mental health AIDS

A Quarterly Update from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) Volume 7, Issue 1 – Fall 2005

Biopsychosocial Update

HIV Prevention News

About Persons With Severe Mental Illnesses

Kalichman, Malow, Dévieux, Stein, and Piedman (2005) used the **information-motivation-behavioral skills** (IMB) **model**[1] to predict unprotected sexual behavior among 320 substance-abusing men and women, primarily of minority ethnicity, diagnosed with severe mental illness. The investigators noted that "greater condom skills were predicted by female gender, positive condom attitudes, and transmission knowledge. Engaging in lower rates of unprotected sex was predicted by pro-condom norms, less perceived susceptibility, and greater condom self-efficacy. Positive attitudes toward condoms had a significant indirect effect on rates of unprotected sex, exerting ... influence through condom use self-efficacy" (p. 277).

Drawing on these findings, Kalichman and colleagues conclude that "[i]nterventions that provide risk and preventive education, sensitize people to their risks, facilitate personal and social normative acceptance of condoms, and enhance self-efficacy for using condoms hold the greatest promise for risk behavior change" (p. 288). With regard to their implementation, "HIV risk reduction interventions delivered in small groups can be integrated into community programs that conduct group education or group therapy, or can be placed within the context of inpatient or outpatient substance abuse treatment services. In addition, case management and one-on-one counseling services can integrate the same IMB intervention components typically found in small group interventions" (p. 288).

(More information on this topic appears in this issue's **Tool Box**, "Reducing HIV Risk Among Adults With Severe Mental Illness," beginning on page 8).

About Women & Men

In New York City, El-Bassel, Gilbert, Wu, Go, and Hill (2005) interviewed a random sample of 416 women receiving methadone maintenance treatment to assess **relationships between intimate partner violence** (IPV) **and sexual risk behaviors**. Interviews were conducted on three occasions: at baseline, 6 months, and 12 months. Forty-six percent of these women reported physical or sexual IPV at baseline. Those who reported at 6 months that they always used a condom were less likely to report IPV at 12 months than those reporting inconsistent or no use of condoms. "Similarly, increased risk of IPV at [12 months] was associated with self-reported [sexually transmitted diseases (STDs)] ... and unprotected anal sex ... [while] always requesting that partners use condoms was associated with a ... decrease in subsequent IPV ... . Findings ... suggest that IPV at [6 months] decreased the subsequent likelihood of always using condoms at [12 months] ... and always requesting that a partner use condoms ..." (p. 171).

In identifying these relationships between risk factors for HIV/STDs and IPV, El-Bassel and colleagues offer the following recommendations:

> Strategies to address IPV in the context of HIV/ST[D] prevention must take into account the balance of power in intimate relationships, level of sexual communication and negotiation skills, relationship dependencies, and an accurate appraisal of risk of IPV. These HIV/ST[D] risk reduction intervention strategies may in-

[1] The IMB model of health behavior change "states that HIV preventive behavior, such as condom use, is a function of HIV prevention information (e.g., risk education and facts about HIV disease), HIV prevention motivation (e.g., risk sensitization, personal risk recognition, intentions to reduce risk), and AIDS prevention behavioral skills (e.g., interpersonal communication skills, condom skills ...)" (p. 279).

In This Issue:

clude interrelated cognitive awareness components and cognitive behavioral skills, such as: (1) raising awareness of the interpersonal contexts and triggers of HIV risk behavior and IPV, the meaning of the relationship, conflicts around drug use, gender roles and expectations around sex and safer sex between long-term heterosexual partners, (2) developing an accurate appraisal of risk of HIV and IPV as well as increasing safety planning, problem-solving, and sexual communication skills to negotiate successful HIV risk reduction with their partners, (3) increasing access to and utilization of services and (4) bolstering informal social support to help women establish and maintain relationship safety. Failure to address the co-occurring problems of HIV risk and IPV in an integrated approach for women in drug treatment may not only increase their risk of HIV, but may also jeopardize their recovery and safety. (p. 180)

Previous studies have linked the availability of highly active antiretroviral therapy (HAART) with increases in sexual risk behavior. On this point, Diamond et al. (2005) surveyed a random sample of 874 sexually active adults receiving care at six public HIV clinics in California and found that 34% reported unprotected anal or vaginal sex (UAV) during the preceding 3-month period. Of the 79% of respondents on HAART, about one-quarter reported < 95% adherence. Importantly, those taking antiretrovirals "reported lower prevalence of UAV. Good antiretroviral adherence [i.e., ≥ 95%] was also associated with a lower likelihood of unprotected sex in most stratified analyses but was not significant in multivariate analysis" (p. 216). Moreover, an undetectable viral load was associated with less likelihood of UAV. Drawing on these data, Diamond and colleagues conclude that

> **antiretroviral use is associated with less sexual risk behavior**. A mechanism for associations of both [antiretroviral] use and adherence with less unprotected sex could be personality traits such as compliance with authority, aversion to risk, or self-protection. Patients who are responsible and health conscious enough to achieve optimal adherence might also be aware of the health risk of unsafe sex and thus be more likely to use condoms. Health care providers need to explore individual patients' rationales for unsafe sex (eg, drug use-associated disinhibition, health beliefs regarding viral load and HIV transmission, or sexual norms among particular populations) and tailor intervention programs to their specific population. (p. 218)

*mental health***AIDS** is produced four times a year under Contract No. 280-02-0202 with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The content of this publication does not necessary reflect the views, opinions, or policies of the CMHS, SAMHSA, or HHS.

Summaries appearing in *mental health***AIDS** are presented to promote awareness and understanding of current and continuing research in the area of HIV and mental health. They are not intended for use as the sole basis for clinical treatment nor as a substitute for reading the original research.

*mental health***AIDS** is compiled and edited by Abraham Feingold, Psy.D. Questions and comments may be directed to the Editor at mentalhealthAIDS@aol.com.

About Women

Drawing on data from interviews with 250 predominantly African American women at risk for HIV infection living in greater Atlanta, Sterk, Klein, and Elifson (2004) add to our understanding of the association between **lower self-esteem** and greater involvement in HIV-related risk behaviors by identifying five factors that underlie self-esteem in women. These include race, religiosity, number of money problems experienced, emotional abuse experiences in childhood, and number of drug-related problems experienced.

> Based on these findings, we believe that HIV intervention efforts would be wise to: (1) avail themselves of the benefits of religious participation (including collaborating with faith-based organizations), (2) provide women with educational opportunities, (3) provide women with vocational training, (4) offer financial counseling and training, (5) emphasize the need for drug treatment, as appropriate, and help drug-dependent and drug-abusing women enter treatment, and (6) target persons who were abused emotionally during their childhood and/or adolescent years. In doing so, there is a good likelihood that self-esteem levels will be elevated and that, in turn, is likely to be followed by diminished involvement in risky behaviors. (pp. 88-89)

About Adolescents & Young Adults

Stein, Rotheram-Borus, Swendeman, and Milburn (2005) explored both proximal and distal **predictors of risky sexual behavior among** 248 **young men** between the ages of 15 and 24 years who were **living with HIV**. Stein and colleagues found that

> demographics (ethnicity, sexual orientation and poverty) and back-

ground psychosocial factors (coping style, peer norms, emotional distress, self-esteem and social support) predicted recent problem behaviors (delinquency, common drug use and hard drug use), which in turn predicted recent high-risk sexual behaviors. Hard drug use and delinquency were found to predict sexual risk behaviors directly, as did lower self-esteem, white ethnicity and being gay/bisexual. Negative peer norms strongly influenced delinquency and substance use and positive coping predicted less delinquency. In turn, less positive coping and negative peer norms exerted indirect effects on sexual transmission risk behavior through delinquency and hard drug use. (p. 433)

Given this constellation of interrelated factors contributing to risky sexual behavior in young men living with HIV,

> [m]ultifaceted prevention strategies are needed that target distal demographic ... and psychosocial factors such as self-esteem, peer relationships and proximal problem behaviors such as substance use and/or delinquent behavior. Various strategies have been employed to intervene for delinquent behaviors, but one of the most effective techniques is multisystemic therapy that targets delinquent behaviors within familial and community contexts ... . Interventions that rely on cognitive restructuring and behavioral skill development often target coping styles, peer behavior and social support.
>
> HIV prevention programs for HIV-positive individuals should [also] recognize the centrality of substance abuse. ... Intervention programs for HIV-positive young men need to include substance abuse treatment components but also should target coping styles and peer relationships. (p. 440)

Continuing this focus on context, Bauman and Berman (2005) present exploratory study findings from four teen advisory group meetings and 11 in-depth interviews with Bronx adolescents between the ages of 14 and 17 on the matter of **how romantic relationship characteristics affect condom use**. The authors identified three types of relationships: *messing* (pronounced "messin'"), *girlfriend-boyfriend*, and *hubby-wifey*.

