

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Women & Men

Corbett, Dickson-Gómez, Hilario, and Weeks (2009) examined “condom use within the context of [25] high-risk urban couples, including both HIV-seroconcordant and HIV-serodiscordant couples. Specifically, [the investigators] explore[d] reasons . . . for condom use or nonuse, and the strategies used to reduce [sexually transmitted disease] risk, within primary partnerships” (p. 219). Corbett and colleagues found that

while factors such as substance use, intimate partner violence and self-efficacy play a role in condom use generally, among these 25 couples, these factors seem to have very little effect on the desire or ability to use or insist on condom use within their relationship. Study participants were overwhelmingly marginalized socially and economically, and many abused drugs; nevertheless, they tended to be in long-term, committed relationships. Because of their marginalized and potentially stigmatized status, they may have had a greater need for security, acceptance and reciprocated love than is typical in heterosexual populations at lower risk for HIV infection. Not using condoms, then, stemmed from their desire to establish and maintain a loving and meaningful relationship, at whatever cost,

including risk to their health. Most participants were well aware of the risks they were taking, but finding their “soul mate” – a partner who would share and help them navigate through their difficult lives – and achieving a sense of “normalcy” were higher priorities. . . .

Because [these] couples . . . saw condom use as inconsistent with establishing and maintaining a committed, primary relationship, they used other strategies – some more thoroughly than others – to assess and reduce their risk. Several couples described using some form of risk assessment and reduction at the beginning of their relationship [e.g., “sharing sexual or drug use history, disclosing HIV test results and using condoms until they decided that their relationship would be monogamous” (p. 218)], but not consistently throughout the relationship. . . .

Given the importance of establishing and maintaining committed, romantic relationships, risk assessment and reduction strategies such as negotiated safety¹

¹ “Negotiated safety refers to an explicit agreement between partners about sexual practices that takes into account the HIV status of both. Couples using this approach undergo mutual HIV testing, then decide to discontinue condom use within their primary relationship and commit to monogamy or establish rules for condom use with outside partners” (Corbett et al., 2009, p. 219).

must be reconceptualized and communicated to high-risk [seroconcordant] heterosexuals as a way of increasing intimacy and strengthening relationships. Risk reduction programs should help high-risk individuals understand that ongoing risk assessment, based on open and honest communication, can help couples increase trust and intimacy within their relationship. Similarly, they should explain that periodic testing may be viewed as a way of expressing love and maintaining trust within the relationship. . . . [The] finding that many couples were attempting to assess risk even though negotiated safety has not been widely promoted in the United States among heterosexuals suggests that this may be a more acceptable HIV prevention tool for those in committed relationships than might be expected on the basis of earlier research findings. (pp. 222-223)

Corbett and colleagues astutely observe that “HIV prevention interventions need to acknowledge the im-

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portant emotional and social needs that primary relationships satisfy. Greater attention must be paid to developing interventions that acknowledge these needs and do not contradict people's beliefs about their relationships to the point where they reject those interventions as irrelevant" (p. 223).

About Adolescents & Young Adults

Clum, Chung, Ellen, and the Adolescent Medicine Trials Network for HIV/AIDS Interventions (2009) sought to identify "**pathways between HIV-related stigma and risk behavior** in 147 young HIV positive women" and found that a diagnosis of **major depressive disorder** "was a significant mediator between HIV-related stigma and risk behavior" (p. 1455). Clum, Chung, and colleagues conjecture that "HIV-related stigma may result in a heightened and negative self-awareness that depletes resources and leads to depressive symptoms, which results in risk behavior as a way to escape aversive self-awareness and negative affect" (p. 1459).

Importantly, the investigators observe "the relatively small amount of variance explained by [this] model. It appears that there are other important pathways to risk behavior for young HIV positive women that are not examined here, including individual, interpersonal, and social/cultural effects" (p. 1460). At the same

time, Clum, Chung, and colleagues suggest that "interventions targeting risk behavior in young women should consider inclusion of mental health components, such as cognitive behavior therapy, to address depressive symptoms" and that "depression should be screened for and targeted in treatment planning or in prevention interventions" (p. 1459). Additionally, "interventions with young HIV infected women could benefit from including identification of triggers for activation of stigma and maladaptive coping, such as in negotiations of safe[r] sex in intimate relationships, and provide skills for alternative coping strategies in the face of negative affect, including skills for emotional regulation. . . . Furthermore, . . . attention to [the] desire for intimacy and stability in relationships, and partner communication skills might be necessary to assist with changes in risk behavior" (pp. 1459-1460).

In another study by this research group (Clum, Andrinopoulos, Muesig, Ellen, & the Adolescent Medicine Trials Network for HIV/AIDS Interventions, 2009), 40 young women receiving HIV primary care in Miami, New York City, or Philadelphia "who experienced physical and/or sexual abuse in childhood" were interviewed and reported "**complex abuse histories**, often experiencing more than one type of abuse in the context of other difficult life events. Avoidance and substance use were frequently utilized as **cop-**

ing strategies for abuse-related distress. Young women reported **sexual and relationship concerns**, including avoidance of sex, sexual dysfunction, sex as a trigger for abuse memories, and difficulty establishing intimacy and trust" (p. 1755). Among the thoughts the investigators offer on intervention with this population are these:

Because intimate relationships are robustly associated with quality of life, and relationships were noted by women in this study as strongly affected by abuse sequelae, interventions should . . . focus on ways of improving relationships for these young women and their partners. . . . Increasing comfort with discussions of sexuality and intimacy between partners might be a useful starting point. Interventions addressing trauma-related symptoms in young women should also incorporate a focus on intimacy and sexuality, including identification of triggers for sexual avoidance, anxiety, or distress. Efficacious cognitive-behavioral interventions for [posttraumatic stress disorder] that include at least some focus on sexuality, trust, and intimacy are available for abuse victims . . . , and would likely be beneficial for inclusion in interventions targeting abuse in HIV-positive women; likewise, those efficacious treatments for abuse-related sequelae should include a strong focus on HIV prevention. Child sexual abuse victims have shown reduced sexual risk behavior when a focus on abuse was included in a risk-reduction intervention. . . . Partner-focused interventions for enhancing intimacy, couples communication, and negotiation of sexual practices could be useful for those engaged in long-term relationships. . . .

. . . Secondary prevention efforts

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must also target families in which abuse has occurred. Significant vulnerability to risk behaviors such as unprotected sex and sex with riskier partners, substance use, and exposure to additional violence and abuse emerge in the period of young and middle adolescence. . . . [F]indings suggest that some of this engagement in risk behavior could be mediated by cognitive, emotional, and behavioral responses to abuse. Additionally, increased exposure to environmental risk after abuse experiences was a concern in this study, consistent with research exploring relationships between abuse and subsequent homelessness, unstable housing, and increased engagement in risk behaviors. . . . In deciding to leave unsafe home environments, young women were placed in situations that again increased exposure to risks such as homelessness, lack of economic and social resources, risky peers and sexual partners, and communities with high rates of violence and substance use. Interventions should thus focus on addressing the mental health needs of older children and younger adolescents, barriers to services . . . , and include comprehensive approaches targeting safe home and community environments, including viable housing alternatives for homeless youth. (p. 1764)

Clum, Andrinopoulos, and colleagues stress “the need for multilevel interventions that address several different points of vulnerability that include, but are not limited to, addressing emotional sequelae of abuse at the individual level. Comprehensive interventions will include environmental and contextual levels such as safe housing, parent[al or caregiver] mental illness and substance use, and improving skills in intimate relationships” (p. 1765).

HIV Assessment News

Psychiatric Assessment

Marhefka et al. (2009) examined “**mental health problems, diagnoses, and service utilization among 164 [youth living with HIV] ages 13-21 years**” (p. 1450) from three American cities. The investigators describe the study sample as

Black (81%), female (52%), Heterosexually identified (62%), and perinatally HIV-infected (60%). Thirty-one percent . . . reported levels of internalizing (i.e., self-focused/emotional), externalizing (i.e., outwardly focused/behavioral), or overall symptoms consistent with clinical psychopathology. In multivariate analyses, questioning one’s sexual identity was associated with greater internalizing problems, whereas identifying as Bisexual was associated with greater externalizing problems. . . . Symptoms were not associated with HIV transmission group. Participants with ≥ 1 composite score within the clinical range were more likely to have received ≥ 1 psychiatric service . . . and a psychiatric diagnosis in the past year. . . . However, 27% with clinically elevated scores had never received psychiatric care. (p. 1447)

Marhefka and colleagues conclude that “among youth with HIV, those who identify as Bisexual or Questioning are at greatest risk for emotional and behavioral problems. Despite available mental health services, some youth with HIV are not receiving needed mental health care. Enhanced evaluation, referral and mental health service linkage is needed for these high-risk youth” (p. 1447).

Basta, Shacham, and Reece (2009) explored “the nature and range of **psychological distress symptoms experienced by [47] individuals living in rural areas** [i.e., areas

with a population of fewer than 50,000 persons] who had self-enrolled into [publicly funded] HIV-related mental health care” at a rural clinic and compared “their levels of distress to . . . [48 matched] urban counterparts accessing care” (p. 1053) at an urban clinic; both mental health clinics were in the southeastern United States. All study participants completed the Brief Symptom Inventory, a measure of psychological distress.

