) among women living with HIV (described most recently in the [Winter 2009](#) issue of *mental health AIDS*), by exploring associations between **depressive symptoms** and **cervical neoplasia** in 58 women infected with both human papillomavirus (HPV) and HIV. Dodd and colleagues found that the “presence and severity of clinically significant depressive symptomatology were associated with cervical neoplasia. . . . [Further]

analysis revealed that women with greater depressive symptoms had marginally greater odds of presenting with cervical neoplasia” (p. 181). Notably, “although there was no significant relationship between the cognitive-affective, positive or negative affect, or interpersonal symptoms of depression and cervical neoplasia . . . [.] greater levels of somatic depressive symptoms . . . [i.e., disturbances in sleep and appetite] were significantly associated with greater odds of cervical neoplasia. This finding persisted after controlling for recent negative life event stress, a factor associated with the progression and/or persistence of cervical neoplasia in . . . prior research” (p. 186).

The investigators advise caution when interpreting these findings, given the “modest sample size, undersampling of severely depressed women, and cross-sectional design, the latter of which precludes the ability to establish whether somatic depression causes cervical neoplasia or vice versa” (p. 187). Nevertheless, Dodd and colleagues conclude that these findings “suggest that screening HIV+ women for somatic depression may help identify those at risk for cervical neoplasia” and that “future depression research with medical populations should discern somatic

*(Biopsychosocial Update is continued on Page 19)*

Unfortunately, the most severe patients are still the most difficult to treat. Creating realistic expectations in both patient and therapist may be considered a task for the . . . [clinician] responsible for the treatment selection process. The presence of a comorbid PD [personality disorder] may require some additional efforts from the therapist to build a working alliance in the first phase of therapy, although PDs [have] not necessarily . . . been found to affect the results of treatment. (pp. 55-56)

Vervaeke and Emmelkamp conclude their guidelines for treatment selection with the caveat that, “in most of the reviewed research the reported relationships between the studied variables is weak to moderate, leaving a lot of variance of psychotherapy process and outcome unexplained. This means that even a sophisticated and manualized procedure of treatment selection before the start of psychotherapy will never completely decrease the importance of a flexible professional psychotherapist who adapts procedures and attitudes to the moment[-]to[-]moment interaction with the patient” (p. 57).

#### **Wending One’s Way Through HIV-Related Pain**

A recent example of matching clients living with HIV to treatment comes from Cucciare, Sorrell, and Trafton (2009),

who set out to identify client characteristics that might predict participation in a 12-week CBT-based pain management protocol. According to the investigators,

considerable data support . . . CBT . . . for pain management among heterogeneous pain populations. . . . These effects may be at least partly due to the focus of CBT for pain management, which is to help patients develop more effective coping strategies for managing dysfunctional fear and anxiety associated with pain-related experiences. . . . The fear-avoidance model of chronic pain proposes that some individuals avoid activities to reduce anxiety associated with the possibility of experiencing pain. . . . Through the process of negative reinforcement, the reduction of anxiety associated with avoiding feared activities reinforces this increased avoidance, thus maintaining the cycle. . . . The goals of CBT for pain management are to help patients understand this process, identify avoidance behaviors, learn and develop more effective strategies for coping with fear, stress, and anxiety, and ultimately change the manner in which they behave with regard to feared activities. . . . As life activities increase and pain-related fear decreases, a new cycle powered by positive reinforcement is initiated[,] leading

to an increase in important life activities and quality of life. (p. 341)

CBT has also been demonstrated to improve pain management among persons living with HIV/AIDS. Cucciare and colleagues point to a study by Evans, Fishman, Spielman, and Haley (2003) that

showed significant reductions in pain intensity and functional interference related to peripheral neuropathy in HIV-positive patients completing 6 weeks of group-delivered CBT. The results of these findings are limited, however, by the small sample size ( $n = 12$ ) and high drop[-]out rate (57% or 16 of the 28 participants) of the CBT condition. While the effects of CBT as a pain management strategy are promising, [Evans and colleagues] highlight the importance of making CBT more accessible and acceptable to this patient population. (Cucciare et al., 2009, p. 341)

To that end, Cucciare and colleagues hypothesized that attendance rates for a 12-week group CBT intervention could be improved by conducting the CBT group sessions in an HIV primary care clinic. Pain-related functioning was assessed among 60 study participants at baseline and again at 12 weeks post-intervention. The manual

