

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Women & Men

Richardson et al. (2004) examined self-reported unprotected anal or vaginal intercourse (UAV) in 585 HIV clinic service recipients across six California clinics. Each clinic was randomized to one of three intervention conditions: brief counseling by primary care providers involving either gain-framed safer sex messages, loss-framed safer sex messages, or an attention control condition focusing on medication adherence. Participants were provided supplemental written material in all conditions and post-intervention measures were taken up to seven months following the intervention.

The intervention ('Partnership for Health') emphasized the importance of a patient-provider team approach to help patients stay as healthy as possible. Providers discussed [this] concept with patients and provided gain- or loss-framed messages (e.g., Gain: 'We encourage you to make choices that protect yourself and others. Safer sex protects you from other sexually transmitted diseases [STDs] and from other strains of HIV'; Loss: 'We encourage you to make choices that do not put yourself or others at risk. Unsafe sex may expose you to other [STDs] and others strains of HIV'). Providers also discussed safer-sex goals and risk-reduction behaviors. The counseling was brief (3-5 min) but was given at all visits except for those dealing with acute illness. (p. 1181)

Analysis revealed that brief safer-sex counseling emphasizing the *negative* consequences of unsafe sex was effective in reducing HIV sexual risk behaviors, although

the intervention appears to be more effective with those who have multiple or casual sex partners than those engaged in a steady relationship. In closing, Richardson and colleagues emphasize that they "cannot specify the source of the motivation for behavior change (self- or partner-protection, or both). Until this is clarified, counseling strategies should include both messages in order to address motivations that may vary across patients" (p. 1185).

Condom negotiation strategies can also vary from person to person. Lam, Mak, Lindsay, and Russell (2004) compared strategies employed by 234 single, heterosexually-active white and Asian-American university students, categorized dichotomously as verbal/nonverbal and direct/indirect. Although verbal-direct condom negotiation strategies (e.g., persuading through threats ["no condom, no sex"], pleading, or health concerns related to pregnancy or STDs) are assumed to be the most likely to lead to condom use and are, therefore, the most likely to be taught, Lam and colleagues found that *all* types of condom negotiation strategies can be effective. "Although direct strategies (both verbal and nonverbal) were still the most widely used strategies, over forty percent of individuals used verbal-indirect and nonverbal-indirect strategies" (p. 167). Importantly, Asians utilized verbal-indirect strategies (e.g., dropping hints, flattering or deceiving partner [talking about pregnancy prevention when their actual concern is STDs]) more than whites, while women utilized nonverbal-indirect strategies (e.g., placing condoms or a safer sex pamphlet in their partner's view) more than men. While the authors suggest that clinicians incorporate these culture- and gender-based differences in communication

style into HIV prevention interventions, they "note with strong caution that while our study yields important implications for intervention and prevention regarding condom use, we do not advocate these strategies for all dimensions of intimate relationships. Prevention and intervention efforts must consider our findings while simultaneously attending to the potential that nonverbal and indirect strategies may reinforce power dynamics that often disadvantage women and ethnic minorities" (p. 169).

What helps to sustain prevention efforts? Reilly and Woo (2004) explored the impact of social support on the maintenance of safer sexual practices in a diverse convenience sample of 360 adults living with HIV recruited from outpatient medical facilities, 34% of whom had engaged in at least one act of UAV over the preceding six months. Most frequent sources of support included medical professionals, friends, and siblings. Regular sex partners, medical professionals, and community organizations were identified as the most helpful resources, while casual sex partners, siblings, and *social service professionals* were seen as least helpful. In general, individuals who perceived that their sources of support were helpful engaged in fewer sexual risk practices. Reilly and Woo conclude that clinicians "need to understand the support sys-

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tems used by their clients, especially clients engaging in unsafe sexual practices, and assess ... willingness to expand their networks or strengthen them" (pp. 103-104).

About the Severely Mentally Ill

Carey et al. (2004b) evaluated 202 male and 228 female psychiatric outpatients (66% with a mood disorder, 34% with a schizophrenia-spectrum disorder). They found that those diagnosed with a mood disorder engaged in more frequent HIV sexual risk behavior than those diagnosed with a schizophrenia-spectrum disorder and those diagnosed with a comorbid substance use disorder engaged in more frequent HIV sexual risk behavior than those without a concurrent disorder. The authors recommend "routine screening for sexual risk behavior in psychiatric treatment settings and implementation of risk reduction programs for patients who are at risk" (p. 295).

What form might such a program take? This same research group (Carey et al., 2004a) randomly assigned 221 women and 187 men engaged in outpatient psychiatric care for severe mental illness (SMI) to one of three conditions: a twice weekly, five-week HIV risk-reduction intervention that offered information, motivational enhancement, and training in behavioral skills (manual may be found at http://www.chb.syr.edu/PDF_Resources/); a twice weekly, five-week substance use reduction (SUR) intervention; or standard care. Participants were assessed at baseline, at the conclusion of the inter-

vention, and again at three and six months post-intervention. "Patients receiving the HIV-risk-reduction intervention reported less unprotected sex, fewer casual sex partners, fewer new [STDs], more safer sex communications, improved HIV knowledge, more positive condom attitudes, stronger condom use intentions, and improved behavioral skills relative to patients in the SUR and control conditions. Patients receiving the SUR intervention reported fewer total and casual sex partners compared with control patients" (p. 252). Carey and colleagues further note that female participants as well as those diagnosed with major depressive disorder experienced the greatest benefit from the HIV prevention intervention.

About Substance Users

Metsch, McCoy, Miles, and Wohler (2004) surveyed 526 active injecting drug users (IDUs) and crack users in South Florida at high risk for HIV and found that those who believed that HIV prevention strategies other than condoms (e.g., washing the genitals with soap, alcohol, or bleach; douching before or after sex) were effective in preventing infection were also less likely to report using condoms during intercourse. Many of these pre- and postexposure strategies are categorized by the authors as "HIV prevention myths" and may prompt drug users to disregard condoms in the belief that their alternative prevention strategies are equally effective. Clinicians are encouraged to elicit all risk reduction beliefs and behaviors from clients and to "actively work to

debunk myths and beliefs in ineffective prevention strategies. However, practice of ineffective strategies can be framed in a positive light as evidence of a concern for HIV prevention that needs to be refocused and redirected into effective HIV prevention efforts" (p. 157).