> The three types of relationships were given meaning by several factors: (a) the extent to which current sexual behavior implies a future commitment (none in messing, some in boyfriend-girlfriend and definite in hubby-wifey); (b) degree of love and caring (little in messing, some in boyfriend-girlfriend, and strong in hubby-wifey); (c) degree the relationship is a secret (always in messing, rarely in boyfriend-girlfriend, never with hubby-wifey); and (d) expectation of monogamy (rarely in messing, often in boyfriend-girlfriend, usually in hubby-wifey). The combination of these factors generates the degree to which partners trust each other to be safe – to not have a disease, to not cheat on them and to stay together if the girl becomes pregnant. (p. 219)

With regard to condoms, their use

> was directly and strongly related to ... the degree of long-term commitment, love and trust in the adolescent relationship. ... Thus, when adolescents began a new relationship, or were in a messing relationship that they did not expect to last, they tended to use condoms. In boyfriend-girlfriend relationships, condoms tended to be used until the relationship became more intimate, more committed and trusting. Condom use then became more intermittent, and if the condom was used primarily for pregnancy prevention, the girl tended to obtain another form of birth control and condoms were discontinued.
>
> When the relationship progressed to hubby-wifey status, and they perceived their partner to be the person they love, the one they expected to be with forever, they stopped condom use. This was an expression of trust, and sometimes meant that the couple is acting as if they are married and will accept a pregnancy and a child. Again, if pregnancy prevention was an issue, most girls obtained another form of birth control. (p. 219)

Although the specific terms used to describe these relationships will likely change, and may already differ by age, geographic location, and culture, clinicians

> need to distinguish between lack of *intention* to use condoms from problems in *using* condoms once intention is present. Although most of these adolescents were relatively knowledgeable about ... HIV/STDs, had access to condoms, knew how to use them properly, and were willing to use them, many *did not intend* to use condoms with a partner to whom they were committed and in love. Those intending to cheat did plan to use condoms in their messing relationships and sometimes with their girlfriend or boyfriend, but with hubby/wifey they would not. (p. 220)

With respect to interventions, those grounded in "social learning and social cognitive theories may be effective in increasing condom use in messing and boyfriend/girlfriend relationships, but ... may be less effective for the many adolescents in

loving committed relationships who see no need for condoms. HIV preventive interventions with adolescents will be more effective ... when programs address the relationship context of condom decision-making, and how commitment, trust, and love affect risk" (p. 220).

About Men Who Have Sex With Men

Context was also a key consideration for Martin, Pryce, and Leeper (2005), who surveyed a community sample of 470 gay and bisexual men regarding coping strategies used in connection with a recent life problem and found that "[m]ore participants who reported recent [unprotected anal intercourse (UAI)] endorsed avoidance strategies than did those who did not report UAI. There was a positive relationship between avoidance coping scores and odds for reported UAI" (p. 193).

In discussing this **association between avoidance coping and HIV risk behavior** in gay men, Martin and colleagues highlight "the larger context in which prevention efforts with this population occur, one that is marked by stigmatization, discrimination, loneliness, and other stresses" (p. 193).

> HIV prevention strategies with gay men must be based on a conceptualization of risky sexual behavior that acknowledges the normality and multifaceted importance of sex, and they should provide opportunities for gay men to talk honestly about the role of sex in their lives. They should widen their focus to include gay men's life problems in general, including victimization, discrimination, and prejudice. HIV prevention materials should state clearly that maintaining safer sex habits over time could be stressful. The role of coping strategies should be integrated into prevention efforts, with a focus on the ways in which reliance on avoidance coping could contribute to episodic risky behavior. Interventions should be delivered in a group format whenever possible to maximize the opportunities for engagement, and they should include information about avoidance coping. Interventions should include examples of avoidance coping responses, taking care not to pathologize them, and they should help participants examine the extent to which they rely on such responses to cope with stress. More elaborated interventions can help gay men recognize the situations that elicit avoidance coping responses and develop alternative strategies for managing such situations. (p. 200)

Using computer-assisted self-interview technology with audio enhancement, Poppen, Reisen, Zea, Bianchi, and Echeverry (2005) surveyed (in English or Spanish) 219 HIV-infected Latino men who have sex with men (MSM) regarding **contextual factors that can influence sexual risk behavior**. The investigators found that "disclosure of HIV-positive status, partner's serostatus [i.e., the seroconcordance of the partner], and emotional relationship between partners were all interrelated. Moreover, as a group, … [these factors] were strongly predictive of the likelihood of [UAI] between partners. When examined individually in a model containing all of them as predictors, however, only seroconcordance achieved significance" (p. 234).

As have other investigators, Poppen and colleagues contend that an appreciation of contextual factors is key in the planning of interventions.

> Interventions aimed at preventing the spread of HIV could benefit from an approach that addresses the configuration of factors that influence the likelihood of [UAI], including disclosure, seroconcordance, and partner relationship. Programs that encourage disclosure of serostatus, for example, may not affect sexual risk behaviors unless they also deal with responses to the resulting knowledge of seroconcordance or discordance. Although disclosure is to be encouraged so that individuals are aware of potential risk, the discovery of seroconcordance may result in increased likelihood of unprotected sex. This is an issue that should be openly addressed in interventions, which should include discussion of the risks associated with sex between seroconcordant positive and seroconcordant negative partners. The efficacy of interventions could also be increased by attention to differential factors that lead to unprotected sex for committed versus casual partners. (p. 235)

Intensifying this focus on intervention effectiveness, Herbst et al. (2005) conducted a meta-analysis of 65 published and unpublished English-language reports evaluating changes in sexual risk behavior or biological outcomes associated with sexual risk in MSM.

> The findings of this review support the view that **behavior change interventions for MSM work**. Not only do behavioral interventions reduce rates of UAI, decrease numbers of sexual partners, and increase condom use during anal sex; they also support behavioral risk reductions up to 12 months after interventions. Although it has been speculated that the introduction of HAART might lead to increases in risky sexual behavior ... and less efficacious interventions, ... intervention studies conducted after the introduction of HAART achieved the same reductions in risk behavior as those reported before

the introduction of these life-saving medications. The effect sizes associated with these behavioral interventions are substantial: the interventions resulted in a 23% ... reduction in odds of UAI and a 61% increase in odds of condom use during anal sex. When translated into final health outcomes (eg, quality-adjusted life-years gained), effect sizes of this magnitude are well within the range of those considered to be cost-effective. (p. 237)

Regarding the effectiveness of various intervention components,

> [i]nterventions that reported a basis in behavioral theory were associated with efficacy. ... Although no behavioral theory in particular was associated with significantly better intervention efficacy than any other theory, interventions based on the diffusion of innovations theory ... and the model of relapse prevention ... showed greater point estimates for reductions in risk behavior in the intervention group relative to the comparison group. Diffusion of innovations posits that popular people who endorse innovations (eg, HIV risk reduction) can help to refine behavioral norms and standards. ... Relapse prevention approaches aid at-risk individuals to identify situational risk factors (eg, unprotected sex) and develop cognitive coping skills to resist lapses. ...
>
> Additional intervention components suggestive of intervention efficacy include interpersonal skills training; skills training delivered by role plays or lectures; multiple delivery methods; and greater intervention exposure complexity ... [defined as more than one session, a duration lasting 4 or more hours, and a time span of at least 3 weeks]. Although [the authors] are not claiming that these components are necessary or sufficient for behavioral interventions for MSM to work, [they] recommend that prevention providers consider these components when developing intervention programs for this population. (pp. 237-238)

From the Block

Human Resources Development Institute

Human Resources Development Institute, Inc. (HRDI), is a not-for-profit, community-based behavioral health and human services organization. It was founded in 1974 by community health advocates concerned with mental health and substance abuse problems in Chicago's African American community. Today, HRDI provides a range of services in Illinois and three other states. Services in Illinois are administered through four divisions: Alcohol, Substance Abuse and Corrective Services; Community Health, Prevention, Youth and Family Services; Community Mental Health and Rehabilitative Services; and Contracts, Research, Education and Information Systems.

With funding from CMHS/SAMHSA, HRDI is expanding mental health service delivery to people living with HIV/AIDS in Englewood, West Englewood, Grand Boulevard, and Roseland communities on the South Side of Chicago. Services include a program orientation (introduction to the program and mental health counseling process); individual, group, and couples counseling; psychiatric evaluation/consultation and psychotropic medication management; support groups; intensive case management for HIV-positive individuals, particularly those newly diagnosed; and outreach services. Services are offered in the "specialized counseling services" section of a building that houses multiple programs, including a methadone clinic, substance abuse services, and several HIV-related service/research projects. Many of the program's referrals come from the in-house methadone maintenance program.

The Principal Investigator is Victor Sutton, MSW, QMHP; the Project Director/ Clinical Director is Nicole Brown, MSW, LCSW. For more information, please call 773/869-0300 or go to http://www.hrdi.org.