Basta and colleagues found that “despite limited differences in demographic variables, significantly more rural individuals living with HIV expressed markedly higher levels of overall psychological distress, hostility, and psychoticism than their urban counterparts. Furthermore, rural individuals had higher mean scores on the hostility dimension of psychological distress” (pp. 1055-1056). The investigators speculate that “these differences may be reflective of situational circumstances in rural areas where access to care, social isolation, and perceived stigma may delay screening for, and treatment of, psychological distress” (p. 1053), and observe that “while it may not be feasible to have a mental health practitioner in all rural areas, more effort[s are needed] . . . to increase the availability of services to individuals who are [HIV-]positive, including the possibility of alternative methods of service delivery (telemedicine, Internet-based, etc.)” (p. 1056). At the same time, the investigators point out that currently, “many rural areas do not have Internet access and many low-income individuals do not have access to computers” (p. 1056).

Shacham, Nurutdinova, Satyanarayana, Stamm, and Overton (2009) “examined the prevalence of **depressive symptoms** that were measured as part of a standard of care behavioral assessment among individuals at an urban HIV clinic in the Midwest” (p. 949). The investigators report that

514 individuals participated in the study, the majority of whom was male and African American. One quarter of the sample endorsed symptoms of other depressive disorder, while 18% ($n = 91$) endorsed symptoms of major depressive disorder as measured by the Patient Health Questionnaire-9 (PHQ-9). Among those on highly active antiretroviral [(ARV)] therapy (HAART), individuals who were unemployed . . . , had a minor dependent[, were] . . . between the ages of 18 and 34 years . . . and [had a] detectable HIV viral load . . . were more likely to report depressive disorder symptoms when controlling for age, gender, race, and education. Nearly 15% of the sample endorsed having suicidal thoughts at least once in the past two weeks. Regardless of HAART prescription, individuals who were unemployed had a higher likelihood of expressing suicidal ideation. . . . Given the association between depressive symptomatology and poor rates of HIV viral suppression, screening and appropriate interventions for depressive symptoms are warranted in the HIV outpatient setting to improve outcomes. (p. 949)

Drawing on national-level hospital discharge data, Bansil, Jamieson, Posner, and Kourtis (2009) examined “trends in **hospitalizations with psychiatric diagnoses** among non-pregnant **HIV-infected women** and the association between specific disorders and women’s lack of adherence to medical treatment and suicide attempt” (p. 1432). The investigators report that

between 1994 and 2004, the estimated number of all hospitalizations among nonpregnant HIV-infected women increased by 8%, while the number of hospitalizations with a psychiatric diagnosis in this population increased

by 73%. After adjusting for demographic factors and alcohol/substance abuse, [Bansil and colleagues] found that HIV-infected women were more likely to be hospitalized for mood . . . , anxiety . . . , and psychotic . . . disorders in 2004 than in 1994. There was a significant association of alcohol/substance abuse with mood, adjustment, anxiety, personality, and psychotic disorders. Noncompliance with medical treatment was significantly associated with psychotic disorders, whereas suicide attempt/self-inflicted injury was significantly associated with mood, adjustment, anxiety, personality, and psychotic disorders. (p. 1432)

The investigators conclude that “the number of hospitalizations with a psychiatric diagnosis among HIV-infected women in the USA has increased substantially” (p. 1432) and that it is necessary to tailor early intervention programs to address the mental health service needs of women living with HIV. “Although the advent of HAART has allowed people with HIV to live longer, healthier lives, unless these people receive adequate treatment for psychiatric disorders, this improvement in their quality-of-life may be undermined” (p. 1437).

Another factor that can affect quality of life is fatigue. Paddison, Fricchione, Gandhi, and Freudenreich (2009) “comprehensively assessed **fatigue** in 38 consecutive HIV patients referred for psychiatric treatment” for the purpose of delineating the “prevalence and severity of fatigue in HIV patients with psychiatric comorbidities and . . . [the] psychological correlates of fatigue” (p. 455). The investigators found that “about 80% of patients reported at least moderate feelings of fatigue, and about 25% judged that fatigue was severely affecting their daily functioning. Depression, anxiety, and

perceived stress explained between 20% and 75% of the variance in fatigue ratings” (p. 455). Paddison and colleagues

suggest, at a minimum, screening all HIV-infected patients for fatigue. Those who report significant fatigue should be further queried about the three factors . . . identified as potentially contributing to fatigue (i.e., depression, anxiety, and stress). When identified, treatment should address syndromal psychiatric diagnoses as well as psychosocial stress, although the best treatment strategy may be unknown.

Symptomatically, treatment with stimulants or modafinil has been shown to be effective in HIV-associated fatigue. . . . Eventually, a better understanding of the neurobiology of fatigue that occurs in the described context of complex medical and psychological comorbidity might lead to new treatment approaches, perhaps targeting cytokine abnormalities that have been linked to depression and fatigue. (p. 459)

Neuropsychological Assessment

Chernoff, Martin, Schrock, and Huy (2010) “administered a baseline neuropsychological (NP) test battery designed to assess estimated full-scale IQ, achievement, attention/concentration, executive function, language, mental speed, motor function, nonverbal memory, verbal memory, and visual-spatial function to a sample of 174 disabled, HIV-positive individuals [who were contemplating **returning to work** and] enrolled in a randomized, controlled trial of a **vocational-rehabilitation program**” (p. 38). The investigators “expected to find a positive relationship between cognitive functioning and reported levels of employment activity, such as part-time or full-time employment, volunteer work, and job training,” but instead “found that cognitive function-

ing did not predict employment activity very well” (p. 45) in this sample. In fact, “the association between executive functioning² and employment, while statistically significant, was weak, accounting for only a small percentage of the variance in [this] model. Moreover, . . . 63.7% of the participants were misclassified using this model. Although this model did predict employment significantly better than chance, it did not predict steps toward employment as well as . . . expected based on the previous literature (i.e., only 36.2% of participants were correctly staged using this model)” (p. 46). These findings

carry several implications for vocational rehabilitation with HIV-infected individuals. A common assumption among practitioners is that NP tests are useful tools for predicting successful employment. However, in [this] sample of participants with HIV who were seeking workforce reentry, cognitive testing generally did not predict employment activity at follow-up, or, in the case of executive functioning, was statistically significant but of marginal clinical utility. These results suggest that NP tests may not be the most clinically useful tools for informing HIV-infected individuals about whether they should attempt workforce reentry or for preparing them to return to work. Additional research tying NP testing results to vocational outcomes is needed before this application of NP testing may be considered useful among people with HIV who are seeking workforce reentry.

An extension of [these] findings

² “Many job-related tasks require executive functions such as decision-making, planning, and judgment, and . . . findings [from this study] are consistent with the findings of earlier investigations that suggest executive functioning affects employment among people with HIV” (Chernoff et al., 2010, p. 45).

is that problems with cognitive functioning may not necessarily be a barrier to employment if those problems are not severely debilitating. In [this] study, those with low cognitive functioning were as likely to engage in employment activities over a two-year period as those with high cognitive functioning. Demographic factors such as age, education, ethnicity, substance use, CD4 count, viral load, and physical and mental health also did not predict employment activity. It may be that motivational factors such as readiness for work, self-efficacy, and sense of purpose are more predictive of employment activity than cognitive functioning. Future research is needed to ascertain whether these or other factors may explain how and why some HIV-infected individuals can successfully engage in employment, while others have more difficulty. (p. 46)

HIV Treatment News

Medical Care

“**Second-generation antipsychotics** (SGAs) are increasingly prescribed to treat psychiatric symptoms in pediatric patients infected with HIV,” according to Kapetanovic et al. (2009), who “examined the relationship between prescribed SGAs and physical growth in a cohort of youth with perinatally acquired HIV-1 infection” (p. 939). SGAs include aripiprazole (Abilify®), olanzapine (Zyprexa®), and risperidone (Risperdal®). “A major advantage of SGAs over conventional antipsychotics is their very low association with extrapyramidal symptoms [i.e., movement disorder side effects, such as tardive dyskinesia], . . . however, growing evidence suggests an association between SGA treatment and **excessive weight gain**” (p. 940).

In this study, “each participant prescribed an SGA was matched . . .

with 1-3 controls without antipsychotic prescriptions. The main outcomes were short-term (approximately 6 months) and long-term (approximately 2 years) changes in BMI [body mass index] z scores [i.e., a statistical measurement comparing weight to height] from baseline. There were 236 participants in the short-term and 198 in the long-term analysis” (p. 939). The investigators discovered

a strong positive association between prescribed SGA treatment, particularly risperidone, and both short- and long-term changes in BMI z scores in children and adolescents with perinatally acquired HIV infection. Clinicians treating children with perinatally acquired HIV infection and comorbid psychiatric disorders requiring SGA treatment should routinely monitor growth and metabolic parameters utilizing a careful history and physical, standardized height and weight assessments, and treatment-directed laboratory studies, and maintain communication with other prescribers involved in the child’s clinical care.