About Women

Through a mail survey completed by 155 American Indian women in the New York metropolitan area, Simoni, Sehgal, and Walters (2004) identified both past and current sex- or drug-related HIV risk behaviors among those sampled. Interestingly, "IDU mediated the relationship between nonpartner sexual trauma and lifetime *high-risk sex*. In other words, for American Indian women, nonpartner sexual trauma was associated with IDU, which, in turn, accounted for a significant part of the relationship between nonpartner sexual trauma and *high-risk sex*" (p. 42). IDU did not appear to mediate the relationship between *physical* trauma and high-risk sex. Strikingly, 36% of these respondents endorsed the statement that "AIDS is another form of germ warfare on Indian peoples" (p. 38). This last finding "suggests that community-based HIV interventions and prevention messages must assume high levels of suspicion and mistrust in this population and plan their interventions accordingly" (p. 42). With regard to intervention, the authors

suggest that assessment of sexual and physical trauma and substance use be routinely included as part of HIV prevention and intervention efforts, with appropriate referrals made when necessary. ... [T]o assist American Indians with healing from trauma, it is important to directly deal with justifiable mistrust, document the historically traumatic events in families ..., and individual and familial responses to historical and contemporary trauma. Contextualizing traumatic stressors ... will assist practitioners in bridging the cultural divide between Western and indigenous traditions in HIV/AIDS interventions. ... [I]t is [also] important for the practitioner to ... [illuminate] ... survival strategies – individual, familial, and tribal – [to] assist American Indian women in recov-

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ering and reconnecting with ancestral strengths and culture ... (pp. 42-43)

About Men Who Have Sex with Men

Relf, Huang, Campbell, and Catania (2004) analyzed data from a telephone survey involving 2,124 men who have sex with men (MSM) from New York City, Los Angeles, Chicago, and San Francisco (constituting an age- and ethnicity-diverse urban probability sample of MSM) to explore factors theoretically associated with HIV risk behaviors. Not surprisingly, "[t]he findings ... provide empirical evidence that childhood sexual abuse and battering victimization are associated with HIV risk behaviors in urban MSM" (p. 23). Importantly, "battering victimization was identified as a key mediating variable between childhood sexual abuse, gay identity, and adverse early life experiences and HIV risk behaviors among urban MSM" (p. 14). Relf and colleagues recommend routine screening for battering victimization among MSM. They also point out that "when there is a diagnosis of repeat [STDs] among MSM, it becomes paramount to assess for battering victimization because this could be a clue that negotiating safety is not possible due to threat of or actual violence victimization. Finally, when HIV-positive results are discussed, it is essential to address safety issues when discussing partner notification and future safer sex negotiation" (p. 21).

Continuing with this theme, Gwadz, Clatts, Leonard, and Goldsamt (2004) interviewed 569 MSM (ages 17 to 28) recruited from New York City bars, clubs, parks, and bus stations and found, when controlling for demographic factors and having experienced "childhood adversity" (i.e., victimization and/or foster care placement), that a "fearful" attachment style (i.e., viewing others as rejecting/unresponsive, viewing the self as unworthy/unlovable) was associated with being "outside the protective systems of family, school, and work" (p. 402; i.e., out of school, unemployed, and/or homeless), using substances daily, involvement in sex work, and involvement in the criminal justice system. Moreover, young MSM who identified as heterosexual, bisexual, and/or transgender disclosed greater risk behavior than those who identified as gay. Al-

though challenging, the authors submit that "clinicians can address issues of attachment by attending to core views of self and others and providing a secure base from which clients can explore and change these deeply-held views and potentially maladaptive relational patterns" (p. 410).

Sheon and Crosby (2004) interviewed 150 San Francisco MSM regarding a recent occasion of unprotected anal intercourse (UAI); their findings illuminate the continuing challenge of supporting safer sexual behavior in the clinical setting.

In justifying their risky sexual practices, MSM cited a community-wide shift toward non-disclosure and barebacking since the advent of [highly active antiretroviral therapy or] HAART. Fearing rejection by HIV-positive partners who refuse to use condoms, HIV-negative men saw little advantage in disclosing to casual partners whom they perceived as overwhelmingly HIV-positive. By contrast, HIV-positive men appeared eager to disclose their positive status to release themselves from responsibility for transmission and facilitate "bareback" or unprotected sex. Disavowal of individual responsibility for safer sex in deference to community norms may contribute to the recent spiraling of risk behavior and HIV incidence. (p. 2105)

In terms of intervention, Sheon and Crosby keenly observe that

stressing the risks of a certain behavior to someone who holds ambivalent feelings about that behavior is likely to have an unintended effect. ... For example messages that stress the need to ask and tell one's HIV status, the negative effects of HIV seroconversion or the side effects of HAART will tend to make ambivalent men counter argue, and perhaps become even more entrenched in their beliefs, that they do "know" their partner's serostatus, that HIV seroconversion and the side-effects of HAART are not so bad. Rather than see such ambivalence as an impediment to prevention efforts, ambivalence could serve as a key focus of ... inter-

ventions. Until prevention interventions explicitly address this ambivalence they are unlikely to have much effect on the risk behavior of MSM who no longer perceive HIV as the threat it posed to previous generations. (p. 2117)

Halkitis, Wilton, Parsons, and Hoff (2004) studied 91 gay men living in *HIV-seroconcordant* primary relationships in New York and San Francisco and found UAI to be common in these partnerships, associated with perceiving a lower risk for HIV reinfection, lower condom use intentions, and higher CD4 cell counts. "In light of the fact that other STDs as well as potential reinfection may impact on HIV+ gay men's health, discussion about safer sex should focus on partnering with both HIV- men as well as other HIV+ men" (p. 108). Halkitis and colleagues go on to observe that, if men are involved in seroconcordant relationships, providers will need to explore their perceptions of the risks involved should they engage in UAI with their primary partner (e.g., some couples elect to engage in UAI when both partners share a common strain of HIV and agree not to engage in unprotected sex outside their dyad) and provide factual information regarding health risks when risks are identified.

Turning to *HIV-serodiscordant* pairings, Colfax et al. (2004), in a well-controlled study involving 4,295 urban, HIV-negative MSM, found UAI to be independently associated with having used amyl nitrites ("poppers"), amphetamines, sniffed cocaine, or alcohol (the last of these heavily) during the preceding six months. In looking at recent sexual episodes, consuming six alcoholic drinks or the use *any* of the substances previously noted just before or during sex was also independently associated with UAI. The authors urge clinicians to stress the link between substance use (including a partner's substance use) during sex and the increased likelihood of risky behavior. Findings suggest that clinicians "should focus not only on sexual risk but also on substance use itself, given that the simple presence of alcohol or drugs during a sexual episode was associated with [UAI]" (p. 1008). Colfax and colleagues go on to observe that, excluding alcohol, "[t]he relatively

Tool Box

Methamphetamine on the Brain (Part 2)

Part 1 of this series (presented in the Spring 2004 issue of *mental health AIDS*) offered a medical and psychiatric overview of crystal methamphetamine (meth) use and explored the physiological and psychological factors underlying sexual risk among users. This concluding segment expands on risk assessment, treatment approaches, and special concerns at the interface of meth and HIV.