– Compiled by the MHHSC Program Coordinating Center

About Substance Users

In interviews with 34 HIV-positive and HIV-negative **methamphetamine** (meth)**-dependent gay men** receiving outpatient drug treatment, Larkins, Reback, Shoptaw, and Veniegas (2005) identified contextual factors that influence HIV status disclosure. They found that study participants

> selectively disclosed their HIV status, expressing varying degrees of responsibility to disclose based on the social and sexual context. The characteristics of communication during the sexual encounter, the location of the encounter, the type of relationship and the type of sexual behaviors were all considered by these men when deciding about disclosure. Both HIV-positive and HIV-negative participants believed the obligation to disclose HIV status was the responsibility of the HIV-negative partner. Additionally, in public sex venues, where accepted social rules supported no disclosure of HIV status and no condom use, it was felt that HIV-negative partners who chose to break those rules should initiate disclosure and condom use, if they so desired. Finally, ... HIV-positive participants felt an increased responsibility to disclose their HIV status to a primary partner, and reported [themselves] to be more willing to discuss HIV issues when they expected to engage in 'higher risk' sexual acts. (p. 528)

Despite the small sample size and the homogeneity of this white, highly educated, Los Angeles-based sample, these study findings merit careful consideration by clinicians. The authors contend that,

> [w]hile recent prevention interventions have focused on HIV-positive men, it is extremely important that, among [meth]-using gay men, HIV prevention efforts continue to target HIV-negative men by providing skills for negotiating sexual encounters in highly sexualized venues.
>
> In this study, when an HIV-negative sexual partner disclosed his status, this information appeared to influence sexual risk behaviors. HIV-positive participants claimed to deliberately take steps to reduce HIV transmission risk with serodiscordant sexual partners, whether or not they disclosed their own HIV status, a practice referred to as 'uninformed protection' ... . Given that HIV-positive participants' sexual risk behaviors may have been influenced by their knowledge of a partner's seronegativity, it appears that working with HIV-negative men to uniformly disclose their HIV-negative status to all sexual partners may reduce sexual risks. ... Coaching HIV-negative men to identify ... communication barriers and effectively inform sexual partners of their HIV status, while requesting information in return, may encourage mutual disclosure and open dialogue about sexual expectations. (p. 529)

Drawing data from a convenience sample of 49 gay and bisexual meth users in New York City, Halkitis, Shrem, and Martin (2005) reappraised "the widely held belief that [meth] acts as a driving force, which in and of itself is that which alters sexual risk behaviors ... . The question of causality becomes unclear as [these] data indicate ... that [**meth**] does not necessarily induce risk behavior on its own, but **may attract certain hypersexual men who are already predisposed to risk behaviors**. This is corroborated by the equivalent rates of risk behavior ... found across study conditions (high on [meth], high on other drugs, sober)" (p. 713). These investigators "were not able to find any significant differences of [meth] use based on race and income[, but] ... did find significant differences in the frequencies of risky sexual behavior on [meth] based on the serostatus of ... participants, with HIV+ men participating more frequently in unprotected anal sex than HIV - men" (p. 713). Though lacking data on sexual risk behaviors in a comparison group of nonusers, Halkitis and colleagues nonetheless reason that "it is not enough to simply address either the drug use behavior or the sexual risk behavior[;] … rather, an in-depth exploration of an individual's psychological makeup and associated behavior is the most effective way of disentangling the destructive implications of [meth] use and sexual risk behaviors" (p. 715).

In another study conducted in the New York metropolitan area, Parsons, Kutnick, Halkitis, Punzalan, and Carbonari (2005) assessed an ethnically diverse convenience sample of 253 MSM diagnosed with **alcohol use disorders** who were also living with HIV. The investigators found that rates of UAI with casual partners of unknown status were substantially higher than with either known HIV-positive or HIV-negative casual partners, placing these partners at risk for HIV transmission. Of note in this sample of alcohol users,

> men who reported unsafe sex had this kind of sex regardless of whether or not they had been drinking; those who were consistently using condoms were able to do so whether or not they were intoxicated. It is the ... [use of such drugs as hallucinogens, stimulants, opiates, and inhalant nitrates (poppers)], however, that was related to the unsafe sex. It is likely that providers who work with HIV+ alcohol abusers will focus almost exclusively on the potential impact of alcohol use on their lives. These data, however, suggest that [it] is equally important to consider the recreational drug use among HIV+ MSM who abuse alcohol, as this may be the significant risk factor for HIV transmission. (p. 34)

HIV Assessment News

HIV Counseling & Testing

Lekas, Schrimshaw, and Siegel (2005) explored **factors that deterred or facilitated HIV testing** with a self-selected sample of 35 adults who tested HIV positive **at the age of 50 or older**.

> Participants described a variety of pathways to testing, related to gender, sexual orientation, drug use, and era of the epidemic. Older gay and bisexual men described three trajectories: proactively seeking out testing, delaying testing due to fear and hopelessness, and denying exposure to HIV. Heterosexual drug users and their partners followed two trajectories, depending on the phase of the epidemic: (1) delay due to the lack of knowledge or perceived risk for infection, and (2) delay due to psychological barriers and drug use, despite recognizing their risk. Finally, heterosexual non-drug-users were unaware of their risk. Across risk groups, physical symptoms and encouragement from health care providers were the primary triggers that facilitated testing. (p. 674)

Despite the limitations inherent in using a small, self-selected sample,

Lekas and colleagues suggest that their findings indicate "the importance of health care professionals['] having open discussion with their patients ... about their risk behaviours and recommending HIV testing whenever indicated" (p. 685). Additionally, these findings

> support a number of recommendations for the development and implementation of interventions designed to promote earlier testing among older adults. First, the failure of older heterosexual non-drug users to recognize their potential risk suggests that additional educational efforts aimed at promoting accurate risk perceptions need to be targeted to this group. Second, as perception of risk was insufficient to lead to proactive HIV testing in nearly all participants, initiatives must go further to remove the specific barriers and bolster the particular facilitating factors associated with older adult testing behaviour, recognizing that these may vary by risk group. Specifically, interventions to reduce psychological barriers (e.g., denial) to testing are needed for both older gay/bisexual men and drug users. Other programs need to specifically address the age-related misperception shared by older heterosexual non-drug-using women that HIV/AIDS is a disease that afflicts only young, promiscuous, drug-using individuals. (pp. 684-685)

To compare the prevalence of **sexual transmission risk behavior among HIV-positive persons** who had become aware of their serostatus with the prevalence among HIV-positive persons who remained unaware of their status, Marks, Crepaz, Senterfitt, and Janssen (2005) conducted a meta-analysis of 11 independent findings from eight studies conducted in the United States and published between 1988 and 2003. "Six findings compared HIV^+ aware persons with independent groups of HIV^+ unaware persons (between-group comparisons), and 5 findings compared seroconverting individuals before and after being notified of their HIV^+ status (within-subject comparisons). Outcomes were self-reported ... UAV ... during specified recall periods" (p. 446). Marks and colleagues found that "[t]he prevalence of high-risk sexual behavior is reduced substantially after people become aware they are HIV^+" (p. 446) and conclude the "[i]ncreased emphasis on HIV testing and counseling is needed to reduce exposure to HIV from persons unaware they are infected. Ongoing prevention services are needed for persons who know they are $HIV^\pm$ and continue to engage in high-risk behavior" (p. 446).

What if the test result is HIV-negative? DiFranceisco, Pinkerton, Dyatlov, and Swain (2005) surveyed 292 sexually active men and women receiving services at a publicly funded STD clinic who reported previous HIV testing. Study participants were primarily African American (79%) and heterosexual (95%), and 44% of respondents were less than 26 years of age. DiFranceisco and colleagues found that

> recent HIV testing was ... associated with safer sex. Prevalence of condom use at last intercourse was highest among respondents who received an HIV test < 3 months before the survey, whereas frequent condom use during the past 3 months peaked among clients who had been tested 3 to 5 months before assessment. ... [This] **brief 'surge' in safer sex among recent HIV counseling and testing clients**, regardless of serostatus, suggests that these individuals may be particularly amenable to additional interventions designed to achieve longer term reductions in risky behaviors. (p. 606)

Psychiatric Assessment

In "the first ... [descriptive study] to undertake a broad diagnostic assessment of HIV-infected methadone patients, including both Axis I and Axis II disorders" (p. 387), Winiarski et al. (2005) presented "**rates of psychiatric diagnoses** in a convenience sample of HIV-positive, African American and Hispanic clients in methadone treatment in the Bronx, NY" (pp. 379-380).

Of 139 study volunteers, 99 met diagnostic criteria for at least one psychiatric diagnosis in addition to opioid dependence on agonist therapy (100%). The following *past-year and other non-lifetime* psychiatric disorders were reported:

Axis I disorders

Mood disorders

- Major depressive disorder, 36.4%;
- Dysthymic disorder, 14.2% (based on a 2-year assessment);
- Bipolar I disorder, 1.0% (based on at least one lifetime manic/hypomanic episode and current symptoms);
- Bipolar II disorder, 0%; and
- Mood disorder with psychotic features, 3.0%.

Anxiety disorders

- Panic disorder with agoraphobia, 6.1%;
- Panic disorder without agoraphobia, 6.1%;
- Posttraumatic stress disorder, 8.1%; and
- Generalized anxiety disorder, 0%.

Adjustment disorders, assorted, 11.1%

Substance use disorders

- Alcohol dependence, 28.3%;
- Alcohol abuse, 1.01%;
- Non-alcohol substance dependence, 53.5%; and
- Non-alcohol substance abuse, 6.1%.