Treatment-associated adverse effects should be weighed against the risks of untreated psychiatric disorders. When possible, alternative evidence-based treatments should be considered. (p. 945)

Readers of *mental health AIDS* may recall the [Winter 2003 Tool Box](#) detailing a promising but controversial approach to ARV prescription known as structured treatment interruptions, and the subsequent halting of enrollment in a major international HIV/AIDS trial comparing continuous ARV therapy with episodic drug treatment guided by levels of CD4+ cells, reported in the [Spring 2006](#) issue of *mental health AIDS*. This trial, known as Strategies for Management of Anti-Retroviral

Therapy (SMART), involved 318 clinical sites located in 33 countries. At the time enrollment was stopped, "analysis revealed that participants on CD4+ cell-guided episodic treatment faced more than twice the risk of disease progression [i.e., the development of clinical AIDS or death] relative to participants on continuous [ARV therapy]" (NIAID, 2006). Local study investigators were advised to re-initiate continuous ARV therapy with participants in the drug conservation arm of the study.

In Italy and Sweden, Mussini et al. (2009) observed "the **extent of immune reconstitution following HAART resumption after 1 cycle of treatment interruption (TI)**" (p. 588) among 183 individuals who discontinued HAART with a CD4 cell count of > 500 cells/i L. The investigators found that "whilst over two-thirds of patients included in [this] study experienced a CD4 increase of at least 200 cells/i L after a median of 8 months after resuming therapy, only 45.5% of the patients reached their pre-TI CD4 level by 2 years after resuming therapy" (p. 592). Mussini and colleagues urge that "patients willing to discontinue treatment should be advised that immune reconstitution to pre-TI values is possible in fewer than 50% of patients at 2 years after treatment restart" (p. 588) and that, although "data on qualitative immune reconstitution are not available, . . . at least from a quantitative point of view, . . . even 1 cycle of TI could have a detrimental effect on [the] immune system" (pp. 593-594).

Psychiatric/Psychological/ Psychosocial/Spiritual Care Adherence to Treatment

Mugavero et al. (2009) examined "the influence of **incident stressful experiences** on [ARV] medication adherence and treatment outcomes" by *prospectively* measuring "incident stressful and traumatic events, medication adherence, and viral load over

27 months in an eight-site, five-state study" among 474 men and women living with HIV in the southeastern United States, 289 of whom "were interviewed and still received treatment at 27 months" (p. 920). The investigators found that the

occurrence of incident stressful and traumatic events between interviews predicted deteriorations in ARV adherence during 27 months of prospective follow-up, even after adjustment for baseline characteristics, depression, alcohol use, and coping styles. [Mugavero and colleagues] observed a strong exposure-response relationship between incident stressful and traumatic events and ARV nonadherence. . . . Participants experiencing the median number of incident stressful events ($n=9$) had over twice the predicted odds of ARV nonadherence at follow-up compared with those with no events after controlling for baseline adherence. Incident stressful (but not traumatic) events were also associated with an increased risk of virologic failure over the follow-up period. (p. 924)³

The investigators conclude that

incident stressful events are exceedingly common in the lives of HIV-infected individuals engaged in outpatient care; this study concludes that such events negatively affect ARV adherence and virologic outcomes over time. Efforts to improve health outcomes for HIV-infected individuals should address history of severe traumatic experiences . . . , but must

³ "In any 9-month period, over half of participants experienced a major financial stressor; approximately one third experienced a major injury or illness not related to HIV, the death of a family member or close friend, a serious illness of a family member or friend, and a major relationship stressor; and approximately one in five experienced employment-related stressors and safety-related stressors" (Mugavero et al., 2009, p. 924).

also pay particular attention to less severe but more frequent stressful events that may occur as the patient is engaged in clinical care, such as financial, relationship, safety-related and life-transition stresses. Interventions to prevent such stressful events where possible and to improve the ability of patients to cope with events that do occur may play an important role in optimizing health outcomes for HIV patients. (p. 925)

Naar-King et al. (2009) investigated whether Healthy Choices, "a 4-session individual clinic-based **motivational interviewing intervention** delivered during a 10-week period" and "targeting multiple risk behaviors, improved . . . HIV . . . **viral load**" (p. 1092).⁴ A convenience sample of 186 predominantly African American 16- to 24-year-olds living with HIV drawn from adolescent medicine HIV clinics in five American cities was "randomized to the intervention plus specialty care ($n=94$) or specialty care alone ($n=92$). The 3- and 6-month follow-up rates, respectively, were 86% and 82% for the intervention group and 81% and 73% for controls" (p. 1092). Naar-King and colleagues report that the intervention

⁴ "Youth could work on 2 of 3 possible problem behaviors based on their entry screening: substance [ab]use, [unprotected] sex . . . , or HIV medication nonadherence. . . . In session 1, participants chose which of the 2 behaviors to discuss first, and the interventionist elicited their views using standard motivational interviewing techniques. The remainder of the session focused on structured personalized feedback on risk behaviors based on the baseline assessment . . . , building motivation to initiate/maintain changes, decisional balance exercises to clarify the perceived pros and cons of behavior changes, and consideration of a plan to change his or her behavior. The plan was presented as an option, and the youth set his or her plan goal. The second session (week 2) followed the same format but focused on the second target behavior. In the subsequent 2 sessions (weeks 6 and 10), the interventionist reviewed the personalized behavior change plan, continued to monitor and encourage progress, problem-solved barriers, and elicited strategies to maintain health behaviors and to prevent relapse" (Naar-King et al., 2009, p. 1094).

resulted in short-term improvements in viral load for young people living with HIV. . . . However, more than half of youth in the intervention condition, even among those prescribed ARV drugs, were still not achieving optimal viral suppression (undetectable viral load). . . . While brief interventions may be more easily implemented in clinic settings, a more intensive intervention may be needed to sufficiently halt viral replication. . . .

Furthermore, reductions in viral load were not maintained at 9 months of follow-up. . . . Research on maintenance of health behavior change is in its infancy, . . . but it is possible that more intensive intervention is necessary or that frequent repetitions of brief interventions (e.g., booster sessions) may be needed to promote long-term adherence. It may also be that youth with HIV require opportunities for skills-building to achieve long-term change in their risk behaviors. Motivational interviewing combined with cognitive-behavioral skills-building has been shown to confer greater benefit than motivational interviewing alone. . . . Future studies are critically needed to address these issues in child and adolescent health. . . .

[Nevertheless, t]his is the first multisite randomized behavioral intervention trial in the literature to demonstrate a significant impact on health outcomes (viral load) among young HIV patients. The intervention could be easily integrated into existing HIV clinic settings that provide care to young people, as studies have shown that providers from a range of backgrounds (physicians, nurses, social workers, health educators, paraprofessionals, and even peer-outreach workers)

can effectively deliver motivational interviewing. . . . Integration of motivational interviewing into standard care of young HIV patients may prove even more effective, as youth would continue to receive the motivational interviewing at each contact, thus providing ongoing boosters, which may serve to promote long-term risk reduction and better virologic outcomes. (pp. 1096-1097)

Sacajiu, Raveis, and Selwyn (2009) observe that "little is known about the **role of caregivers** regarding . . . HAART . . . and adherence to medication, especially among low income and medically underserved HIV-infected individuals" and so conducted "a qualitative study . . . in an urban teaching hospital in the Bronx, NY, consisting of 144 adults with advanced HIV/AIDS and their informal/familial caregivers" (p. 1528). "Informal or family caregiver was defined as the person regarded by the patient as his/her primary provider of emotional support and practical assistance or as someone who has been designated as the surrogate decision maker, provided that this person has known the patient for three years or longer" (p. 1529).

Through the analysis of in-depth interviews, the investigators discovered that

most participants had only partial understanding of HAART and did not view it differently than other HIV therapeutic approaches, such as prophylaxis against opportunistic infections and nutritional supplements. Those who had a grasp of HAART referred to the biomedical markers of viral load and CD4 count as reflective of its efficacy. They also added a personal discourse to efficacy, namely: hope and self-care. Even those participants, who perceived HAART as effective, reported that side ef-

fects can be a major hurdle in adherence and greatly influence therapeutic history. . . . Nonetheless, the narrative accounts supported that most individuals comprehended the importance of tight adherence for successful therapy. . . .

As regards the caregivers' contribution to adherence, . . . [i]n this sample, while a number of informal caregivers were highly involved with the patient's care and served as a critical instrument in adherence to medication, many caregivers had limited knowledge of their loved ones' medication and medical care. This information gap has important implications, given that both social support and satisfaction with care ha[ve] . . . a profound influence on adherence. (p. 1534)

Additionally, Sacajiu and colleagues "found that perceptions and knowledge about HAART can be consistent or discordant within the patient/caregiver dyads," (p. 1534) and that "the accounts of both members of the dyad were more likely to reflect positive feelings about the patient's healthcare experience when they shared perceptions about the treatment, and were more likely to have a negative viewpoint when the dyad was discordant [in their perceptions] about treatment" (p. 1528).