Adding HIV to the Molecular and Mental Mix

According to Urbina and Jones (2004), the use of meth may contribute to the acquisition of HIV through its effect on the immune system. More specifically, "[meth] may ... have immunomodulatory activity, particularly by impairing CD8 cell-mediated cytotoxic T lymphocyte function This may be of clinical importance in primary HIV infection, because CD8 cell activity is responsible for early suppression of lentiviral replication and viral set point ..." (p. 891). Simply stated, meth seems to impair the ability of the immune system to fight HIV following exposure, thus facilitating the establishment of infection.

Among those who become infected and continue to use, the neurotoxic effects of HIV and meth may be compounded because "both [meth] and HIV target dopamine neurons. HIV affects the dopamine neurons in subcortical structures, particularly the basal ganglia [while meth] targets dopamine in many regions of the brain, including the orbitofrontal cortex (which is thought to be implicated in impulse behavior), as well as the dorsolateral prefrontal cortices and the amygdala ..." (Urbina & Jones, 2004, p. 892). The upshot of this synergy, as suggested by animal studies, is that HIV and meth can play off one another in such a way that the risk for and severity of HIV-associated dementia may be heightened among those who are not taking antiretrovirals.

On this point, Rippeth et al. (2004) examined

low frequency of heavy substance use in this cohort suggests that ... interventions based on addiction ... treatment models may be less useful than [those] that more directly address the effect of episodic use on sexual and other risk" (p. 1008).

Finally, over an 18-month period, Golden, Brewer, Kurth, Holmes, and Handsfield (2004) studied 1,953 urban STD clinic at-

200 individuals, divided into four groups matched for age, education, and ethnicity: HIV-positive/meth dependent ($n = 43$); HIV-negative/meth dependent ($n = 47$); HIV-positive/meth nondependent ($n = 50$); and HIV-negative/meth nondependent ($n = 60$). They found that "HIV infection, [meth] dependence, and the combination of HIV infection and [meth] dependence are all associated with neuropsychological [NP] impairment. In addition to global [impairment], impairments were noted ... in several cognitive domains, including attention/working memory, learning, delayed recall, and motor skills. ... [T]he results suggest that the combination of HIV and [meth] dependence is associated with additive deleterious effects on [NP] functioning relative to either risk factor alone" (p. 10).

The combination of meth and antiretrovirals can be deleterious as well, both in terms of antiretroviral adherence and the potential for a meth overdose. With regard to the former, Reback, Larkins, and Shoptaw (2003) interviewed 23 gay and bisexual men living with HIV who were participating in an outpatient drug treatment research project on meth abuse, all of whom acknowledged that meth use interfered with their adherence to antiretrovirals. *Unplanned* nonadherence was associated with meth-related disruptions in eating and sleeping, while *planned* nonadherence was identified as a strategy to address the recognition that a rigorous treatment schedule would not be maintained while using meth or else was related to participating in sexual activities (as often accompanies meth use) or to concerns about mixing meth and HIV medications. It is important to note that,

[e]ven though the [men] did not take their medications according to prescribed directions, they did not interpret skipping, stretching, or modifying their medication doses as non-adherence. These medication adjustments were viewed as a positive coping strategy that served to create a sense of control over their lives. Short-term, drug- and sex-related non-adherence was rationalized as an acceptable compromise

tendees – 234 HIV-positive, 1,570 HIV-negative, and 149 untested (based on self-report) – in an effort to identify MSM at greatest risk for acquiring or transmitting HIV. Among those men not previously identified as HIV-positive who agreed to testing, they found that UAI with a partner who was either HIV-positive or of unknown status was strongly associated with seroconversion. Among the men who already self-identified

needed to perceive themselves as adherent to their overall medication regimen. In fact, these men never considered their partial or inconsistent adherence as anything other than full adherence. ... [They] believed that if they caught up with missed doses by increasing their dosage for perhaps 2 or 3 days following a drug- and sex-related interruption, they would still qualify as medication adherent. [Clinicians] should be aware of this distortion when substance-using patients discuss their medication taking. (p. 781)

With regard to the latter, meth has the potential to interact with HIV medications, particularly protease inhibitors, resulting in increased toxicity or death (Urbina & Jones, 2004). According to Halkitis, Parsons, and Stirratt (2001), "The effect of [meth] has been demonstrated to be two to three times greater for individuals on combination therapy, especially combinations including ritonavir [Norvir®] ..." (p. 21).

Assessing Meth-Related HIV Risk

Semple, Patterson, and Grant (2003) compared binge and nonbinge use of crystal meth in 90 men who have sex with men (MSM) living with HIV and found that those who self-identified as binge users did *not* use any more meth over a 30-day period than nonbinge users, but reported more social difficulties, a greater number of mental and physical health problems, and riskier sexual behavior when compared to nonbinge users. For this reason, the authors encourage clinicians to gather data on a client's pattern of meth use, not just the amount used when assessing sexual risk.

What about the use of formal HIV risk assessment tools with this population? Twitchell, Huber, Reback, and Shoptaw (2002) compared two HIV risk assessment instruments – a standardized, general measure (Risk for AIDS Behavior, RAB) and a more behaviorally detailed measure (Behavioral Questionnaire-Amphetamine, BQA) – in three samples of meth-dependent people receiving drug treatment: 76 gay men, 57 heterosexual men, and 33 het-

as HIV-positive, an association was noted between the use of methamphetamine (meth) and UAI with HIV-negative partners or those of unknown status [see **Tool Box** above]. Taken together, Golden and colleagues conclude from these findings that

incorporating partner HIV status into routine sexual histories obtained by clinicians from MSM in an STD clinic iden-

erosexual women. While the RAB suggested that gay men were at far greater risk for HIV than either the heterosexual men or women sampled, it was not able to discriminate between gay men who were already infected and those who were not, as did the BQA. The authors conclude that, while general measures of HIV risk may discern broad risk factors in diverse groupings of substance users, more detailed measures may offer greater utility in identifying risk behavior in populations with high prevalence of HIV based on sexual risk behavior as, in this case, with substance-abusing gay men.

What's My Motivation?

While meth use is not confined to MSM, the preponderance of treatment studies have been conducted with this population and so inform current intervention techniques.