With regard to *lifetime* psychiatric

Tool Box

Reducing HIV Risk Among Adults With Severe Mental Illness

As a prelude to formulating an agenda for HIV/sexually transmitted disease (STD) prevention among adults with severe mental illness (SMI),[1] Meade and Sikkema (2005) conducted a systematic review of 52 studies on HIV risk behavior of adults with SMI that appeared in 63 papers published between 1989 and 2004. They found that

> the majority of adults with SMI are sexually active, and that many engage in sexual and drug use behaviors that place them at high risk for HIV, STDs, and blood-borne infections. Among sexually active participants, nearly half had multiple partners and never used condoms in the past year. Strikingly, a quarter of Americans with SMI had traded sex for money, drugs, or other goods, and over half had done so in the past year; rates were substantially lower in other countries. Overall, 29% of participants reported a lifetime STD, and the rate may actually be higher due to reporting bias, lack of testing, and asymptomatic infections. Finally, while current injection drug use was rare, over 20% of participants reported a history of injection drug use, and most had shared needles. (p. 446)

Clearly, then, "adults with SMI, as a population, are at high risk for HIV infection and in need of targeted prevention services" (p. 446).

[1] "Severe mental illness refers to the presence of a severe psychiatric disorder (including schizophrenia, schizoaffective disorder, major depression, and bipolar disorder) accompanied by significant functional impairment, disruption of normal life tasks, periods of hospitalization, and need for psychotropic medication" (American Psychiatric Association Web site, n.d.).

Multiple Pathways to Risk and Prevention

What are the correlates of HIV risk behavior among adults with SMI? Meade and Sikkema's review suggests that such behavior "is influenced by factors from multiple domains, including characteristics of the psychiatric illness, substance use, childhood abuse, social relationships, and cognitive-behavioral factors. Accordingly, ... HIV prevention interventions targeting this population must be broadened to address the multiple pathways of risk and accommodate the heterogeneity of persons with SMI" (p. 449).

To this end, Meade and Sikkema offer recommendations for the prevention of HIV and STDs in people with SMI. These include:

o Universal risk assessment – "The high rate of sexual risk behavior calls for routine HIV/STD risk assessment for all patients with SMI. This should be an essential component of psychiatric evaluations. Specifically, patients should be asked about sexual and drug use behaviors (e.g., current activity, number of partners, sex trade, condom use, injection drug use/needle sharing) and risk factors (e.g., sexual abuse, substance use, partner characteristics). The assessment process may itself be an educational experience and serve as a motivator for risk reduction ..." (p. 450).

o HIV/STD testing – "In 2003, the Centers for Disease Control and Prevention launched a new initiative for advancing HIV prevention that recommends HIV testing as a routine part of health care ... . As mental health professionals are often the primary point of contact to the heath care system ..., they are in an ideal position to offer voluntary HIV, STD, and hepatitis testing to all patients with risk factors. ... Ideally, testing should occur within the mental health agency to facilitate access and follow-up. Patients who test positive for HIV, STDs, and/or hepatitis should be referred for further medical evaluation, treatment, and secondary prevention services" (p. 450).

o Condom availability – "The availability of condoms through clinics and other programs serving adults with SMI is a cost-effective primary prevention measure ... . Poverty may be a significant barrier to condom use for this population. The availability of condoms also communicates that clinicians value their use, as well as patients' sexuality and health" (p. 450).

o Clinician training – "[T]o deliver effective HIV/STD prevention interventions in mental health settings, it is critical that clinicians are well informed about HIV/STDs, risk factors, prevention services, and treatment. ... Equally as important, clinicians must feel comfortable acknowledging patients' sexuality and discussing sexual issues" (p. 450).

o Multi-level interventions – "To account for the multiple factors that influence sexual risk behavior, the most promising interventions will likely be multidimensional and occur at the individual-, group-, and community-level" (p. 450).

Leveling the Playing Field

According to Meade and Sikkema, when clinicians work at the individual level,

> psychotherapy and medication are essential for treating psychiatric symptoms, intrapsychic barriers, and interpersonal difficulties that may underlie HIV risk behavior among adults with SMI. For example, mood stabilization, trauma recovery, and social skills training may be essential precursors to risk reduction among some patients. It may also be necessary for clinicians to directly address HIV risk behaviors within a ... framework ... [that reduces the adverse medical, social, and eco-

disorders (i.e., disorders with psychotic features, Axis II disorders), 15.2% of participants met diagnostic criteria for non-mood psychotic disorders, 38.4% met diagnostic criteria for borderline personality disorder, and 55.6% met diagnostic criteria for antisocial personality disorder.

Notably, 80.9% of study participants met criteria for three or more diagnoses (including opioid dependence) during the study period. According to Winiarski and colleagues, "[u]ndiagnosed, or incorrectly diag-

***Group Interventions for Adults With SMI:* "Start Spreadin' the News"**[1]

Sex, Games, and Videotapes (SexG) is an HIV sexual risk-reduction intervention designed for and tested on a sample of homeless men with SMI living in a New York City shelter. The curriculum "combines skills-training methods with clinical approaches and is built around activities that are central to life in the shelter: competitive games, storytelling, and watching videos" (Susser, Valencia, & Torres, 1994, p. 31).

An overview of this 15-session intervention follows:

Sessions 1-2: Say the word – *Create an environment in which men feel comfortable talking about sex*
- o Establish a group dictionary of commonly used words
- o Discuss popular misconceptions about HIV
- o Teach about STDs as cofactors for HIV
- o Teach correct condom use

Sessions 3-6: A quick fix – *Sex with female commercial and other casual partners*
- o Teach rapid condom application
- o Eroticize condom use

Sessions 7-10: All you need is love – *Sex with special partners*
- o Address misconceptions about HIV transmission with this type of partner
- o Develop skills to handle emotional responses to the discussion of condom use

Sessions 11-14: Peanut butter – *Anal sex with men and women*
- o Teach why anal sex is a high-risk behavior
- o Discuss same sex behavior, introduce alternatives to unprotected anal sex

Session 15: Graduation – *Receive identification cards as HIV Prevention Specialists*
- o Reinforce learning from the entire training
- o Empower the men to act as helpers in the future

"Throughout the curriculum there is an emphasis on developing risk-reduction skills that can be generalized across settings. Particular attention is placed on the relationship between drug use and sexual behaviors in each session. Finally, in the post-intervention phase, the men receive 'booster' sessions to reinforce risk reduction behaviors" (Susser, Valencia, & Torres, 1994, p. 35).

In a test of the SexG intervention, Susser et al. (1998) randomly assigned 97 shelter residents, 59 of whom were sexually active at baseline, to one of two conditions: SexG or a two-session control intervention. Study participants were observed for 18 months following the intervention. "Among the 59 sexually active men, ... [t]he mean score on a sexual risk index for the [SexG] group was 3 times lower than for the control group ... during the initial 6-month follow-up and 2 times lower during the remainder of the 18-month follow-up" (p. 266). While the effect diminished over the 18-month observational period, SexG was successful in reducing sexual risk behaviors among homeless men with SMI. Importantly, although SexG *generally* did not stimulate sexual activity in men who had been sexually inactive at baseline, *caution is still required*, as one sexually inexperienced man randomized to the SexG group reported unprotected sex at follow-up.

In a further refinement of data on 57 of the 59 sexually active men, Berkman et al. (2005) compared rates of sexual risk behavior among the 26 men with a lifetime history of substance dependence and the 31 men who did not meet substance dependence criteria. Thirty-two of these men were in the SexG group and 25 in the control group. Berkman and colleagues found that "[a]t each follow-up interval (six, 12 and 18 months), the intervention group as a whole and the non-substance dependent participants showed a significant reduction in risk; the substance-dependent men showed no difference from controls" (p. 635). They conclude that "men with [SMI] and a history of alcohol or drug dependency may have increased difficulty altering sexual behaviors that put them at risk of HIV" (p. 637).

[1] "New York, New York," *New York, New York*, Kander & Ebb, 1977.

nomic consequences of behavioral risk, assuming that some level of risk will continue]. Finally, given the high rates of HIV risk behavior among persons with substance use disorders and/or trauma histories, it may also be effective to integrate HIV prevention into existing treatments for substance abuse and trauma recovery. (p. 451)

With regard to group work, "[t]he current standard-of-care in HIV prevention for adults with SMI is the use of small group interventions based on cognitive-behavioral change principles to improve condom use and communication skills, self-efficacy, and behavioral intentions ... . Randomized controlled trials indicate that these interventions can effectively promote short-term behavioral change, but intervention effects are relatively weak and diminish over time ... " (p. 451). Nevertheless, Meade and Sikkema call for the "widespread dissemination of ... group interventions [for adults with SMI] into ongoing mental health treatment settings" (p. 451). In support of this agenda item, a trio of ***Group Interventions for Adults With SMI*** may be found in the sidebars (Berkman et al., 2005; Carey et al., 2004; Otto-Salaj, Kelly, & Stevenson, 1998; Otto-Salaj, Kelly, Stevenson, Hoffmann, & Kalichman, 2001; Susser et al., 1998; Susser, Valencia, & Torres, 1994).

"[C]ommunity-level HIV prevention interventions ... are based on the theory that supportive role models and social norms, in addition ... to education and skills training, are essential for promoting meaningful and sustained behavior change ... . Supportive housing programs or psychosocial programs may be ideal settings in which to deliver community-level interventions for adults with SMI" (p. 451).