On the basis of these findings, Sacajiu and colleagues conclude that "patients with advanced HIV/AIDS and their caregivers do not commonly share similar perceptions and understanding about HAART. However, such shared knowledge seems to be associated with more favorable perceptions of care experiences. These findings support the importance for HIV healthcare providers to include both patients and their caregivers in discussions about HAART, in order to improve their understanding of and satisfaction with

Tool Box

HIV & Hepatitis C: Coping with Coinfection (Part 1)

Bova, Ogawa, and Sullivan-Bolyai (2010) report that “an estimated 25% to 40% of HIV-infected patients are also infected with HCV [hepatitis C virus], and in some practices the prevalence is as high as 75% to 90%. . . . Recent estimates suggest that approximately 250,000 persons are coinfecting with HIV and HCV in the United States” (p. 63), “and with HIV antiretroviral therapy (ART) extending the life of people living with HIV, end-stage liver disease is now a leading cause of death in this population. . . . Studies show that a majority of coinfecting patients have at least moderate liver inflammation or other signs of disease progression, . . . however, several studies published over the past 5 years have shown that less than one third of HIV coinfecting patients in the United States are deemed eligible for HCV treatment, and under 10% actually receive treatment” (Wagner et al., 2009, p. 715).

Increasing attention has been directed to individuals coinfecting with HIV and HCV because

in patients infected only with HCV, the time between infection and development of fibrosis [scar tissue resulting from inflammation of the liver] averages 20 years, whereas in patients coinfecting with HIV/HCV, liver disease may develop in 5 to 10 years. . . . [Additionally,] HCV infection . . . influences the course and management of HIV disease, particularly by increasing the risk of ART-induced hepatotoxicity [liver damage]. . . . The goal of HCV treatment is to achieve a sustained virologic response (SVR), which is defined as the absence of serum

hepatitis C RNA for 24 weeks after treatment completion. . . . Without HCV treatment, increasing numbers of HIV-infected patients will die either from end-stage liver disease or from HIV-related complications resulting from the inability to use antiretroviral agents because of their hepatotoxicity. (Bova et al., 2010, p. 64)

This is the first of a two-part series. Part 1 provides a medical, psychiatric, psychosocial, and neuropsychological overview of HIV/HCV coinfection, the process of determining eligibility for HCV treatment, and the important role mental health clinicians play in assessing eligibility and intervening with clients who elect to receive treatment for HCV.

Part 2 (to be presented in the Summer 2010 issue of *mental health AIDS*) will expand on how providers make the decision to offer HCV treatment to individuals living with HIV and chronic HCV infection, how coinfecting individuals make decisions to accept or defer treatment for HCV, and the latest thinking on HCV-treatment interventions.

The Chance of a Cure

“A patient’s willingness to undergo HCV treatment is likely influenced by how the patient views the efficacy and burden or risk of treatment” (Osilla et al., 2009, p. 993).

On the question of efficacy, it’s important to know that “at least six distinct genotypes (numbered 1-6) and more than 30 subtypes of HCV are known,” but “the most common genotype present in the United States, genotype 1, is also the most resistant to treatment” (Bova et al., 2010, pp. 63-64).

involvement, and patient perspectives on the perceived consequences of such involvement. For those who have not had others present,” Mosack and Petroll wanted to “investigate the barriers to their involvement, the reason for which others have been excluded, and how not having someone present might have

According to Osilla et al. (2009), “standard HCV treatment, which consists of 48 weeks of weekly pegylated interferon (PEG-IFN) injections in combination with daily ribavirin (RBV), . . . has demonstrated a success rate of 30%-45% among HIV coinfecting patients across all genotypes, . . . but only 17%-29% among HIV patients with . . . HCV . . . genotype 1” (p. 993). Although “new treatment agents (e.g., protease and polymerase inhibitors) that may improve treatment efficacy are at various stages of development and testing, . . . [they] are not expected to be available for routine practice for at least a few years and [IFN] will remain a component of treatment” (Wagner et al., 2009, p. 715).

As for the risks involved, treatment for HCV has been characterized as “lengthy, rigorous, and associated with side effects that are difficult to manage” (Silberbogen, Ulloa, Janke, & Mori, 2009, p. 114). “Flu-like symptoms (nausea, diarrhea, weight loss)” and “fatigue associated with hematologic abnormalities (anemia, neutropenia) . . . [are] highly prevalent” (Wagner et al., 2009, pp. 715-716). “In addition to physiological side effects, there are also significant neuropsychiatric side effects, including depression, anxiety, irritability, psychosis, suicidality, apathy/malaise, fatigue, impaired concentration, anhedonia, and recurrence of posttraumatic stress disorder symptoms” (Silberbogen et al., 2009, p. 114).

“Not surprisingly, a general fear and apprehension regarding side effects and their impact on quality of life and functioning are common among patients considering treatment” (Osilla et al., 2009, p. 993), and Wagner and colleagues report “dropout rates as high as 40%-50% in community samples of coinfecting patients”

the medication, and, to ultimately contribute to patients’ adherence” (p. 1535).

Similarly, Mosack and Petroll (2009) examined the extent to which **informal caregivers** in Milwaukee, Wisconsin, “are **present at medical appointments**, the nature of their in-

affected their medical care” (p. 1044). The investigators interviewed 42 adults living with HIV who were predominantly African American and who were partnered at the time they were first diagnosed.

Mosack and Petroll report that “a minority of those interviewed were

(p. 716). Yet, “despite these side effects and related patient concerns,” proponents of HCV treatment “recommend early treatment for coinfecting patients to prevent more serious disease development” (Osilla et al., 2009, pp. 993-994) and “can argue that PEG-IFN/RBV, unlike ART, has a limited duration and at least a chance of a cure” (Wagner et al., 2009, p. 716; see also [neuropsychology sidebar](#)).

The Offer of Treatment

“Upon detection of HCV infection, for treatment to be provided, providers must first consider a patient an appropriate treatment candidate, and multiple medical and psychosocial factors can contribute to a provider’s reluctance to recommend or offer treatment to a patient” (Osilla et al., 2009, p. 993). In a Seattle HIV-specialty clinic, for example, among 248 predominantly

white and male, HCV/HIV-coinfecting patients,

fewer than half . . . were evaluated for possible [IFN]-based HCV treatment. Only 16% received treatment, and only 2.4% of the entire cohort achieved an SVR. The median time to evaluation for treatment was almost 3 years, a significant period of delay in patients who may have a much more rapid progression to cirrhosis [the final stage of fibrosis], compared to patients without HIV. . . . Similarly, the median time elapsing between evaluation and treatment initiation was 1.4 years. Substance abuse and advanced HIV infection were the primary reasons for non-evaluation. (Scott et al., 2009, p. 928)

According to Wagner and colleagues (2009),

substance abuse and mental illness each account for 20%-30% of coinfecting patients being deemed ineligible for treatment, as clinicians are concerned that the side effects of HCV treatment may lead to psychiatric deterioration, relapse into substance abuse, poor adherence, and treatment discontinuation. . . . Psychiatric and substance abuse patients have been excluded from most clinical trials, but the little data available show mixed results; some studies find that such patients do equally as well in terms of ability to complete and respond to treatment, . . . while others suggest that patients with active substance abuse and psychiatric problems are less likely to respond and more likely to drop out of treatment. (p. 716)

(Tool Box is continued on Page 10)

Neuropsychology of HIV/HCV Coinfection

“HCV mono-infection is associated with significant impairment in neuropsychological domains typically characterized as ‘subcortical’ in nature, with predominant impact on attention, information processing speed, and verbal memory. Further, evidence of neuropsychological impairment among HCV mono-infected individuals exists independent of comorbid substance abuse and severe liver disease, raising the possibility of direct brain involvement from HCV” (Martin-Thormeyer & Paul, 2009, p. 223). Moreover,

individuals infected with both HCV and HIV express more severe neuropsychological impairment than individuals with HIV alone but the mechanisms underlying these effects remain unclear. To date a handful of studies have examined neuropsychological function among individuals co-infected with HCV and HIV. Among these studies there is notable variability in the methods to examine neuropsychological function, the use of various comparison groups (e.g., HCV alone, HIV alone, both mono-infected groups compared to co-infected patients), and the focus on various laboratory indices of disease burden. These methodological differences require some caution when drawing conclusions regarding the impact of co-infection on cognitive outcome. For example, a number of studies did not involve a comprehensive neuropsychological assessment, and therefore, conclusions regarding the neuropsychological pattern associated with co-infection remains premature. With that caveat noted, there is some suggestion in the literature that several domains of cognitive function are more likely impacted by co-infection than others.

Decreased processing speed and psychomotor speed among co-infected individuals is a commonly reported outcome of the studies . . . [although] evidence of selective impairment in psychomotor speed/information processing is not universal. . . . [In fact, not] all studies have reported greater cognitive impairment among co-infected patients. . . . When taken collectively the majority of studies have reported more severe neuropsychological impairment among co-infected patients than mono-infected patients. (Martin-Thormeyer & Paul, 2009, pp. 224-225)

Importantly, “recent studies of dually infected subjects indicate that neurocognitive function may improve with successful therapy for either disorder” (Gonzalez, Quartana, & Martin, 2009, p. 223).