On the topic of intervention, Halkitis, Parsons, and Stirratt (2001) make the following general observations:

First, any prevention or treatment approach to [meth] use must recognize that many gay men use the drug to initiate, enhance, and prolong sexual encounters. Interventions to reduce [meth] use will not be effective unless they address the underlying sexual motivations that promote the use of the drug. ... [T]o fully assess the effects of the substance on their lives, gay men will need to consider the connection between use of the drug and their sexual attitudes, behaviors, and risk taking. ... Second, prevention and treatment approaches should be mindful of contexts that may sponsor or encourage [meth] use. Gay and bisexual users of [meth] are characterized by greater involvement with bars, sex clubs, and "circuit" parties. Participation in these contexts may put men at-risk for initiating use of [meth] and will likely inhibit the ability of present users to resist use of the drug. Although prevention and treatment efforts should remain sex-positive to maximize their appeal for many gay

tifies potential HIV transmitters as well as those at highest risk for new HIV diagnosis. ... Where practical considerations preclude detailed behavioral histories, we believe that at a minimum, all clinicians should routinely ask their HIV negative MSM patients a single question: "In the last year, have you had anal sex without a condom with anyone who was HIV-positive or whose HIV sta-

men, they should also bring attention to these contexts of drug use and sexual risk taking. Finally, prevention and treatment efforts should be informed by the clearly documented relationship between [meth] use and HIV transmission among gay men. Use of the drug puts HIV seronegative men at substantial risk for behaviors that can lead to HIV infection, and it also hold potentially harmful effects for men who are HIV+. (pp. 29-30)

When working with MSM who are at risk for infection, the timing of prevention interventions may be critical. Shoptaw, Reback, and Freese (2002) collected data from 68 MSM seeking outpatient treatment for meth abuse or dependence and found high rates of HIV infection associated with a history of genital gonorrhea, having unprotected receptive anal intercourse with more partners in the 30 days preceding intake, and drug injecting. Interestingly, suicidal ideation was associated with being HIV-negative in this sample. According to the authors, "[c]hanges in usual drug use or sexual behaviors toward high risk may provide leverage points, when working with [meth] abusers who are seronegative, to activate treatment messages (e.g., motivational interviewing: harm reduction) or to implement prevention messages, especially during periods of active [meth] use" (p. 103).

Turning to men who have become infected, Semple, Patterson, and Grant (2002) interviewed a convenience sample of 25 HIV-positive MSM and found that their use of meth was associated with "high rates of anal sex, low rates of condom use, multiple sex partners, sexual marathons, and anonymous sex" (p. 149). These men attributed their use of meth to sexual enhancement as well as self-medication of negative feelings associated with being HIV-positive.

Although Patterson and Semple (2003) were unable to locate any published sexual risk reduction interventions conducted with HIV-positive
(Tool Box is continued on Page 6)

tus you did not know?" HIV positive patients should be asked about UAI with partners who are HIV negative or of unknown HIV status. Obtaining a history of drug use, particularly of [meth], also should be routine. (p. 740)

HIV Assessment News

Psychiatric Assessment

Robbins, Phillips, Dudgeon, and Hand

(2004) surveyed an ethnically-diverse convenience sample of 79 people living with HIV (predominantly middle-aged, African-American women) and found that 97% reported sleep disturbances. The quality of sleep was associated with HIV-related symptoms, fatigue and daytime sleepiness, total pain, depression, state anxiety, and number of adults (but not the number of children) in the household. "Disturbed sleep ... continues to be underdiagnosed and therefore undertreated in these individuals. ... [F]indings ... support the need for holistic interventions and treatment of specific symptoms that contribute to sleep disturbances so common in people infected with HIV Both pharmacological and non-pharmacological therapies for sleep disturbances can be beneficial ..." (pp. 48-49).

HIV Treatment News

Medical Care

Gulick et al. (2004) conducted a randomized, double-blind, placebo-controlled trial of three initial, protease inhibitor-sparing HAART regimens: one triple nucleoside reverse transcriptase inhibitor (NRTI) regimen (zidovudine [ZDV, AZT or Retrovir®]-lamivudine [3TC or Epivir®]-abacavir [ABC or Ziagen®]); and two containing one non-nucleoside reverse transcriptase inhibitor (NNRTI; AZT-3TC-efavirenz [EFV or Sustiva®], and AZT-3TC-ABC-EFV). Based on a median follow-up period of 32 weeks with 1,147 study participants, the authors conclude that "an [EFV]-containing regimen is more potent than the triple-nucleoside regimen and support current guidelines that recommend [EFV]-based regimens among the preferred options for the initial treatment of HIV-1 infection" (p. 1858).

Psychiatric/Psychological/ Psychosocial/Spiritual Care Psychopharmacology

In a six-week, open-label, flexible-dose study (dosage ranged from 10 to 40 mg/day), Currier, Molina, and Kato (2004) administered citalopram (Celexa®) to 14 Hispanic and six non-Hispanic outpatients living with HIV/AIDS and diagnosed with major depressive disorder. Among the 14 participants completing the study, 50% experienced a reduction in depressive symptoms at a mean dosage of 34 mg/day, with no

observed variation based on ethnicity (as noted in the use of tricyclic antidepressants). Although the sample size was small and there was no comparison group, the findings suggest that "citalopram is effective in the treatment of depressed HIV-infected patients, regardless of disease stage or Hispanic ethnicity. It is well tolerated and has minimal potential for drug interactions with the antiretroviral medication commonly prescribed in this population" (p. 215).

Neuropsychological Impairment

Heaton et al. (2004) performed neuropsychological (NP), neuromedical, and standardized assessments of "everyday" functioning (i.e., cooking, shopping, financial management, medication management, and vocational abilities) on 267 individuals living with HIV and found that those with NP impairment performed more poorly on *all* measures of everyday functioning than those without NP impairment. In particular, impairment in the domains of abstraction/executive function, attention/working memory, learning, and verbal abilities was most consistently associated with failures on the functional battery. Both NP and functional impairment were associated with cognitive complaints, unemployment, and reliance on others when performing activities of daily living. Of all factors examined, only functional battery impairment and depressed mood were uniquely predictive of problems in "real-world" functioning. "[These] findings confirm the importance of assessing NP status in the prediction of everyday functional ability both in the laboratory and in real life, and suggest that HIV-related NP impairments consistent with frontostriatal involvement, in particular, are strongly predictive of functional impairment. In addition, measures of depression and laboratory-based measures of functional ability appear to be key predictors of real-life functioning, such that clinicians' ... appreciation of patients' problems in everyday functioning may ... be incomplete without such ... information" (p. 329).