Contexualizing the need for multidi-

(Tool Box is continued on Page 10)

nosed, substance users stand little chance of benefiting from appropriate mental health treatment, which in turn can affect any substance use treatment they may be participating in" (p. 387) and that "[t]hese findings confirm the need to target mental health as part of the national response to the HIV/AIDS epidemic in inner cities" (p. 380).

Stein et al. (2005) interviewed 262 adults receiving HIV medical care (58% male, 40% white, 67% self-identified as heterosexual) and found

(Biopsychosocial Update is continued on Page 12)

Group Interventions for Adults With SMI: "Doin' It Our Way"[1]

In Milwaukee, Wisconsin, Otto-Salaj, Kelly, and Stevenson (1998) operationalized a theory-based HIV risk reduction model into intervention techniques that can be presented in small-group programs of outpatients with SMI who are at risk for HIV. "This intervention use[s] a social-cognitive skills building approach to allow participants to appraise their personal HIV risk vulnerability, strengthen behavior change attitudes, plan and practice skills needed to reduce HIV risk, problem solve strategies to implement risk reduction skills, and receive reinforcement for behavior change efforts" (Otto-Salaj, Kelly, Stevenson, Hoffmann, & Kalichman, 2001, pp. 128-129).

As described in these two papers, an overview of this seven-session intervention follows:

Sessions 1-2 – *HIV risk education, threat personalization, and preparedness to change/ perceived efficacy of change*
- o Present information about HIV and how it is transmitted
- o Discuss methods of reducing HIV risk through behavior change
- o Correct misconceptions about HIV/AIDS risk
- o Use discussion and exercises to:
  - o Analyze factors that may increase personal vulnerability to HIV risk
  - o Foster beliefs that risk can be avoided and that HIV can be prevented
  - o Identify benefits of change and cost of not changing
  - o Identify personal successes in HIV risk behavior avoidance

Session 3 – *Risk reduction behavioral skills acquisition and cognitive problem-solving skills for behavior change and maintenance*
- o Educate, model, and rehearse proper condom use with replicas
- o Provide self-management, self-reinforcement, and risk reduction cognitive problem-solving training to handle "triggers" for HIV risk behaviors (e.g., loneliness, alcohol use)

Session 4 – *Elements from Session 3 (continued) and intention to act*
- o Continue cognitive problem-solving training to handle "triggers" for HIV risk behaviors
- o Help with decision-making about personal risk reduction goals and the design of personalized strategies to reduce or avoid HIV risks

Session 5 – *Elements from Session 3 (continued)*
- o Discuss, model, and role-play training in sexual communication, negotiation, and assertiveness skills (e.g., refusing to have sex, handling coercion to engage in unwanted or unprotected sex, negotiating condom use with partners)

Session 6 – *Elements from Session 3 (continued)*
- o Practice sexual communication, negotiation, and assertiveness skills through role playing
- o Apply new skills to examples of real-life risky situations drawn from group
- o Problem-solve lapse and "near-lapse" situations

Session 7 – *Reinforcement of behavior change efforts*
- o Review each individual's plan for enacting behavior change
- o Encourage the establishment of long-term HIV risk reduction goals

Follow-up "booster" sessions are offered 1 and again 2 months later. "Each of the two booster sessions review[s] ... participants' handling of risk situations occurring since the previous session, problem solv[es] difficulties and reinforc[es] behavior change efforts" (Otto-Salaj, Kelly, Stevenson, Hoffmann, & Kalichman, 2001, p. 129).

To evaluate the effectiveness of this intervention, Otto-Salaj, Kelly, Stevenson, Hoffmann, and Kalichman (2001) randomized 189 men and women receiving outpatient services for SMI to either this seven-session small-group intervention or a comparison intervention and found that those receiving the risk reduction intervention increased their use of condoms. Notably, women demonstrated greater responsiveness to the intervention (which influences attitudes toward condoms, intentions, *and* behavior) than did the men studied. Unfortunately, behavior change tended to diminish by 12 months post-intervention, underscoring the need to provide tailored HIV prevention messages to people with SMI on an ongoing basis, to integrate prevention into mental health service programs, and to provide social services to sustain risk avoidance.

[1] "Making Our Dreams Come True," *Laverne and Shirley* TV theme song, Gimbel & Fox, 1976.

(Tool Box -- continued from Page 9)

mensional service delivery, Meade and Sikkema observe that

> [a]dults with SMI face multiple social stressors that may directly or indirectly contribute to sexual risk behavior (e.g., poverty, homelessness, stigma, relationship problems). Unfortunately, given these more immediate problems, HIV/ STD may be perceived as a low priority ... . Therefore, prevention interventions must occur in the context of integrated multidimensional services that address their full range of needs, including mental health and substance abuse treatment, vocational training, housing, and financial assistance ... . Integration of HIV/STD prevention into existing services for adults with SMI may increase participation and engagement, improve outcomes, be resource efficient, and have wide dissemination potential. While the responsibility for addressing HIV risk may seem overwhelming for public mental health systems that are already underfunded and overburdened, a recent study found that integration of HIV prevention into ongoing mental health services for adults with SMI is cost-effective ... . (p. 451)

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– Compiled by Abraham Feingold, Psy.D.

Group Interventions for Adults With SMI: "I Was Unwise with Eyes Unable to See"[1]

In Syracuse, New York, Carey et al. (2004) developed a theory-based HIV prevention intervention involving information dissemination, motivational enhancement, and behavior skills training to reduce HIV risk in adults engaged in outpatient psychiatric care for SMI.

An overview of this 10-session intervention[2] follows:

Sessions 1-2 – *Enhancing knowledge about HIV transmission and prevention*
- o *Introduction:* Present intervention goals and ground rules for participation
- o *Concerns and questions about HIV:* Facilitate a discussion to enhance motivation to participate
- o *HIV transmission basics:* Present overview of HIV transmission modes, transmission myths, self-protection methods, and HIV testing
- o *"Risk continuum" exercise:* Enhance awareness of how sexual activities vary in HIV risk and highlight healthy, pleasurable activities
- o *Assessing partner risks exercise:* Enhance awareness that HIV serostatus cannot be determined by physical attributes and discuss common misperceptions regarding "safe" vs. "risky" partners
- o *"Crowded bedroom" exercise:* Reinforce the importance of considering partners' sexual histories when assessing HIV risks

Sessions 3-4 – *Enhancing motivation for HIV behavior change*
- o *HIV risk sensitization:* Review high- and lower risk sexual activities by using a stoplight exercise (i.e., behaviors that are in the red, yellow, or green zone) and invite group members to discuss which (if any) of their own behaviors fall into the "risky" zone
- o *Healthy sexual choices exercise:* Have members generate a list of steps that could be taken to reduce their risks of contracting HIV
- o *Decisional balance exercise:* Have members discuss the pros and cons of risk reduction strategies, including condom use and HIV testing
- o *Realistic change options:* Have members identify and discuss behavior change strategies that they plan to adopt for protection against HIV

Sessions 5-10 – *Strengthening HIV behavioral skills and self-management training*
- o *Condom acquisition discussion:* Discuss barriers and strategies for obtaining condoms and increasing their availability in contexts where sex may occur
- o *Condom application skills:* Instruct members in proper application of male and female condoms and allow members to practice applying and removing a condom using models. Review condom use "do's and don'ts" (e.g., the importance of water-based lubricants, proper condom storage, the importance of using latex condoms)
- o *Risk "triggers" exercise:* Have members identify personal situations, mood states, and thought processes that may lead to unsafe sex and discuss strategies for coping with risk triggers
- o *Reaffirming specific behavior change goals to reduce HIV risk:* Ask members to discuss personalized risk reduction goals and specific steps required to reach and maintain those goals
- o *Assertive communication overview:* Present overview of critical components of an assertive statement
- o *Assertiveness Training I*: Demonstrate assertive interactions using role-plays, pair members with a facilitator to practice a simple (nonsexual) self-assertion role-play, as facilitators and members offer corrective feedback and reinforcement
- o *Assertiveness Training II:* Continue role-playing between members, rehearsing assertiveness skills in hypothetical sexual situations in which they are asked to discuss the need for safer sex
- o *Assertiveness Training III:* Conclude role-playing between members with challenging scenarios in which a hypothetical sexual partner initially refuses a request for condom use or safer sex activity
- o *Final intervention review and reaffirmation of goals:* Review core content areas from Sessions 1–9 and invite each member to present long-term behavior change goals

To evaluate the effectiveness of this intervention, Carey et al. (2004) randomly assigned 221 women and 187 men engaged in outpatient psychiatric care for SMI to one of three conditions: the twice-weekly, 5-week HIV risk reduction intervention outlined above; a twice-weekly, 5-week substance use reduction (SUR) intervention; or standard care. Participants were assessed at baseline, at the conclusion of the intervention, and again at 3 and 6 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 this HIV prevention intervention.

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[1] "Falling in Love with Love," *The Boys from Syracuse*, Rodgers & Hart, 1938.

[2] The intervention manual may be found at http://www.chb.syr.edu/PDF_Resources/.