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accompanied to medical appointments. Still, participants overwhelmingly identified more potential benefits than disadvantages to others’ involvement. Benefits categories include improved information communication, the development of stronger relationships, improved family health, and successful treatment

outcomes” (p. 1043). Elaborating on these benefits, the investigators note that

in addition to helping the patient remember to take medications, an informal caregiver could help identify salient environmental cues that the patient could use

to remember to take medications. . . . The presence of a family member may help the provider more fully understand the patient’s life circumstances and the circumstances which might create barriers to optimal adherence. In some cases, informal

(Biopsychosocial Update is continued on Page 12)

For this reason, mental health clinicians

are often called upon to conduct a psychological evaluation to determine appropriateness for this course of treatment. . . . A pre-treatment psychological evaluation should assess for those factors that will maximize the likelihood of a successful treatment course. Therefore, clinicians should assess for: psychiatric stability and safety (e.g., suicidal ideation, uncontrolled depression), current and past substance use and abuse, knowledge and expectations about treatment for HCV, motivation and ability to adhere to treatment, and psychosocial support.¹ . . . After an assessment, clinicians can help prepare patients for treatment by providing education, establishing realistic expectations of treatment success, developing stress-management skills, and identifying areas of concern that patients and/or providers can monitor throughout the course of treatment. Also, a clinician can discuss the potential benefits of a referral for psychiatry consultation to consider psychotropic medication. However, it is important to note that there have been few large-sample, controlled studies evaluating the benefits of prophylactic psychotropic medications in HCV patients on IFN treatment, and that studies with small

¹ One version of the pre-treatment psychological evaluation, "the Structured Interview for the Treatment of the Hepatitis C Virus (SIT-HCV), developed by the Medical Psychology Service at the VA Boston Healthcare System in collaboration with the VA Liver Clinic[,] . . . expands upon a standard psychiatric interview by addressing those psychological and behavioral factors that are unique to this population and essential to consider prior to recommending a patient for IFN therapy. . . . On the basis of the information gathered during the administration of the SIT-HCV, clinicians can make behavioral recommendations that will enhance a patient's likelihood of attaining an optimal treatment outcome while minimizing the impact of incapacitating side effects" (Silberbogen, Mori, & Sogg, 2005, p. 58). The complete protocol can be found in the appendix of Silberbogen and colleagues' article.

Psychiatry & HIV/HCV Coinfection

According to Silberbogen and colleagues (2009), "numerous studies . . . document high prevalence rates of preexisting psychiatric disorders among patients with HCV. . . . Within the HCV-positive population, approximately 27%-78% of patients are diagnosed with past or current substance abuse, 15%-62% with mood disorders, and 30%-40% with anxiety disorders such as PTSD [posttraumatic stress disorder]" (p. 115).

With regard to the population of co-infected individuals, however, and "in the absence of established guidelines for the management of [the] psychiatric status of HIV/HCV-coinfected patients initiating PEG-IFN/RBV therapy," Weiss and Morgello (2009) "sought to determine what the state of practice is for providers actively engaged in the care of these patients" (p. 532). The investigators developed and reported on "a provider survey designed to determine whether consensus exists in the management of these patients and what factors might impact differing treatment approaches taken by health care providers" (p. 532). They focused in particular on "the use of prophylactic treatment with antidepressants [to] prevent . . . the development of depressive side effects during HCV treatment" (p. 532).

From a pool of 236 "expert" providers invited to participate, the sample consisted of 92 providers who completed the anonymous online survey, 26% of whom were psychiatrists. With regard to practice setting and provider discipline, Weiss and Morgello found that "the psychiatric management of HIV-coinfected patients being treated for HCV occurs in multiple contexts (varying from comprehensive integrated clinics to individual practices) and is done by providers from a wide range of disciplines (infectious disease, psychiatry, internal medicine, nurse practitioner). The survey was able to establish the practice patterns of expert providers who are predominantly physicians working in varied practice settings internationally" (p. 535).¹ Notably, most of the nonpsychiatrist survey respondents have "very limited access to psychiatric consultation" (p. 535).

With regard to these practice patterns,

more than one third of providers indicate[d] that they use or offer the option of antidepressant use prophylactically in HIV-positive patients with no past or current depression beginning HCV treatment, and more than three quarters do so in patients with a history of depression but no current symptoms of depression. The most experienced nonpsychiatrist providers were more likely to use antidepressants prior to the start of treatment in HIV-coinfected patients as compared to in HCV mono[-]infected patients. There . . . [wa]s consensus among providers to leave psychiatric medication unchanged in patients currently treated for unipolar depression. (p. 531)

Weiss and Morgello conclude that "many expert providers prescribe antidepressants to HIV/HCV-coinfected patients initiating [HCV] treatment in the absence of symptoms of depression, despite the lack of data supporting this approach in this population" (p. 531). The investigators surmise that "this pattern of prescribing . . . may be related to . . . limited access to psychiatric consultation, with providers viewing the prophylactic use of antidepressants as the safest and most cautious treatment approach" (p. 536). Weiss and Morgello advocate for "increasing [nonpsychiatrist] provider skills and competence through advanced training in psychiatric assessment and management[, because this] would likely reduce the extent to which these providers use antidepressants prophylactically and could potentially lead to better HCV treatment outcomes" (p. 536). Additionally (and importantly), "research is needed to provide an evidence base to guide the optimal psychiatric management of HIV/HCV-coinfected patients beginning [HCV] treatment" (p. 531).

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¹ Wagner et al. (2009) point out that "unlike HCV mono-infected patients, who are typically treated by liver specialists (e.g., hepatologist or gastroenterologist) with extensive experience with HCV treatment, HIV coinfected patients are most often treated by HIV primary care providers (with relatively limited experience with PEG-IFN/RBV) because liver specialists are unavailable" (p. 716).

sample sizes have found inconsistent results. (Silberbogen et al., 2009, p. 117; see also [psychiatry sidebar](#))

The Role of the Mental Health Clinician

Silberbogen and colleagues (2009) "have identified areas in which clinicians can intervene [with patients diagnosed with HCV]; these include adjustment to having a chronic medical illness, coping with stigma and relationship changes, management of side effects, and implementing healthy lifestyle changes" (p. 114). Some of the recommendations from these authors in each of these areas follow:

Adjustment to having a chronic medical illness – At the time of diagnosis with HCV, "a mental health clinician can help a patient to process this new diagnosis, generate effective coping strategies, facilitate communication between the patient and hepatologists, and serve as a resource for patients' questions and concerns while providing stability and support" (p. 115). In fact,

a key role for the mental health clinician is to ensure that HCV-positive patients have a thorough understanding of their diagnosis and to help translate this knowledge into behavioral change. A well-informed clinician can assess patients' current level of understanding, correct inaccurate beliefs, increase their base of knowledge, and help patients set behaviorally-based goals consistent with treatment recommendations.

Although education may be sufficient to assist some during this adjustment process, other patients may benefit from counseling that helps them to make sense of this diagnosis. Cognitive-behavioral stress-management interventions have proven effective in reducing depressive symptoms and enhancing benefit-finding, positive reframing, and perceived social support in chronic medical populations, including those with HIV. . . . Stress- and anger-man-

agement interventions are likely to benefit patients struggling with the unpredictability that often accompanies the diagnosis of a chronic illness. Mental health clinicians can also help patients to identify areas of their life in which they can exert some control (i.e., response to stressors) that may counterbalance these negative psychological sequelae. (pp. 115-116)

Coping with stigma and relationship changes – Clinician can help individuals living with HCV to "identity ways to buffer themselves from the impact of stigmatization, such as building a supportive network of friends, family, and medical providers, advocating assertively for . . . [their] needs, and learning how to disclose information while being self-protective. Therapy can also focus on enhancing patients' self-esteem by identifying and building on their positive attributes. Some patients may find value in activities that give them a sense of purpose (e.g., public-awareness programs, political advocacy)" (p. 116). In addition, "mental health clinicians can assist individuals with HCV to navigate . . . changes within their social support network. Communication and problem-solving skills training specifically focused on managing role-changes may prove beneficial, as well as acceptance-based work. Also, participation in couples or family therapy can allow patients to practice these skills in a supportive environment" (p. 116). Finally,

clinicians can help patients build their social support networks by treating mood disorders that interfere with social efforts and by setting small goals toward increased socialization. Clinicians can also assist HCV patients to identify and enhance existing relationships that they may initially overlook or discount. Patients may find it beneficial to engage in "safer" outlets for social interaction, such as online support communities, volunteer positions, or psycho-educational/support groups for patients with HCV, liver disease, or chronic medical conditions. Support groups can be a useful source of information and connection for patients with chronic illness. Mental health pro-

viders can make an important contribution to the care of patients with HCV by organizing and/or facilitating support groups focused on issues relevant to this patient population. In addition to providing much-needed social support, these groups can provide education, promote positive health behaviors, and moderate experiences of stigma or discrimination. (p. 117)²

Management of side effects – Once treatment has been initiated,

mental health clinicians can use brief standardized measures (e.g., the Beck Depression Inventory) . . . to monitor the presence and severity of psychiatric symptoms . . . and can address specific symptoms in the context of therapy. Stress-management (e.g., relaxation exercises, problem-solving practice), behavioral activation, cognitive restructuring, and enhancement of self-care behaviors (e.g., exercise, proper diet, sleep hygiene) are useful strategies for minimizing potential side effects. Clinicians are also in an excellent position to provide feedback to medical staff, such as psychiatrists, should greater intervention be necessary (i.e., psychotropic medications). (pp. 117-118)

In the area of medication adherence, "clinicians can help patients to identify and problem-solve barriers to treatment-adherence, assist in the organization and scheduling of medications, manage side effects, and facilitate access to medical providers" (p. 118).