Robertson et al. (2004) evaluated 48 HAART recipients upon initiating an antiretroviral regimen and again six months later. "Both plasma and cerebrospinal fluid viral levels significantly declined after treat-

ment. There was significant improvement in neurologic and [NP] functioning after HAART. These results indicate that despite the poor central nervous system penetration of most of these agents, there is satisfactory short-term improvement in both central nervous system viral burden and nervous system function with HAART" (p. 562).

And yet, investigators in Italy (Tozzi et al., 2004) evaluated 70 individuals receiving HAART at a large urban clinic in Rome for neurocognitive impairment and found impairment *in nearly one-third of those tested*. Furthermore, neurocognitive impairment was associated with reductions in health-related quality of life in *all* functional domains (physical, social, cognitive, role) and *all* measures of well-being (pain, mental health, energy, health distress, current health perception). Given this reduced quality of life, Tozzi and colleagues urge clinicians to assess for neurocognitive impairment, even in HAART recipients.

Ryan et al. (2004) compared two groups of adults living with advanced HIV disease: 67 who were co-infected with hepatitis C (HIV+/HCV+) and 49 who were not (HIV+/HCV-). Unlike those with HIV disease alone, those who were co-infected were more likely to: have been dependent on opiates, cocaine, or stimulants in the past; exhibit higher rates of past substance-induced major depression; demonstrate more perseveration and greater impairment on tests of executive function; and be diagnosed with HIV-associated dementia. No significant differences in primary mental disorder rates were noted between the groups, and 42% of each group met diagnostic criteria for current major depression. The authors conclude that, even in a stage of advanced HIV disease, HCV appears to affect neurocognitive and psychiatric functioning.

Further teasing out the impact of co-infection, German investigators (von Giesen et al., 2004) compared the performance of HIV-infected and/or HCV-infected patients (43 HIV+/HCV-; 43 HIV+/HCV+; 44 HIV-/HCV+) on tests of cognition, motor speed, and affective disturbance. While performance did not vary across groups in many areas, these investigators noted that affective

disorders were *less* often found in HIV-/HCV+ study participants, a group which also displayed less depressive symptomatology. All three groups did, however, demonstrate psychomotor slowing. The authors conclude that, "[a]lthough clinically asymptomatic, both HIV-positive and HCV-positive patients may show affective distur-

(Tool Box -- continued from Page 5)

tive meth users, their qualitative interviews with five MSM living with HIV who were regular users led them to conclude that "safer sex can occur in the context of [meth] use. We interviewed heavy users who always used condoms and light users who never used condoms. ... [F]actors other than drug use (e.g. motivation) are important determinants of condom use" (p. iii81).

With this in mind, Semple, Patterson, and Grant (2002) offer the following advice when addressing the interface of meth use and sexual behavior in HIV-infected MSM:

[M]any [MSM] reported they could not have sex unless they were high on meth. The fear of no longer being sexual was identified as a major barrier to giving up meth. ... One clinical approach to this issue involves the use of motivational interviewing techniques to help the client develop insights into the link between his meth use and his sexual experience. Over time, the therapist can help the client to apply these insights in terms of developing a plan and setting goals for behavior change

... [I]t is [also] important to get high-risk individuals to recognize the relationship between cognitive escapism and their use of substances. By inducing awareness of the relationship between drug use and the individual's motivation to escape the emotional pain associated with being HIV+, the clinician may be able to help the client identify moods, emotions, expectancies, and coping styles that contribute to an ongoing pattern of drug use. ... Meth use may [then] be reduced ... [by] providing strategies for self-monitoring and controlling these underlying motivations of drug use

In general, HIV+ meth-using MSM may benefit from ... treatment approaches that address underlying motivation for meth use, and the link between meth use and sexual risk behavior. The three major behavioral approaches ... currently used ...

bances and significant psychomotor slowing" (p. 131).

Adherence to Treatment

Adamian, Golin, Shain, and DeVellis (2004) developed an adherence intervention based on brief (15- to 30-minute) motivational interviewing (MI) and pilot-tested it on

are cognitive behavioral therapy (CBT), motivational enhancement therapy (MET), and self-help groups Client insights into motivations for meth use can be readily incorporated into each treatment approach. ...

[Finally,] an important issue in the treatment of HIV+ MSM is the need to recognize the role of gay sexuality and HIV+ identity in the recovery process. Therapists must acknowledge and address the powerful links between gay sexuality, HIV+ identity, and meth use. (p. 154)

In one of the few studies involving heterosexual adults, Semple, Patterson, and Grant (2004) explored sexual risk behavior among 139 HIV-negative, heterosexually-identified, meth-dependent men and women enrolling in a sexual risk reduction intervention. They found that motivations for use varied (e.g., to get high, to get more energy, to party) and that use was associated with unprotected sexual behavior with multiple partners in the preceding two-month period. Though these data are purely descriptive of a selected sample and therefore limited, Semple and colleagues offer the following suggestions to reduce sexual risk among HIV-negative, heterosexual meth users: 1) take a client-centered, individual approach, so that sessions can be tailored to individual motivations and risk practices; 2) teach clients who are unwilling or unable to engage in drug treatment to engage in safer sexual practices when they use meth (e.g., reducing the number of partners, selecting partners who pose less risk, limiting involvement in sexual marathons); and 3) teach more adaptive coping skills for managing emotional distress (e.g., reaching out for social support rather than engaging in sex to alleviate negative feelings).

Measures of Hope

Reback, Larkins, and Shoptaw (2004) combined quantitative and qualitative research methods to explore sexual risk behaviors among 162 urban, educated gay and bisexual men diagnosed with meth abuse or dependence (60.5% of whom were living with HIV) as they initiated outpatient drug treatment and again at one year. A subset of 34 men partici-

ated in interviews to enrich the quantitative data collected. "A major finding from the quantitative data was the substantial reductions in sexual risk behaviors that occurred consequent to drug abuse treatment and lasted up to the 1-year follow-up evaluations. Qualitative data complemented the findings by revealing the meaning of these risk behavior changes Participants reported that their reduction in high-risk sexual behaviors and a developed sense of responsibility for their own and others' health were a result of their regaining control over their decision-making processes and actions subsequent to drug abuse treatment and reductions in or the elimination of [meth] use" (p. 95). "These findings demonstrate that drug abuse treatment for [meth] can be effective in modifying high-risk sexual behaviors, and follow-up findings indicate that these behavioral changes can be sustained over one year" (p. 96).