(Biopsychosocial Update -- continued from Page 9)

that "[n]early two thirds of HIV-infected patients in [this] cohort were sexually active, and two thirds of these patients had unsafe sex in the past 6 months. **Alcohol**, consumed by approximately one half of [this] cohort, was significantly associated at all levels of use with both increased sexual activity and unsafe sex" (p. 840). The authors conclude that "[a]lthough the relationship between alcohol consumption and inconsistent condom use among HIV-infected persons is complex, [these] findings bolster the argument for routine assessment of alcohol use in HIV-infected persons, particularly as a correlate of sexual risk taking" (p. 842).

Pain Assessment

Griswold, Evans, Spielman, and Fishman (2005) studied 78 individuals experiencing mild to moderate **HIV-related peripheral neuropathic pain**. The investigators found that

> [c]atastrophizing[2] ... was significantly associated with increased interference with daily activities, depressive symptoms, and decreased physical functioning. ... [In addition,] depressive symptomatology significantly predict[ed] pain intensity and interference. Also, of all the coping strategies, only catastrophizing had significant predictive value on pain interference and depressive symptoms. Interestingly, catastrophizing did not contribute significantly to the variance in pain intensity. This finding highlights the multidimensional nature of the pain experience and the importance of assessing both pain intensity and interference in daily activities and mood. (p. 717)

[2] "Catastrophizing is defined as a mechanism of cognitively coping with pain where negative self-statements and overly negative thoughts and ideas about the future are pervasive in thinking patterns ..." (p. 712).

HIV Treatment News

Medical Care

On June 22, 2005, the U.S. Food and Drug Administration (FDA) announced approval of the protease inhibitor **tipranavir** (Aptivus®). Tipranavir, when taken in conjunction with low-dose ritonavir (RTV or Norvir®), was found to be effective in treating adults with a type of HIV that is resistant to currently available antiretrovirals. The drug can cause serious liver problems, particularly in people with liver disease, as well as skin rashes and elevated cholesterol and triglyceride levels. In addition, "[c]ertain medicines should never be given to patients taking [tipranavir] plus ritonavir because serious side effects can occur. These [medicines] include antiarrhythmics (medicines that treat irregular heart beats), antihistamines, ergot derivatives (found in some medicines to treat migraine headaches), medicines that speed up the digestive tract, herbal products, some medicines that lower cholesterol levels, and medicines to treat mental problems" (FDA, 2005).

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Adherence to Treatment

Anastos et al. (2005) investigated the **relationship between race and response to HAART** among 961 women receiving HIV medical care at one of six clinical locations in the United States. Over a median of 5.1 years of follow-up,

> white women had more favorable virologic, immunologic, and clinical responses to HAART. The poorer responses to HAART found in African American and Latina women, however, were explained largely by HAART discontinuation and to a lesser extent, by depression. Although discontinuation of therapy may be secondary to toxicity that results from specific genetic determinants of drug metabolism and transport, both depression and therapy discontinuation are potentially mutable. This suggests that treating depression and ascertaining and addressing reasons for treatment discontinuation could substantially improve outcomes in African American and Latina women. (p. 542)

Phillips et al. (2005) assessed 173 low-income women living with HIV in South Carolina and found that "[w]omen who reported greater **sleep disturbance** also reported a higher level of depressive symptoms and reported poor adherence to their medication regimen" (p. 273). "[P]oor sleepers may sleep through doses, forget to take their medications, and run out of pills" (p. 288). Phillips and colleagues conclude that "assessment and management of sleep disturbance and depressive symptoms in women with HIV disease ... [are] important to promote medication adherence" (p. 273).

Canadian investigators (Godin, Côté, Naccache, Lambert, & Trottier, 2005) collected data from 376 antiretroviral therapy recipients at baseline and again at 3, 6, 9, and 12 months.

> **Predictors of adherence** ... were: high perception of self-efficacy [i.e., confidence in one's ability to perform a behavior under varying circumstances] ..., positive attitude towards taking medication ..., not living alone ... and being a male ... . Subsequent analysis showed that a positive attitude towards taking medication was associated with a high level of patient satisfaction with their physician, high perceived social support, being optimistic, living with HIV for five years or less and experiencing no side effects. Also, a strong sense of self-efficacy was associated with positive perception of social support, high level of patient satisfaction with their physician and not living alone. (p. 493)

These findings suggest that "interventions aimed at improving adherence ... should focus on reinforcing self-efficacy and developing a positive attitude toward taking medication. ... [P]atient's sense of self-efficacy can be improved by enhancing the relationship between patients and health care professionals. ... [G]roup interventions should also be considered as a strategy to promote social support. Community groups can also be involved in providing social support and promoting the importance of not living in social isolation" (p. 501).

Another group of Canadian investigators (Kerr et al., 2005) sought to identify the **reasons that injecting drug users** (IDUs) **discontinue HAART**. In a sample of 160 HIV-positive IDUs, Kerr and colleagues "found that 44% ... had discontinued HAART during the study period. ... Factors independently and positively associated with discontinuation of HAART included recent incarceration and negative outcome expectations, while higher efficacy expectations and self-regulatory efficacy were negatively associated with HAART discontinuation. The most frequently cited reasons for discontinuation of HAART included incarceration and medication side effects" (p. 543). Because several psychological variables were associated with HAART discontinuation, the authors suggest that

> [i]nterventions based on self-efficacy may help to prevent discontinuation of HAART. ... With respect to negative outcome expectations concerning HAART, psycho-educational methods focused on providing accurate information about HIV disease progression, drug resistance and the clinical effects of HAART should be employed to alter existing beliefs about conditional relationships between HAART and health ... . These approaches could also be supported through use of cognitive restructuring techniques designed to identify and modify negative cognitions concerning HAART and the related side effects ... . (p. 546)

Braithwaite et al. (2005) conducted telephone surveys with 2,702 HIV-positive and matched HIV-negative veterans receiving medical care. Among these respondents, 1,532 (56.6%) were abstainers (i.e., no alcohol in the preceding 30 days), 931 (34.5%) were nonbinge drinkers (i.e., alcohol in the preceding 30 days but $\leq$ four standard drinks on each day), and 239 (8.9%) were binge drinkers (i.e., $\geq$ five standard drinks on at least 1 day). The investigators found

> a strong temporal and dose-response association between alcohol consumption and poor [medication] adherence. We asked individuals to recount their histories of alcohol consumption and adherence over the past 30 days and found that alcohol consumption on a particular day was associated with a higher risk of failing to adhere to their medication regimen on that day than on days not proximal to a drinking day. Furthermore, our results suggested dose-response relationships of poor adherence with quantity of alcohol consumed, with particularly poor adherence on days when quantities of alcohol were consumed that met the criteria for ... binging. The majority of these associations were similar in HIV+ persons compared with HIV- persons, suggesting that our results may apply more broadly. However, alcohol consumption among nonbinge drinkers appeared to only impact the adherence of HIV+ individuals, suggesting that **HIV+ individuals may experience adverse effects at a lower threshold of alcohol consumption**. (pp. 1194-1195)

With regard to HIV disease, Braithwaite and colleagues observe that "interventions that aim to decrease alcohol consumption may have the potential to reduce morbidity and mortality, in addition to any beneficial impact they might have on alcohol-related diseases" (p. 1195).

Access to Care

Winiarski, Beckett, and Salcedo (2005) compared 47 people living with HIV who received psychiatric and psychotherapy services integrated into inner-city HIV primary care services and "emphasizing **cultural responsiveness**" with 100 counterparts receiving "care as usual." These 47 individuals had an average of 8.34 clinical encounters over an average period of 36.23 weeks. Winiarski and colleagues found that "utilization was related to reduction in reported mental health problems, HIV-related physical symptoms, and use of alcohol and powdered cocaine, as well as to improvement in social functioning" (p. 747). The authors conclude that these clients, "often viewed as not likely to avail themselves of or benefit from mental health care, were highly motivated for self-improvement and, given access to competent, convenient and culturally respectful services, improved their well-being in significant domains" (p. 747).

Substance Use & Abuse

von Unger and Collins (2005) conducted interviews with 15 women involved in a dual-diagnosis residential program designed to address HIV and chemical dependency. The investigators were particularly interested in the **meaning of HIV infection for** these women in their journey from drug use to recovery. Within this small sample, von Unger and Collins discovered that HIV infection may be of secondary importance to **women's initiation of** their **recovery**, although it may still have the

> potential for aiding the process of recovery from substance use.

For many drug-using women, testing positive for HIV during active addiction only seems to encourage more substance use. Once the conditions for change are ripe, however, and especially once women are enrolled in a treatment program that attends to both their HIV-related and drug treatment needs, HIV can assume a very different meaning. When treated in a gender-sensitive fashion, surrounded by others with HIV/AIDS, and provided with much-needed HIV education, treatment, and care, women are able to transform the meaning of their HIV infection. It becomes a building block of their recovery and a reason to abstain from drug use in the future. (p. 322)

Serostatus Disclosure

British investigators (Jarman, Walsh, & De Lacey, 2005) interviewed six women living with HIV for the purpose of exploring how these women experienced their intimate partner relationships. In the analysis, **psychological protection**, defined as "a perceived need to protect oneself from the psychological threats associated with an HIV-positive identity" (p. 533), emerged as a central organizing theme, reflecting "an underlying tension, for these women, between psychological safety and a need for connection with others" (p. 533). The authors found that tension may be reduced when the woman's positive serostatus is known to or shared by her partner. These relationships offer women "a refuge from the sense of isolation associated with hiding their HIV-positive status and provid[e] psychological protection from the experience of 'otherness' associated with living with an HIV-positive diagnosis" (p. 546).