(Tool Box is continued on Page 12)

² "As the nation's largest care-provider of patients with HCV, the [Department of Veterans Affairs] has developed a comprehensive website designed to meet both patients' and providers' needs (www.hepatitis.va.gov). . . . Available resources for mental health providers include a 'how-to' program guide that outlines the basic steps for initiating and maintaining a hepatitis C support group. This valuable resource includes a discussion of issues to consider when developing a group, suggestions for group topics, descriptions of therapeutic and facilitation techniques, and sample forms and handouts" (Silberbogen, Ulloa, Janke, & Mori, 2009, p. 117).

caregivers could emphasize medication dosing requirements, dispense medications into pill boxes, or provide injections.

Besides influencing patient behavior, informal caregivers . . . might make a provider more comfortable prescribing HAART[,]

which could ultimately benefit the patient. Of course, a family member's opinion could also convince a provider to withhold HAART, such as if a family member provides evidence that the patient would have difficulty complying with treatment recommendations. Such information (assuming that it is accurate) could

be critical when making medication-related decisions. (p. 1048)

On the other hand,

perhaps the most salient disadvantage of and barrier to involvement related to the feared or actual relational consequences of [HIV] disclosure. . . . These con-

(Tool Box -- continued from Page 11)

Implementing healthy lifestyle changes – Because alcohol has a detrimental effect on liver functioning, “reduction in alcohol use is one of the most important behavioral changes patients can make to slow the rate of HCV progression” (p. 118), and “patients with an understanding of the relationship between HCV and alcohol use may be increasingly motivated to make and sustain healthy lifestyle changes” (p. 119). In support of this effort,

mental health clinicians can work with patients to develop a concrete change plan based on their stated goals for treatment and anticipate challenges that may interfere with the execution of these goals. Also, patients on IFN treatment who have a history of alcohol abuse or dependence may benefit from ongoing monitoring and support from a clinician with experience in substance-abuse counseling, because the side effects of treatment may result in increased urges and cravings. . . .

Several standardized instruments, such as the Alcohol Use Disorders Identification Test (AUDIT) . . . or the Alcohol Abstinence Self-Efficacy Scale. . . . may prove useful to the clinician assessing and monitoring alcohol intake for patients with HCV. These brief measures are easy to administer and can be used to identify patients in need of additional intervention. All patients should be educated regarding the effects of alcohol on the course of HCV, and, when appropriate, should be evaluated by a chemical-dependency specialist. (p. 118)

Because cigarette-smoking can affect

“liver health, treatment efficacy, and quality of life,” clinicians are encouraged to review “evidence-based recommendations from research in general populations that can be used as guides for . . . assisting . . . HCV-positive patient[s] to quit smoking or reduce the amount that they smoke. . . . Goals of these recommendations are to increase screening, enhance motivation, and assist patients to reduce tobacco use through problem-solving techniques” (p. 119).

Since “it is likely that improved nutritional status will have a positive effect on disease-progression and long-term outcome for HCV-positive patients,” mental health clinicians

can take several steps to assist the HCV-positive patient to achieve his or her individual dietary goals. First, clinicians should encourage all HCV-positive patients to pursue a healthy diet and educate patients about how diet can affect their disease progression and quality of life. Unhealthy diet patterns should be identified (e.g., high-sugar and high-fat diets, high daily caloric intake, frequent fast-food consumption, limited fruit and vegetable intake) and addressed. Finally, referrals to nutrition services may be appropriate for some patients, particularly for cases in which the nutritional needs may require a unique or intensive intervention, such as with HCV-positive patients who are overweight/obese, those for whom there are concerns about iron overload, and those who have comorbid metabolic concerns, such as diabetes. (p. 119)

Additionally,

with medical-provider approval, HCV-positive patients should be

encouraged to participate in regular physical activity to address weight-management, quality of life, and symptom-management. Clinicians can assist HCV patients with setting exercise goals, enhancing motivation to exercise, addressing barriers to activities, and challenging any unhelpful thoughts that interfere with exercise. Devices such as pedometers may motivate patients who are ready to make changes in activity levels. When appropriate, a referral to rehabilitation or physical therapy services for exercise recommendations can be extremely useful. (p. 119)

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cerns are not unfounded as participants reported varying reactions from others in the face of the diagnosis, including anger, blame, and emotional abandonment. In effect, some of these reactions lead to emotional upset and violence during and in response to the information that is exchanged during medical appointments. Besides nondisclosure, other barriers to family participation included relationship instability resulting from the HIV-positive person's anger that the partner had infected him or her, a health care culture that does not actively encourage family participation, and incarceration. (p. 1048)

Mindful of the potential for "negative emotional and behavioral consequences for the patient and disrupted patient-provider communication" (p. 1043), Mosack and Petroll suggest that

as a matter of protocol, the provider could meet privately with patients at the first appointment and discuss their available support system . . . [and] explicitly invite patients to include a supportive other in subsequent appointments. During such private conversations, the provider should carefully screen for abuse and discuss the topics which might be off limits when others are involved. As an additional protection related to confidentiality and HIPAA, providers could routinely have patients sign releases of information prior to commencing an appointment with another person present if they believed this to be necessary.

Alternatively, social or case workers could meet with patients prior to their health care appointments. During that meeting, they could screen for abuse, and help patients brainstorm about individu-

als who might be enlisted to join them at health care appointments. If no appropriate person is available, having a caseworker who could attend initial treatment planning appointments could potentially improve the likelihood of getting the patient engaged in treatment and more likely to comply with medical recommendations.

On a related note, although the benefits of having informal caregivers present during treatment planning are overwhelmingly apparent, many patients do not have such support available to them early in their diagnosis. However, volunteer or clinic-sponsored programs could be established in which a non-related treatment advocate or mentor who is also HIV positive attends one or more initial appointments. A patient advocate may provide many of the same benefits described of the informal caregivers without some of the disadvantages that were found when including family in this context.

A final recommendation is to schedule evening or weekend appointments for initial treatment planning appointments. Although this would require greater effort and resources, securing others' support early on in treatment planning and prior to the commencement of a medication protocol could yield important dividends, particularly in terms of adherence and secondary prevention. (p. 1049)

Serostatus Disclosure

Fekete et al. (2009) examined "(1) how **HIV-specific social support** may modify the associations between patterns of **serostatus disclosure** to specific family members on psychological (i.e., **depressive symptoms**) and physiological (i.e., **cortisol**) health⁵ and (2) how **percep-**

tions of general stress may account for the interactive effects of disclosure and support on depressive symptoms and cortisol" (pp. 367-368) among 82 low-income, ethnic minority women living with HIV. The investigators found that "the effects of serostatus disclosure on perceived stress and health in [women living with HIV] may depend, in part, on women's family environment and to whom they disclose ... within that environment" (p. 367). More specifically, and

consistent with . . . predictions, if women had directly disclosed their serostatus to their mothers and if the family was perceived as being empathic, affectionate, or providing instrumental assistance, women appraised events in their lives as being less stressful and also experienced fewer depressive symptoms. Further, women who had directly disclosed their serostatus to mothers had lower levels of cortisol if they also perceived that they were in a supportive family environment. Inconsistent with predictions, however, direct disclosure to spouses coupled with higher levels of support from the family was associated with increased, rather than decreased, perceived stress, which in turn was associated with greater depressive symptoms. Similarly, disclosure to children coupled with high family support was marginally associated with greater depressive symptoms in [women living with HIV]. (p. 373)

With regard to the finding on spousal disclosure, the investigators conjecture that women might not have been "receiving adequate spousal support or were dissatisfied with the quality of their marital relationship.

⁵ "Elevated levels of cortisol have immunosuppressive effects in patients living with HIV . . . and might contribute to long-term negative health outcomes" (Fekete et al., 2009, p. 368).