*(Tool Box is continued on Page 18)*

guiding the intervention

was developed by the group leader. It was based on standard [CBT] topics tailored to focus on chronic pain management. . . . Topics included: an introduction to the theory underlying CBT for pain; education about chronic pain; goal setting; relaxation training; the activity-rest cycle; cognitive reconceptualization; cognitive restructuring; attention diversion and behavioral activation; exercise and sleep management; assertiveness and communication skills; problem solving; and relapse prevention. A CD-ROM with guided relaxation exercises, including progressive muscle relaxation, guided imagery and breathing, was also created. (p. 342)

The investigators found that the collocation of group CBT sessions with HIV primary care services did *not* improve client attendance, although "participation in this program was associated with improvements in pain-related functioning at post-treatment" (p. 346). More specifically, "higher baseline levels of pain-related anxiety were related to greater improvement in pain-related functioning at post-treatment, and non-Caucasian participants reported a greater response to treatment when compared to Caucasian participants" (p. 340). Moreover, attending "particular treatment sessions (e.g., progressive muscle relaxation and cognitive reconceptualization) added a statistically significant amount of variance in explaining pain[-]related functioning immediately following the end of treatment" (p. 346).<sup>3</sup>

Although "this study design did not include a randomized control group and thus . . . [the] analysis do[es] not

<sup>3</sup> The major objective of the session on cognitive reconceptualization is "to create a shift in a patient's perspective from seeing their situation with pain as one that is unmanageable and out of control to seeing that they can cope and exert control in their pain management. This session focused on teaching patients that painful sensations do not always indicate physical injury but may be amplified by thoughts and emotions" (Cucciare et al., 2009, p. 347).

establish efficacy of this treatment program" (p. 346), Cucciare and colleagues suggest that "non-Caucasian patients reporting higher levels of pain-related anxiety may respond particularly well" to a group CBT intervention and that "treatment sessions focused on progressive muscle relaxation and cognitive reconceptualization of pain may be particularly helpful" (p. 340). The investigators further suggest that a brief intervention delivered by HIV primary care staff "emphasizing that pain does not necessarily equal injury or sickness, thoughts and behaviors can modify patients' experience of pain, and teaching patients relaxation techniques may provide a good first[-]step treatment approach for improving pain management in HIV patients, especially when paired with self-help workbooks and exercises for self-guided learning" (p. 347).<sup>4</sup>

Cucciare and colleagues' finding that non-Caucasian individuals had a greater response to treatment is of particular interest in view of a recent pilot study suggesting that "there are ethnic disparities in the clinical mani-

<sup>4</sup> Notably, in this study, Curriare and colleagues "approached the issue of attendance in a more flexible manner than past research. For example, all participating patients received the treatment manual regardless of their level of attendance at the group CBT sessions. Thus, patients were able to self-study at their own pace and could choose to selectively attend sessions based on their interest in the upcoming session's content. . . . Treatment session reminder calls were provided to patients upon the patient's request, [and] patients were welcome to attend as many sessions as they desired. Patients were not told that attendance at all sessions was mandatory. The chaotic nature of some of the participants' lives precluded attendance at a majority of sessions. Patients reported a variety of life difficulties including problems finding transportation to and from the clinic, unstable housing, child and eldercare responsibilities, and illness-related problems. . . . [In fact,] attendance at the primary care clinic for medical follow-up appointments in and of itself may be extremely challenging for some of the clients. For example, a number of patients lived very far from the clinic, ha[d] . . . excessive difficulty finding viable transportation to get to appointments, and require[d] an entire day be set aside for travel. It may be that additional appointments for CBT are overly burdensome at an increased frequency, even when the appointments are in the same clinic where they normally receive primary care" (p. 346).

festations of HIV-related neuropathies including pain and the susceptibility to ARV-DSP [antiretroviral-induced distal sensory polyneuropathy]" (Robinson-Papp, Gonzalez-Duarte, Simpson, Rivera-Mindt, & Morgello, 2009, p. 569). In this pilot study, "ARV-DSP was more common in Hispanics . . . [and t]here was a trend for higher pain scores in Hispanics with symptomatic DSP" (p. 569).

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depressive symptoms from disease symptoms, as they may have important value in independently predicting health outcomes” (p. 181).

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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.

Crawford, J., Rawstorne, P., Grulich, A., Jin, F., & Kippax, S. (2009). Gay men's current practice of HIV seroconcordant unprotected anal inter-

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

Bartlett, J.G., & Gallant, J.E. (2007). *Medical management of HIV infection, 2007 edition*. Baltimore: Johns Hopkins University, Division of Infectious Diseases.

Fernandez, F., & Ruiz, P. (Eds.). (2006). *Psychiatric aspects of HIV/AIDS*. Philadelphia: Lippincott Williams & Wilkins.

course: Serosorting or seroguessing? *AIDS Care*, 21(4), 501-510.

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