Of course, such protection may be accessed only through the disclosure of HIV status. According to Jarman and colleagues, "this study suggests whilst these women experience similar conflicts to gay men in relation to disclosure, they experience particular relational tension between the need to maintain psychological protection of the self, a desire to protect others from the psychological impact of knowing their HIV status, a sense of responsibility to ensure the physical protection of partners during sex, and the fear of losing a relationship" (p. 547). "The ending of partner relationships may ... serve to reinforce feelings of isolation associated with living with a stigmatized identity" (p. 547), especially when community supports are limited.

Although this research was exploratory and conducted with a small sample, the findings highlight

> a number of issues of relevance to those working with women who are HIV-positive. First, this study reveals that a complexity of issues relating to psychological protection of the self and others may impinge on ... [women's] decisions about disclosure of their HIV-positive diagnosis to family, friends and partners. The

Tool Box

Books & Articles

Campo, R.E., Alvarez, D., Santos, G., & Latorre, J. (2005). Antiretroviral treatment considerations in Latino patients. *AIDS Patient Care & STDs, 19*(6), 366-374.
"This article explores the demographics of HIV infection among Latinos in the United States, discusses cultural beliefs among Latinos that have an impact on prevention and access to care, and reviews strategies for managing HIV infection in this population" (p. 366).

Dean, H.D., Steele, C.B., Cagle, M.C., & Gayle, H. (Eds.). (2005). HIV/AIDS in racial and ethnic minorities. *Journal of the National Medical Association, 97*(7 Suppl.), 1S-63S.
"African-American and Latino populations continue to be disproportionately affected by the HIV epidemic. However, each minority race and ethnicity has unique cultural values, beliefs and practices about health promotion and illness prevention that may affect their risk factors for HIV infection and contribute to disparities in HIV diagnoses and care. To help better highlight some of the cultural aspects, as well as related social, economic and environmental factors that may affect the spread of HIV in communities made up of minority races and ethnicities, the Centers for Disease Control and Prevention (CDC) provided funding for this supplement" (p. 3S).

Donenberg, G.R., & Pao, M. (2005). Youths and HIV/AIDS: Psychiatry's role in a changing epidemic. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(8), 728-747.
"HIV/AIDS has significant mental health implications, and psychiatry can play a critical role in curbing the epidemic. With minimal effort, mental health professionals can adapt and apply the strategies that they use to treat psychiatric symptoms to prevent HIV transmission behaviors" (p. 728).

Dubé, B., Benton, T., Cruess, D.G., & Evans, D.L. (2005). Neuropsychiatric manifestations of HIV infection and AIDS. *Journal of Psychiatry & Neuroscience,* 30(4), 237-246.
"In this paper, we describe the major neuropsychiatric manifestations of HIV spectrum disease and also discuss the diagnosis and treatment of these types of conditions" (pp. 237-238).

Hilsabeck, R.C., Castellon, S.A., & Hinkin, C.H. (2005). Neuropsychological aspects of coinfection with HIV and hepatitis C virus. *Clinical Infectious Diseases, 41*(Suppl. 1), S38-S44.
"Infection with hepatitis C virus (HCV) is commonly seen in persons with human immunodeficiency virus (HIV) infection, because the viruses share risk factors for transmission; coinfection is a leading cause of morbidity and mortality among HIV-infected persons. ... This review summarizes what is known about neuropsychological aspects of monoinfection with HIV and HCV, as well as coinfection, discusses implications of these find-

exploration of issues of psychological protection may be helpful for women experiencing difficulties in relation to disclosure. It could be useful to consider the pro's and con's of disclosure in terms of psychological protection, especially in the context of partner-relationships where the long-term costs of non-disclosure may outweigh the short-term gains ... .

The importance of exploring the area of intimate relationships during assessment of HIV-positive women experiencing significant psychological distress is also indicated. Questioning about recent transitions 'into' or 'out of' partner-relationships appears particularly relevant, as these are times when the emotional impact of HIV infection may come to the fore of women's experiences. This study suggests the importance of offering support to individuals and couples in relation to helping them adjust to the impact of living with HIV infection, and to help them find ways to frame the problem as a shared problem, establish healthy boundaries and manage togetherness and separateness, which may help to sustain their relationship ... . The value of support groups for HIV-positive women is also indicated, which can help to reduce feelings of isolation and otherness ... . However, those who are most concerned about disclosure of their status may be the least likely to attend such groups. (pp. 548-549)

As for serostatus disclosure among men, Shehan et al. (2005) interviewed a racially and socioeconomically diverse sample of 166 **men** who were living with HIV in the southeastern United States and found that

> [t]he majority ... had **disclosed** [their HIV-positive status] **to their mothers** and had received positive responses from them. But a significant minority of respondents (over 25%) did not share information about their serostatus with their mothers. Older men and those with higher levels of education were significantly less likely to disclose, whereas those who contracted the virus through homosexual contact and those who experienced more symptoms were significantly more likely to disclose to their mothers. Being aware of these correlates and exploring their links with disclosure may help clinicians proactively address the difficulties associated with disclosure decisions among those who are living with ... [HIV/AIDS]. (p. 195)

Stress Management

Leserman et al. (2005) interviewed 611 adults seeking medical care in eight rural HIV clinics in five states in the American South. These investigators found that "[p]ast **trauma**, including sexual and physical abuse history, recent severe stressful events, and [posttraumatic stress disorder (PTSD)] symptoms were

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ings, and suggests future directions for this research area" (p. S38).

Kalichman, S.C. (Ed.). (2005). *Positive prevention: Reducing HIV transmission among people living with HIV/AIDS.* New York: Kluwer Academic/Plenum.
"It is rare for edited scientific texts to be as timely as this one. Each section addresses pivotal issues in HIV prevention with positive persons, new data are presented, and innovative recommendations are offered" (p. ix).

Stampley, C.D., Mallory, C., & Gabrielson, M. (2005). HIV/AIDS among midlife African American women: An integrated review of literature. *Research in Nursing & Health, 28*(4), 295-305.
"This review reveals that midlife African American women tend to hold misconceptions about HIV/AIDS, with variation in knowledge level being related in part to age and education. Findings also suggest that these women generally do not believe themselves to be at risk for contracting the virus despite evidence that they engage in unprotected sexual activity with men whose risk factors are unknown to them. Midlife African American women rely primarily on monogamy to protect themselves from infection and tend not to discuss sexual matters, such as condom use, with their partners. These findings also suggest that risk taking behavior may be modified by improving understanding about HIV/AIDS, helping women to realistically appraise their vulnerability to infection, and assisting them to develop assertive sexual communication skills needed to implement safer sex practices" (pp. 302-303).

Wolitski, R.J., Parsons, J.T., Gómez, C.A., Purcell, D.W., Hoff, C.C., & Halkitis, P.N. (Eds.). (2005). Seropositive Urban Men's Intervention Trial (SUMIT). *AIDS, 19*(Suppl. 1), S1-S127.
"[A]lthough the SUMIT trial did not yield statistically significant differences between the treatment and control groups at the 6-month wave of data collection, this does not mean that the study did not yield important results. ... [T]he results ... have raised important questions about how best to conduct prevention with positive individuals. These topics include the need to focus on understanding more about how seropositive individuals conceptualize transmission risk, a more in-depth understanding of the effects of multiple epidemics among HIV-seropositive individuals, the sharing of responsibility between seropositive and seronegative individuals, the need to understand more about maintaining sexual safety for long periods of time, and the need to find an optimal balance between self-interest and altruism. It is to be hoped that this set of questions, among others ..., will result in the definition of research studies whose answers will provide empirically supported methods for supporting ongoing safe behaviors among HIV-positive MSM" (p. S126).

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associated with worse health-related quality of life [HRQOL] in terms of poorer physical functioning, higher risk of bed disability, and greater use of health services. These findings underscore the importance of addressing past trauma and stress [as well as current PTSD symptoms such as hyperarousal] within the medical setting"(p. 506).

Do stress management interventions really work? Mills, Wu, and Ernst (2005) systematically reviewed literature published prior to April 2004 and came across 30 randomized clinical trials assessing the effectiveness of complementary and alternative medicine (CAM) for HIV and HIV-related symptoms: 18 trials focusing on stress management, 5 on natural health products, 4 on massage or therapeutic touch, 2 on homeopathy, and 1 on acupuncture. "Most trials were small and of limited methodological rigour. The results suggest that **stress management may prove to be an effective way to increase the quality of life**. For all other treatments, data are insufficient for demonstrating effectiveness. Despite the widespread use of CAM by people living with HIV/AIDS, the effectiveness of these therapies has not been established. *Vis à vis* CAM's popularity, the paucity of clinical trials and their low methodological quality are concerning" (p. 395).