. . . Family members may have stepped in to provide emotional and tangible assistance to women[,] thus accounting for the high levels of perceived family support in the women who showed an association between disclosure, increased perceived stress, and greater depressive symptoms” (p. 374). To remedy this situation, Fekete and colleagues point to research suggesting that

interventions including family members may be advantageous for women who have disclosed to family members but are not reaping the psychological benefits of support available to them, and interventions including stress management components aimed at reducing interpersonal stressors may have physiological health benefits for women in the process of disclosing to their families. The results of the present study suggest that psychosocial interventions that help women solicit or accept support from their families may facilitate both psychosocial and physiological adjustment to HIV. (p. 375)

Coping, Social Support, & Quality of Life

Drawing data from study participants in 13 European countries, Gordillo et al. (2009) explored “how **emotional support received from partners and family/friends** and gender explains psychological well-being (i.e., stress, depression, anxiety) in a sample of 409 partnered European HIV positive individuals” (p. 523). The investigators “hypothesized that gender would modify the associations between support and psychological well-being such that men would benefit more from partner support whereas women would benefit more from family/friend support. Results revealed that regardless of the source of support, men’s well-being was more positively influenced by support than was women’s well-being. Women’s difficulties in receiving

emotional support may have deleterious effects on their psychological well-being” (p. 523). On this last point, the investigators observe that

emotional support may be defined as the expression of concern, compassion, sympathy, and esteem for an individual . . . , [yet w]omen who did receive emotional support, particularly from their family and friends, tended to also report higher levels of distress. One explanation . . . is that there may have been a mismatch between the amount of support women perceived that they needed and the amount of support they actually received. Not receiving adequate support may explain why women living with HIV in [this] study did not obtain psychological benefits from receiving emotional support from their families.

It is also possible that women in [this] study did not want to relinquish their role of care provider and nurturer as a result of their illness. . . . If family members provided unsolicited instrumental or emotional support by offering to help with child care, providing advice, or even offering financial assistance, women may have perceived the message that they were not capable of managing the norms and responsibilities of their social role. Support that is not asked for can be perceived by support recipients as controlling or interfering, and is often met with negative reactions and feelings of incompetence. . . . Moreover, even well-intentioned support efforts from others may have negative effects, especially if support recipients perceive that the support efforts are insensitive or inconsistent with their needs. . . . In contrast, men whose social roles prescribe that they be recipients of care rather than providers of care . . . may have seen involvement from family as well-

come and helpful, and likely did not feel as if the norms of their social role were being threatened. (pp. 527-528)

Gordillo and colleagues suggest that

defining HIV as a dyadic or family disease may . . . provide a particularly valuable approach in psychosocial HIV care. While

Tool Box

Resources

Books & Articles

Baumgartner, L.M., & David, K.N. (2009). Accepting being poz: The incorporation of the HIV identity into the self. *Qualitative Health Research*, 19(12), 1730-1743.

“In a previous study, the first author of the current study examined how people who were diagnosed with . . . HIV/AIDS . . . when it was considered a terminal illness incorporated their HIV/AIDS identity into the self over time.¹ In the qualitative study reported here, we examined HIV identity incorporation in participants diagnosed with HIV after 1996, when it was considered a chronic illness in the United States. We uncovered a three-step process: diagnosis, a postdiagnosis turning point, and integration. We compared and contrasted the results to those from the previous study and studies of other chronic illnesses. The findings advance our understanding of HIV/AIDS, chronic illness, and identity. Practical implications for HIV/AIDS educators are also discussed” (p. 1730).

Childs, J., & Maxwell, M. (2009). Psychosocial snapshots: Perinatally infected HIV+ adolescents’ sexual behaviors and pregnancies. *Social Work in Health Care*, 48(8), 777-797. “Perinatally infected HIV+ adolescents are confronted with unique psychosocial challenges as they navigate sexual behaviors and pregnancies. How their health and the nature of their chronic illness affect the normal developmental challenges of adolescence is explored through

¹ This article is highlighted in the “Books & Articles” Tool Box in the [Winter 2008](#) issue of *mental health AIDS*.

there may be limits to this approach in most routine HIV care settings, it would help to strengthen partner and family relations by enabling the couple or members of the family system to become involved in the illness management of men and women living with HIV. Knowledge of how social support is perceived by HIV positive persons seems to be

a necessary requisite for effective psychological treatment; therefore, a gender specific approach should be applied as much in clinical practice as in social support research. (p. 529)

Lastly, the Atlanta-based team of Farber et al. (2010) “examined the association of **personal meaning** to psychological well-being in [132]

adults living with HIV/AIDS receiving mental health services. Personal meaning refers to a framework for delineating the purposes and goals that make life worth living and for evaluating the degree to which these purposes and goals are being fulfilled” (p. 73). The investigators found that “personal meaning was positively associated with psychological well-being, although it did not contribute

case vignettes taken from social workers’ clinical practice at an East Harlem Medical Center. The successes and difficulties faced by both the patient and the practitioner are illustrated” (p. 777).

Goforth, H.W., Lowery, J., Cutson, T.M., McMillan, E.S., Kenedi, C., & Cohen, M.A. (2009). Impact of bereavement on progression of AIDS and HIV infection: A review. *Psychosomatics*, 50(5), 433-439.

“The goal of this review is to assess the current literature regarding grief, HIV, and immunity,” according to Goforth and colleagues, who report that “patients who experience maladaptive grief show more rapid losses of CD4 T-cells over time, even when controlling for age, health status, use of antiretrovirals [(ARVs)], and illicit drug abuse. This immune dysfunction may be managed by a variety of psychotherapeutic techniques” (p. 433).

Han, C.-s. (2009). Chopsticks don’t make it culturally competent: Addressing larger issues for HIV prevention among gay, bisexual, and queer Asian Pacific Islander men. *Health & Social Work*, 34(4), 273-281.

“This article explores what factors HIV prevention service providers and active volunteers who are also members of the groups that they serve believe need to be addressed before a culturally appropriate intervention strategy for gay, bisexual, and queer Asian Pacific Islander [(API)] men can be developed. . . . Analysis of qualitative data revealed five issues that participants said need to be addressed when working with members of this group” (p. 273): “(1) the need to address racism in the gay community, (2) the need to address homophobia in the API community, (3) the need to increase self-esteem, (4) the need to promote a gay

API community, and (5) the need to provide positive role models” (p. 275).

Hart, G.J., & Elford, J. (2010). Sexual risk behaviour of men who have sex with men: Emerging patterns and new challenges. *Current Opinion in Infectious Diseases*, 23(1), 39-44.

This review “focuses on behavioural research in the era of ART [ARV therapy], with particular reference to continuing transmission of HIV, current risk factors for HIV infection in negative MSM [men who have sex with men], risk behaviour and risk reduction interventions among HIV-positive MSM and old and new sexually transmitted infections (STIs). We also consider the implications of ageing for HIV-positive men, as well as new and emerging populations of HIV-positive MSM communities” (p. 39). Hart and Elford believe that “combination prevention” – using social structural, behavioural and biomedical approaches in tandem – could reduce the risk of HIV transmission, and may be particularly suited to HIV-positive MSM” (p. 39).

Kelly, J.S., Langdon, D., & Serpell, L. (2009). The phenomenology of body image in men living with HIV. *AIDS Care*, 21(12), 1560-1567.

“This study explores the experience of body image in HIV+ gay men. It investigates how gay men identify and experience HIV and HAART [highly active ART]-related body changes, what meanings are applied to such changes and how they cope with them” (p. 1561). “The study concludes with a cognitive-behavioural model of body image . . . and suggestions for intervention. Further research is needed to validate the model and investigate whether the findings are generalisable. However, body image concerns should be acknowledged when addressing HIV-related health” (p. 1560).

Kwong, J., & Bouchard-Miller, K. (2010). Smoking cessation for persons living with HIV: A review of currently available interventions. *Journal of the Association of Nurses in AIDS Care*, 21(1), 3-10.

“This article provides an overview of currently available interventions for smoking cessation, reviews considerations for patients with HIV, and discusses clinical implications for nurses and advanced practice clinicians” (p. 3).

Lescano, C.M., Brown, L.K., Raffaelli, M., & Lima, L.-A. (2009). Cultural factors and family-based HIV prevention intervention for Latino youth. *Journal of Pediatric Psychology*, 34(10), 1041-1052.

“Given the emphasis on *familismo* and collectivism among Latinos, family-based programs are likely to be well received and could contribute to long-term maintenance of adolescent safety. In this synthesis of the relevant literature, cultural factors that have been identified as relevant to Latino sexuality are reviewed and implications for family-based intervention with Latinos are addressed” (p. 1041).

Morales, E.S. (2009). Contextual community prevention theory: Building interventions with community agency collaboration. *American Psychologist*, 64(8), 805-816.

“Contextual community prevention theory is an innovative approach that focuses on changing behaviors of community members by creating a visible institutional presence that draws and pulls the targeted population into the organization’s activities and interventions. The result is an institution or organization within the community that provides a new active and dynamic context, engaging its

(Tool Box is continued on Page 16)

(Tool Box -- continued from Page 15)

community members into its activities, interventions, and functions. An HIV prevention program developed collaboratively from the ground up for Latino gay/bisexual men is presented. Results from the program evaluation efforts across the years suggest promise for testing its efficacy through a randomized trial. HIV prevention efforts need to develop dynamic support systems within communities where these men have ownership, have control, and feel safe; otherwise HIV infection rates in this population will increase" (p. 806).