Hope extends as well into the medical treatment of former meth users who are HIV-infected. Ellis et al. (2003) examined viral load in 230 research volunteers living with HIV who were classified into three groups: current meth users ($n = 88$), meth users who had been clean for at least 30 days ($n = 66$), and individuals with no history of meth use ($n = 76$). Current users demonstrated higher blood plasma viral loads (and trended toward higher cerebrospinal fluid viral loads) than the other two groups. Importantly, viral loads were elevated only among those current users who were also receiving highly active antiretroviral therapy (HAART), while former users on HAART were capable of suppressing viral replication. Thus,

[d]espite concerns that the complexities of HAART therapy make it impractical for persons with a history of drug abuse, our findings demonstrate that former [meth] users who maintain abstinence can effectively suppress HIV replication with potent [antiretroviral therapy]. These data suggest that providers involved in the clinical care of HIV-infected persons who are [meth] users will need to make efforts to get their patients into substance abuse treatment programs to assist them in achieving stable abstinence. Once abstinence is achieved, the responses to [antiretroviral therapy] by

lor helps the patient find his or her own solutions by resolving ambivalence about that behavior rather than directing the patient to take a particular course of action. By discussing barriers and facilitators, patients easily identified both deficits in their self-efficacy and strategies to improve self-efficacy. This represents an innovative and

former [meth]-dependent persons are similar to those of non-substance abusing control subjects. (p. 1825)

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- Compiled by Abraham Feingold, Psy.D.

empowering approach to health behavior counseling for HIV-positive persons" (p. 235) and merits further evaluation.

In an effort to understand more about how internal representations of HIV-related symptoms and treatment side effects are associated with quality of life and medical adherence, Johnson and Folkman (2004) interviewed a convenience sample of 109 adults receiving HAART and found that "[f]irst, side effects play a role in [quality of life] that is as important as the role played by symptoms of diseases. Second, exploring an individual side effect or disease-related symptom in depth explains [quality of life] more fully compared to aggregated symptom counts. ... [Therefore], helping individuals reduce the adverse consequences of individual symptoms, assisting them in gaining a sense of personal control of physical problems, and intervening on negative emotional representations of side effects may increase the beneficial influence of these factors on adherence to care and [quality of life]" (p. 145).

Harzke et al. (2004) interviewed a convenience sample of 137 African-American drug users receiving antiretrovirals and found adherence to be *independently* associated with forgetting to take medications and with the perceived efficacy of antiretrovirals. Other factors that correlated with antiretroviral adherence included pill burden, concern about side effects (potential or actual), the impact of treatment on feelings (positive or negative) about HIV/AIDS, a higher quality relationship with primary care provider(s), and greater social support and less social isolation. Turning to intervention, the authors

suggest that limiting the pill burden and/or number of medications to the extent possible may be an important first step for adherence for active drug users. Providing informational and other support to influence perceptions and attitudes about pill burden appears equally important for promoting adherence. Our findings ... suggest that interventions must emphasize the potential for positive physical and affective effects of antiretroviral therapies. Such commu-

nication may improve adherence by reducing concerns about medication side effects and by enhancing perceived efficacy of medications to improve physical and emotional health outcomes. Our study ... appears to recommend interventions in this population that aim at improving the quality of the patient-provider relationship specifically and of social support more generally. (p. 466)

Kleeberger et al. (2004) followed a cohort of 597 men taking HAART and assessed adherence over a four-day period every six months. Examining 942 pairings of visits in which 100% adherence was self-reported in the first visit, 88.7% self-reported 100% adherence at their next six-month visit, while 11.3% reported a decline in adherence. Among other things, decreases were associated with having no recent outpatient visits, having less than a college education, younger age, and depression. Turning to the 186 pairings of visits in which less than 100% adherence was self-reported in the first visit, 28.5% self-reported lower adherence at their next six-month visit, while 71.5% reported that their adherence had improved to 100%. Improving adherence was associated with not being African American, not taking recreational drugs, and having received more than three different regimens of HAART. Kleeberger and colleagues observe that "healthcare providers need to be alert for conditions that may lead to a decrease in adherence, such as skipping outpatient visits and symptoms of depression. Also, younger and less educated individuals may need more stress put on the importance of continued high levels of adherence" (p. 687).

On a similar note, Wagner, Kanouse, Koegel, and Sullivan (2004) examined the relationship between SMI and antiretroviral adherence in 45 individuals completing a two-week study in which adherence was measured through use of electronic monitoring medication bottle caps. While many adherence correlates noted in the general HIV population (e.g., side effects, treatment-related beliefs and attitudes, substance use) were also observed in this population, attendance at recent clinic appointments emerged as the single predictor of adher-

ence readiness. An important study limitation was the absence of a measure of current psychotic symptoms among these individuals, who were generally stable on psychotropic medications, and its relationship to antiretroviral adherence. Nevertheless, while "not sufficient to serve as the basis for treatment decision making, review of appointment-keeping records may provide clinicians with a simple, cost-effective method for predicting adherence to ongoing treatment, as well as for evaluating adherence readiness to inform the decision of whether to prescribe or defer treatment" (p. 501) among people with SMI.

From the Block

People Encouraging People

People Encouraging People, Inc. (PEP), located in Baltimore, Maryland, is using CMHS/SAMHSA funding to extend its model of mobile mental health treatment from its historic target population of African-American people living with severe mental illness (SMI) – many of whom also present with substance abuse/dependence diagnoses – to those who are living with SMI as well as HIV.

PEP's Mobile Treatment Program for people living with HIV/AIDS has been implemented in collaboration with the Park Heights Community Health Alliance (PHCHA). The program also works closely with the Baltimore City Health Department as well as other providers of medical, mental health, housing, and spiritual services in their local community. Through this mobile treatment model, PEP has been able to offer individual, group, and family psychotherapy, crisis intervention, and supportive counseling to traditionally hard-to-reach clients in the Lower Park Heights section of Baltimore.

The Principal Investigator is Dimitrios Cavathas, LCSW-C; the Clinical Director is Patricia Patterson, RN, BSN, MSN. For more information, please call 410/367-9220 or write dimitriosc@peponline.org.

– *Compiled by the MHSC Program Coordinating Center*

Coping, Social Support, & Quality of Life
Timmons and Fesko (2004) explored employment concerns through interviews with 29 people living with HIV/AIDS.