What might further increase the effectiveness of a stress management intervention? Moskowitz and Wrubel (2005) analyzed 2 years' worth of bimonthly stressful event narratives completed by 57 gay men living with HIV in San Francisco in the years preceding the widespread availability of HAART. Analysis

> revealed six groups that differed on their **appraisals of HIV-associated events**, their characteristic ways of coping, and their emotional reactions to the stressful events. The groupings illustrate different ways in which being HIV+ was integrated into the participants' lives. The men in the *Future Focus* group tended to interpret stressful events in terms of implications for their death, despite the fact that they were relatively healthy. The *Detached* group tended to experience stressful events at arm's length – that is, the events did not appear to affect them strongly in terms of either negative or positive emotions. The *Stigma* group had an overriding theme of stigma in the events they reported. They felt stigmatized by their HIV+ status but also tended to stigmatize others with HIV. They were also stressed by any way that HIV limited their pursuit of pleasure. The *Outward Focus* group attended to others – they offered as well as received social support. Compared to the other groups, they were able to maintain relatively high levels of positive affect over the course of the study. The *Aware/Avoid* group valued the cognitive awareness of HIV and its implications, but at the same time spent a lot of effort trying to avoid the negative emotions that accompanied such an awareness. Finally, because [these] data followed men over the course of two years, [Moskowitz and Wrubel] were able to classify a group of men as changing from one of these five stances to another. The majority of the men in the Change group changed to Outward Focus, although there was one exception in which a participant appeared to change to Aware/Avoid. (p. 526)

Importantly, "[t]here was no formula or prescription for achieving adjustment in the face of HIV. Instead, ... there were multiple pathways through which well-being could be achieved and the best way depended on the individual, his circumstances, and his way of understanding HIV" (p. 526). Moskowitz and Wrubel further contend that

> interventions need to start not with coping, but with appraisal,

From the Block

Latin American Health Institute

The Latin American Health Institute (LHI) is a community-based public health organization located in Boston, Massachusetts. Founded by Latin American health professionals and community activists in 1987, the organization today offers more than 60 direct-care programs for Latin American and other minority individuals and families through offices in Boston, Lowell, and Brockton, Massachusetts. Additionally, LHI works with many public and private organizations in five programmatic areas: research, policy, education, service, and technical assistance.

LHI's *Proyecto Futuro*, developed with funding from CMHS/SAMHSA, is designed to enhance quality of life as well as improve the physical and mental health status of Latinos living with HIV/AIDS through the provision of culturally competent and linguistically appropriate mental health services. Services include community outreach, psychosocial assessment, treatment/service planning, case management, and peer counseling, as well as office-based and home-based mental health counseling. The project targets a variety of underserved groups, including monolingual, Spanish-speaking men and women living with HIV/AIDS (who may also be injecting drug users) and Latino GLBT youth.

The Interim Principal Investigator/Project Director is Rubén Montano-López, MA; the Clinical Director is Victor Griffiths, LMFT. For more information, please call 617/350-6900 or go to http://www.lhi.org.

– Compiled by the MHHSC Program Coordinating Center

because different types of intervention are required, depending on the meaning of HIV for the individual. Maintaining and increasing social support could benefit an Outward Focus participant, particularly if his social network contracts because of his own or another's illness. Cognitive/behavioral approaches might be effective in helping both a Future Focus and an Aware/Avoid participant to manage negative emotional states and reframe the situation. Stigma group participants could possibly benefit from both safer sex interventions and interventions like those directed toward internalized homophobia. As long as they remain detached and that approach works for them, Detached participants would not necessarily be candidates for intervention. (p. 527)

Coping, Social Support, & Quality of Life

Emlet (2005) administered the 13-item **HIV Stigma Scale** to a convenience sample of 88 adults living with HIV; half of the participants were between the ages of 20 and 39, and the other half were 50 years of age and older. Three new subscales – Distancing, Blaming, and Discrimination – were identified. Interestingly, younger adults recorded higher mean scores on the Discrimination subscale than did their older counterparts, while African Americans recorded higher mean scores on the Blaming subscale and higher overall stigma scores than did counterparts who were white or from other racial/ethnic groups. As Emlet sees it,

> [t]he identification of various manifestations of HIV stigma can ... [help clinicians] to better identify how [such] stigma ... [may affect] the lives of their clients. Those individuals who are experiencing greater level[s] of a discriminatory type of HIV stigma may need assistance and advocacy pertaining to issues of civil rights and social justice. Depending on the source of blaming or distancing stigma, interventions may involve psychosocial support, conflict resolution, and, perhaps, family counseling. ... The types and intensity of these experiences can be ascertained through the clinical use of these scales and more focused and meaningful interventions initiated. (p. 299)

Jia, Uphold, Wu, Chen, and Duncan (2005) assessed HRQOL at baseline and again 12 months later in a cohort of 226 men receiving HIV medical care in north Florida. "[R]esults indicated that higher **family support** and **CD4 cell counts** at baseline were predictive of improved changes in physical and social functioning over time, and higher **depressive symptoms** at baseline were predictive of diminished role functioning, emotional well-being, and general health perception. These findings underline the importance of enhancing family social support, identifying and treating depression, and improving immune function to optimize HRQOL among men with HIV infection" (p. 395).

Although much of the coping-with-loss literature has focused on psychological distress in **bereaved persons**, Rogers, Hansen, Levy, Tate, and Sikkema (2005) examined the effects of *positive* psychological states (i.e., optimism, hopefulness) on a diverse sample of 172 men and 92 women living with HIV who had also lost loved ones to AIDS.[3] Rogers and colleagues found that

> active coping is positively associated with optimism and negatively associated with hopelessness. Conversely, avoidant coping was found to be negatively associated with optimism and positively associated with hopelessness. The findings supported the overall hypothesis that active and avoidant coping (with loss) strategies are, respectively, predictive of **optimism and hopelessness**, even while taking into account other important bereavement-related variables. The ... model examining optimism showed that optimism was associated with higher levels of social support and lower levels of depression. The model examining hopelessness revealed the opposite – that hopelessness was significantly associated with lower levels of social support and higher levels of depression. (p. 353)

Drawing on these findings, the authors discuss "the targeting and tailoring of interventions designed to improve coping and to reduce distress following bereavement" (p. 341):

> Identification of optimistic or hopeless characteristics can aid in better recognition of persons at risk for avoidant or maladaptive coping, which in turn allows for better targeting of coping interventions, particularly for HIV-infected groups. ... [S]tudy findings [also] have ... implications for improved tailoring of such interventions to affected groups. Coping interventions should focus on the incorporation of hope-building or optimism-instilling elements, including enhancing the perception that positive outcomes are actual possibilities and that one has the power to effect such outcomes[4] ... . Improved identification of those at risk for avoidant behavior, and enhanced tailoring of coping interventions to such people, could ... potentially lead

[3] Other studies involving this same sample of bereaved, HIV-positive men and women may be found in the Summer 2003, Summer 2004, and Summer 2005 issues of *mental health* **AIDS**.

[4] "Cognitive-Behavioral Techniques Designed to Increase Optimism" are summarized in a **Tool Box** in the Fall 2004 issue of *mental health* **AIDS**.

to reductions in distress.

> ... [I]nterventions ... for HIV-infected bereaved people should also focus on treatment for depression [and] mobilization of social support networks ... [in addition to the] development of coping skills. Clinical care that integrates treatment for depression, a focus on the importance of seeking and utilizing social support, and the incorporation of hope and optimism elements into a coping with loss framework will better address some of the serious issues that confront such a population. (pp. 356-357)

Continuing this focus on bereavement, Pelton and Forehand (2005) monitored 105 African American children between the ages of 6 and 11 living in New Orleans. The children were evaluated on three occasions and were divided into three groups: children with HIV-negative mothers, children with HIV-positive mothers who were living, and children with mothers who died from AIDS. Although not all results achieved statistical significance, a consistent pattern of "findings indicated that, relative to those in one of the two control groups, more children in the **orphans** group had clinical levels of internalizing and externalizing problems before their mother's death and clinical levels of internalizing problems 2 years after her death. No differences emerged at 6 months after the mother's death" (p. 585). Pelton and Forehand

> suggest that interventions to facilitate the adjustment of children whose mothers are HIV infected should be initiated at the pre-orphan stage and can involve both individual interventions with children and parenting interventions with the mother and future caregivers.[5] Furthermore, even if caregivers do not report child behavior problems in the first few months after the mother's death, intervention should continue into the orphan years as children cope with their mothers' death and new caregivers cope with parenting these children. (p. 591)

[5] Rotheram-Borus, Weiss, Alber, and Lester (2005), quoted in the Summer 2005 issue of *mental health* **AIDS**, similarly suggest that "high distress [among bereaved adolescents] more than a year prior to parental death indicates the importance of early identification and preventive interventions for families affected by HIV. ... Interventions that improve coping skills and address HIV-related challenges may help decrease the increases in problem behaviors ... in the period prior to parental death" (p. 227).

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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/hivaids/); and information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

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. (2004). *The Johns Hopkins Hospital 2004 guide to medical care of patients with HIV infection, 12th edition.* Philadelphia: Lippincott Williams & Wilkins.

Shernoff, M. (Ed.). (2000). *AIDS and mental health practice: Clinical and policy issues.* Binghamton, NY: Haworth Press.

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