Nejad, S.H., Gandhi, R.T., & Freudenreich, O. (2009). Clozapine use in HIV-infected schizophrenia patients: A case-based discussion and review [Case report]. *Psychosomatics*, 50(6), 626-632.

"Clozapine is the only antipsychotic that has shown efficacy superior to first- and second-generation antipsychotics. . . . Despite its efficacy, only 5% of patients with schizophrenia in the United States receive clozapine. . . . One reason for clozapine's underuse is its potential for serious side

significantly to the variance in well-being over and above social support, optimism and coping behavior in . . . [this] model. . . . [Additional] analysis showed partial mediation by optimism of the association between personal meaning and well-being" (p. 73). In fact,

dispositional optimism . . .

made the greatest independent contribution to the explained variance in psychological well-being of all variables included in the model. Additionally, the mediation findings suggest that meaning's association to psychological well-being may, in part, be understood in terms of its association to optimism. . . .

Perceived social support also made a significant independent contribution to the variance in psychological well-being in the model examined in this study. . . .

effects. . . . Here we describe two cases in which clozapine has been safely and effectively used in HIV-infected patients, and we discuss the important role this antipsychotic may have in managing these complicated scenarios" (p. 627).

Sanz-Cortés, S., Fashho-Rodriguez, E., Sánchez-Arana Moreno, T., Ruiz-Doblado, S., & Marín-Martín, J. (2009). A case report of schizophrenia and HIV: HAART in association with clozapine [Case report]. *Journal of Psychiatric Intensive Care*, 5(1), 47-49.

"We present the case of a 30-year-old man with a history of schizophrenia who was successfully treated with clozapine following an admission to a psychiatric unit with acute confusional symptoms secondary to HIV-related central nervous system (CNS) involvement" (p. 47).

Singer, E.J., Valdes-Sueiras, M., Commins, D., & Levine, A. (2010). Neurologic presentations of AIDS. *Neurologic Clinics*, 28(1), 253-275.

"HIV is associated with immunodeficiency, neoplasia, and neurologic disease" (p. 253). "HIV is neuroinvasive

Finally, consistent with previous research, study results demonstrated that psychological well-being was positively associated with instrumental (**problem-focused**) coping and negatively associated with emotional preoccupation (emotion-focused) coping. Emotion preoccupation coping also made a significant independent contribution to the variance in psychological well-being in the . . . model, suggesting that reliance on emotion-focused coping strategies among individuals with HIV and psychiatric comorbidities tends to be associated with lower psychological well-being. (p. 77)

Taken together, these findings prompt Farber and colleagues to

suggest that a focus on personal meaning may be a productive avenue for psychotherapy . . . with individuals living with HIV/AIDS

(can enter the . . . CNS . . .), neurotrophic (can live in neural tissues), and neurovirulent (causes disease of the nervous system)" (p. 253). This article reviews the "HIV-associated neurologic syndromes[, which] can be classified as primary HIV neurologic disease (in which HIV is both necessary and sufficient to cause the illness), secondary or opportunistic neurologic disease (in which HIV interacts with other pathogens, resulting in opportunistic infections . . . and tumors), and treatment-related neurologic disease (such as immune reconstitution inflammatory syndrome)" (p. 253).

Vance, D.E., Struzick, T., & Childs, G. (2010). Challenges of depression and suicidal ideation associated with aging with HIV/AIDS: Implications for social work. *Journal of Gerontological Social Work*, 53(2), 159-175.

"Studies show that those aging with HIV/AIDS have a number of stressors that tax their coping mechanisms, increasing vulnerability to depression and suicidal ideation. These stressors can be categorized into three areas. First, there are psychosocial

and co-occurring psychiatric disorders. This begins with assessment of a patient's global meaning framework and specific HIV-related appraisals that flow from this framework. For example, it is important to evaluate the patient's guiding beliefs regarding what gives life value or purpose, and how these beliefs inform the patient's assumptions of what is possible in living with HIV disease. The flexibility of the patient's meaning framework in accommodating HIV-associated realities and constraints should also be carefully assessed. In this regard, as suggested by study findings of partial mediation by optimism of the relationship between meaning and well-being, it is clinically valuable to consider how the patient's global meaning framework might influence goal setting and beliefs about goal attainment. Thus, the psychotherapist can intervene at the level of the

stressors that can contribute to depression. Second, there are health and biochemical stressors that can contribute to depression, as well as compromise cognitive abilities needed to adapt to such stressors. Third, cognitive stressors may create predispositions to depression. In particular, certain cognitive abilities needed to cope with depression and suicidal ideation may be compromised by aging with HIV/AIDS. A model of these stressors is provided for didactic purposes, as well as to suggest implications for social work practice and research” (p. 159).

Wagner, K.D., Brief, D.J., Vielhauer, M.J., Sussman, S., Keane, T.M., & Malow, R. (2009). The potential for PTSD, substance use, and HIV risk behavior among adolescents exposed to Hurricane Katrina. *Substance Use & Misuse, 44*(12), 1749-1767.
“We review existing literature on the effects of exposure to natural disasters and similar traumas on youth and, where data on youth are unavailable, on adults. The effect of natural disasters is discussed in terms of risk for

three negative health outcomes that are of particular concern due to their potential to cause long-term morbidity: post-traumatic stress disorder, substance use disorder, and HIV-risk behavior. Where available, data from studies of the effects of Hurricane Katrina are included” (p. 1749).

Wapenyi, K. (2010). Do lesbians get AIDS? Women who have sex with women, HIV/AIDS, and its mental health impact. *Journal of Gay & Lesbian Mental Health, 14*(1), 52-55.
“The author is a psychiatrist working in a clinic for people who are HIV positive. She discusses issues for lesbians at risk for and affected by HIV. These include the low perceived risk of infection, barriers to getting appropriate health care, and general lack of knowledge about the special needs of lesbians at risk for HIV. The importance of not making assumptions and taking a full sexual history is emphasized” (p. 52).

Webel, A.R., & Holzemer, W.L. (2009). Positive Self-Management Program for women living with HIV: A descriptive analysis. *Journal of the Association of*

Nurses in AIDS Care, 20(6), 458-467.
“The investigators conducted a small descriptive pilot study to assess whether women living with HIV needed and wanted a community-based symptom management workshop, such as the Positive Self-Management Program (PSMP).² . . . This pilot study suggests that urban-dwelling, HIV-infected women are interested in participating in a community-based, peer-led intervention and that the program may facilitate symptom management” (p. 458).

On the Web

The New York State Department of Health AIDS Institute has produced guidelines on the “Disclosure of HIV to Perinatally Infected Children and Adolescents,” located here: <http://www.hivguidelines.org/GuidelineDocuments/p-disclosure.pdf>.

– Compiled by
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² For more information on self-management approaches to HIV disease, see the Tool Box in the [Fall 2007](#) issue of *mental health AIDS* entitled “Enlisting Service Consumers as Active Participants in HIV-Related Assessment & Care.”

patient’s HIV-related narratives to promote positive meaning construction that may then favorably influence the patient’s capacity to realistically evaluate and flexibly adjust goals in accordance with new HIV-associated realities.

Study findings also suggest that promoting optimism in patients living with HIV disease and psychiatric comorbidities is a useful area of clinical focus. Targeted cognitive-behavioral interventions have been outlined that promote patient awareness of and challenge pessimistic thinking, while elaborating a more optimistic framework for understanding and interpreting experience.⁶ . . . To take hold, this framework must be realistically implemented and be credible when measured against existing beliefs and life

⁶ For more information on these techniques, see the Tool Box in the [Fall 2004](#) issue of *mental health AIDS* entitled “Positive & Positive: A Winning Combination?”.

experiences of the patient. A recent encapsulation identified several specific cognitive-behavioral interventions that may be useful for promoting optimism, including self-monitoring of pessimistic thoughts; articulating both favorable and unfavorable expectancies regarding an anticipated event and subsequently comparing these expectancies with actual outcomes; cognitive restructuring of beliefs that interfere with an optimistic outlook; using imagery techniques to practice steps for achieving positive results in response to challenges; and actively identifying potentially favorable possibilities in the context of an overall unfavorable circumstance. . . .

With respect to social support, the study results underscore the critical importance of relationships for psychological well-being. Psychotherapy with patients

living with HIV and co-occurring psychiatric difficulties can target the enhancement of professional, peer and/or existing social network support depending on patient needs and concerns. An important part of this process is helping the patient match specific social support needs with the appropriate support resources for informational, instrumental and/or emotional support. . . . Study results also support a focus in psychotherapy on increasing the patient’s coping behavior that focuses on active problem solving while addressing overreliance on emotional preoccupation as a mode of coping with HIV-associated stressors. It is also clinically important to assess the patient’s appraisals of stressors, including meaning-related appraisals, and to consider controllability of a given stressor in facilitating use of adaptive coping behavior. (pp. 77-78)

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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/Hepatitis/STD/TB Prevention News Update* (<http://www.cdcnpin.org/news/NewsList.asp>); *Kaiser Health News* (<http://www.kaiserhealthnews.org/>); and information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

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

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.

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