Although participants noted the value of employment, they also reported limi-

tations in employment options that were the consequence of their health status. Other work-related obstacles and concerns included disincentives for social security beneficiaries to work and the fear of discrimination related to disclosing their disability in the workplace. Unemployed individuals ... had concerns about the job search and inadequate assistance with job training that they had received from service delivery systems; employed participants were more concerned about job accommodations. Finally, fewer than one-quarter of ... participants had used the state vocational rehabilitation agency for assistance, and participants also reported that [AIDS service organizations] were only partially responsive to their employment concerns. (p. 142)

The authors urge clinicians to educate clients about the Ticket to Work and Work Incentive Improvement Act (TWWIIA) of 1999 (P.L. 106-170), which expands options for social security recipients to maintain health insurance while returning to work and to receive job development assistance, and about work incentive programs through Supplemental Security Income (SSI) or Social Security Disability Income (SSDI); establish connections with state vocational rehabilitation resources, including the Department of Labor and One-Stop Career Centers; and help clients to weigh the risks and benefits of serostatus disclosure and to develop and rehearse a strategy if disclosure is elected. Clinicians can also help clients "advocate for job accommodations by clearly identifying individuals' needs, mapping out potential solutions, and documenting the request and anticipated outcome. ... By understanding their company's policies and formulating potential solutions in advance, individuals with HIV/AIDS can make it easier for their supervisors to incorporate job accommodations into the workplace" (p. 143).

Arns, Martin, and Chernoff (2004) assessed 235 people living with HIV/AIDS in Los Angeles County who enrolled in a back-to-work program. "In addition to help with training and job placement, participants indicated a need for assistance with finances, money

management, housing access and access to health care, as well as with alcohol or drug problems, legal problems and social relationships" (p. 377). While generalizations must be extended cautiously, "[t]he overarching lesson seems to be that individuals who might seek the formal assistance of an HIV employment re-entry programme have a broad range of financial, psychosocial and behavioural problems that need to be addressed either before or concurrently with needs that are directly related to workforce entry" (p. 383).

Formal assistance may also help to facilitate custody planning by HIV-infected parents. Rotheram-Borus, Lester, Wang, and Shen (2004) followed 296 parents living with HIV over a five-year period to identify predictors of legal custody planning. While an increasing number of parents developed plans over this period (23.8% to 52.8%), generally involving extended family members, plans changed frequently and 44.8% of these parents died without making plans. Families less likely to develop plans included those with adolescent children only, those in which the parent had a partner, and those in which the parent was depressed. Importantly, parental disclosure of HIV status, the physical health of the parent, parental substance use, and ethnicity were *not* related to custody planning.

The many children left without a legal custody plan underscores the importance of clinical attention to custody planning for health care providers. ... Making custody plans is associated with having a positive-action coping style, suggesting that interventions that build positive coping styles may enhance planning. Depressed parents are less likely to make custody plans, underscoring the importance of mental health services for [people living with HIV/AIDS]. Fathers with HIV are more likely to need support in developing custody plans Furthermore, parents with young children may need increased support to make plans. (p. 331)

Szapocznik et al. (2004) randomized 209 urban, low-income, African-American women living with HIV to one of three con-

ditions: structural ecosystems therapy (SET), a family-ecological intervention; a person-centered approach (PCA), which functioned as an attention and comparison control group; or a community comparison group, which received standard care.¹ Comparisons across conditions at five time points over an 18-month period showed that those receiving SET experienced greater reductions in psychological distress and family-related hassles than those in either control condition; family support did not, however, increase in the context of SET as predicted. SET appeared to be of particular benefit "for women who, on average, were at or near the clinical threshold for psychological distress and for women with high levels of family hassles" (p. 288). The investigation of this therapy model will continue.

Summers et al. (2004) matched 31 women and 62 men living with HIV who had experienced a loss during the preceding 12-month period; matching was based on lifetime prevalence of major depression. They found that "[b]ereaved HIV+ women presented with intensified bereavement responses, a higher prevalence of current generalized anxiety disorder, and elevated thoughts and gestures of suicide when compared to HIV+ men" (p. 225). The authors conclude that "bereaved women living with HIV may be at increased risk for bereavement complicated with psychiatric morbidity and thoughts of suicide. It is critical that adequate mental health support services be available to this growing risk group of bereaved individuals" (p. 225).

On this topic, Sikkema, Hansen, Kochman, Tate, and Difranceisco (2004) randomly assigned a diverse sample of 235 men and women living with HIV who had lost one or more loved ones over the preceding two years to one of two conditions: a 12-week

¹ Structural ecosystems therapy (SET) "targets social interactions, particularly those that are maladaptive, at the interfaces among the woman, her family, and the social environment The three basic techniques in SET ... are joining, diagnosing, and restructuring" (p. 290). When compared to the person-centered approach (PCA), "PCA is nondirective, whereas SET is directive; PCA targets the individual, whereas SET targets the family and the ecosystems; PCA targets self, whereas SET targets family interactions; and PCA sets no goals for the client, whereas SET is strategic and directive" (p. 291).

bereavement coping group intervention conducted in 90-minute sessions and tailored to gender, ethnicity, and sexual orientation or to a comparison condition that consisted of individual psychotherapy and psychiatric services on demand. Measures of grief and psychiatric distress were taken at baseline and again two weeks following the intervention. "The group format combined semi-structured cognitive-behavioral and support group approaches. ... Specific strategies for dealing with problems of grief included (a) establishing a sense of control and predictability; (b) anger expression and

management; (c) resolution of guilt; (d) promoting self-mastery through empowerment; and (e) development of new relationships" (p. 197). Sikkema and colleagues found that men and women receiving the group intervention experienced a greater reduction in psychiatric distress than those receiving individual intervention. Of note was the finding that "women in the group intervention demonstrated significant reductions in grief and depressive symptoms over men in both conditions and women in the comparison condition " (p. 187). The authors conclude that "[b]rief cognitive-behavioral

group interventions for coping with grief have a positive impact on the psychiatric functioning of HIV-positive participants. This appears to be especially true for HIV-positive women ..." (p. 187).

Finally, Milam, Richardson, Marks, Kemper, and McCutchan (2004) followed an ethnically diverse, low-income sample of 412 sexually active people living with HIV over an average of 18 months. Controlling for baseline CD4 counts as well as ethnicity and depressive symptoms, Milam and colleagues found that "high levels of disposi-

Tool Box

Resources

Books & Articles:

Awad, G.H., Sagrestano, L.M., Kittleson, M.J., & Sarvela, P.D. (2004). Development of a measure of barriers to HIV testing among individuals at high risk. *AIDS Education & Prevention, 16*(2), 115-125.

The authors describe the development of a Barriers to HIV Testing Scale, normed on a diverse sample of individuals at high risk for HIV.

Bhattacharya, G. (2004). Health care seeking for HIV/AIDS among South Asians in the United States. *Health & Social Work, 29*(2), 106-115. "This article explores the factors that may influence HIV/AIDS-related health care seeking by South Asian immigrants to the United States. It focuses on South Asians from Bangladesh, India, and Pakistan" (p. 106).

Dodds, S., Nuehring, E.M., Blaney, N.T., Blakley, T., Lizzotte, J.-M., Lopez, M., Potter, J.E., & O'Sullivan, M.J. (2004). Integrating mental health services into primary HIV care for women: The Whole Life project. *Public Health Reports, 119*(1), 48-59.

"The Whole Life project – a collaboration of the departments of Psychiatry and Obstetrics/Gynecology at the University of Miami School of Medicine – successfully integrated mental health services into primary HIV care for women. This article describes the conceptual framework of the integration, implementation strategies, effects of the service integration, and lessons learned" (p. 48).

Erwin, J., Smith, D.K., & Peters, B.S. (Eds.). (2004). *Ethnicity and HIV: Prevention and care in Europe and the USA*. Atlanta: International Medical Press.

"This easy to read book explores how to deliver effective, comprehensive HIV prevention and care services to [migrant and ethnic mi-

nority] populations and examines the barriers to achieving this goal."

Forehand, R. (Ed.). (2004). Special issue: The Parents Matter! Program. *Journal of Child & Family Studies, 13*(1), 1-123.

The March 2004 issue of this journal is dedicated to a multifaceted description of this large, longitudinal, community-based, randomized, multi-site HIV prevention clinical trial for parents of African-American adolescents.

Green, G., & Smith, R. (2004). The psychosocial and health care needs of HIV-positive people in the United Kingdom: A review. *HIV Medicine, 5*(Suppl. 1), 1-46.

"This work was commissioned by and carried out in collaboration with the British HIV Association (BHIVA) Social and Behavioural Sciences Subcommittee ... [It] aims to identify the changes that HAART has had upon the experiences and psychosocial needs of HIV-positive people living in the UK" (p. 5).

Kopnisky, K.L., Stoff, D.M., & Rausch, D.M. (2004). Workshop report: The effects of psychological variables on the progression of HIV-1 disease. *Brain, Behavior, & Immunity, 18*(3), 246-261.

"[T]o address what is known regarding neuroendocrine-immune interactions in the context of HIV infection, the Center for Mental Health Research on AIDS convened a panel of scientists ... to examine whether stress-induced activation of the neuroendocrine system affects the immune system in a manner that negatively influences HIV disease progression, and whether HIV infection influences the central nervous system and behavior. The ensuing report summarizes their deliberations ..." (p. 246).

Marhefka, S.L., Farley, J.J., Rodrigue, J.R., Sandrik, L.L., Sleasman, J.W., & Tepper, V.J. (2004). Clinical assessment of medication adherence among HIV-infected children: Exami-

nation of the Treatment Interview Protocol (TIP). *AIDS Care, 16*(3), 323-338.

"The TIP is a promising method for assessing adherence in clinical settings. The TIP provides valuable information about caregiver regimen knowledge deficits, administration problems and barriers to adherence. ... [M]embers of the health care team can quickly administer this brief, structured interview to caregivers as part of routine clinical adherence assessment. Information resulting from the TIP can be used by care teams to correct knowledge deficits, to help the family eliminate or address barriers to adherence and to help physicians with clinical decision making regarding ART" (pp. 334-335).

Sherman, A.C., Leszcz, M., Mosier, J., Burlingame, G.M., Cleary, T., Ulman, K.H., Simonton, S., Latif, U., Strauss, B., & Hazelton, L. (2004). Group interventions for patients with cancer and HIV disease: Part II. Effects on immune, endocrine, and disease outcomes at different phases of illness. *International Journal of Group Psychotherapy, 54*(2), 203-233.

"This article reviews the effects of professionally-led groups on immune activity, neuroendocrine function, and survival among patients with cancer or HIV disease" (p. 204).

Smith, B.D., & Bride, B.E. (2004). Positive Impact: A community-based mental health center for people affected by HIV. *Health & Social Work, 29*(2), 145-148.

"The purpose of this article is to describe the efforts of one agency to address inequities in access to mental health services among people who are affected by HIV and face barriers to mental health care because of their financial status. Located in Atlanta, Georgia, Positive Impact, Inc., is a nonprofit, community-based organization that provides free mental health services to low-income individuals, groups, and families affected by HIV by using an extensive network of volunteer mental health professionals and graduate student interns" (p. 145).

tional optimism were not protective against disease progression. Rather, patients who had moderately high levels of optimism had higher CD4 counts at follow-up than did those with low levels of optimism or those with very high levels" (p. 177). By contrast, "higher levels of dispositional pessimism were associated with increased viral load over time" (p. 178). "[These] results suggest that low levels of pessimism or moderately high levels of optimism may protect HIV+ persons on [antiretrovirals] from progression of disease in the short term. The underlying mechanisms remain unclear,

Tietz, A., Davies, S.C., & Moran, J.S. (2004). Guide to sexually transmitted disease resources on the Internet. *Clinical Infectious Diseases*, 38(9), 1304-1310.

Tietz, Davies, and Moran present four annotated tables of STD-related, English-language Web sites, including sites for laypersons, for clinicians and teachers, for researchers, and sites focused on a single STD.

Westerfelt, A. (2004). A qualitative investigation of adherence issues for men who are HIV positive. *Social Work*, 49(2), 231-239.

Westerfelt "presents the results of a qualitative study of HIV-positive individuals who have struggled with the adherence issues endemic to antiretroviral treatment and seeks to give voice to their experiences" (p. 231).

Seal, D.W., & Ehrhardt, A.A. (2004). HIV-prevention-related sexual health promotion for heterosexual men in the United States: Pitfalls and recommendations. *Archives of Sexual Behavior*, 33(3), 211-222.

Seal and Ehrhardt "present several key considerations for the development of sexuality-based HIV health promotion directed toward [heterosexual men], including the importance of developing HIV risk reduction messages that are responsive to (1) their predominant sexual and safer sex behavioral patterns; (2) the societal gender roles, norms, and scripts that guide heterosexual interactions; and (3) developmental and cultural influences on sexual behavior" (p. 211).

Internet Resources:

The March issue of HRSA CARE Action provides helpful information on buprenorphine, the first medication for opiate dependence that can be prescribed in the primary care setting. The newsletter may be found at: <http://www.hab.hrsa.gov/publications/march04/>

--Compiled by Abraham Feingold, Psy.D.

and future research ... is needed to identify potential behavioral and biological mediators" (p. 179). Of note to clinicians: "Negative outcomes in pessimistic HIV-infected patients may be somewhat self-fulfilling and should be taken seriously. Because high pessimists expect negative experiences in the future they may be less inclined to actively pursue their goals" (p. 178).

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Tool Box

A Note on Content

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

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of information are identified when appropriate.

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

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