

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Women & Men

Although preventive interventions are designed to assist persons at risk for HIV infection, Albarracín, Duranti, Earl, Gunnoe, and Leeper (2008) point out that it is these very individuals who may not be willing to take part in interventions of this type. Consequently, in their view, procedures must be devised “to change . . . behavior with respect to the preventive interventions themselves, including participation in them. These procedures, . . . termed **meta-interventions**, entail a standardized introduction or context change (e.g., delivery setting) intended to **increase exposure to a behavioral intervention**” (pp. 638-639).

With this challenge in mind, Albarracín and colleagues randomly assigned 400 infrequent condom users, predominantly African American and female, to one of four conditions “varying the introduction to a counseling program. In the experimental condition, participants were told that the intervention gave participants options but might not change their behavior. In a standard-introduction condition, participants were told that the program was highly effective at changing participants’ behaviors. There was also an information-control group containing a description of the program, and a no-information-control group solely containing an invitation” (p. 638). The investigators measured actual par-

ticipation in the counseling program that was offered and found that the program “attracted most participants when the offer highlighted the audience’s options rather than behavior change.”¹ More important, this program was superior to all the controls when the audience did not intend to use condoms in the future” (p. 642). Albarracín and colleagues conclude that “intervention introductions countering participants’ resistance to change increase participation in HIV-prevention counseling among reluctant clients” (p. 638) and that, “as a result of this work, a seconds-long meta-intervention is available that adds little or no cost to . . . existing HIV-prevention programs but can multiply . . . [their] effectiveness” (p. 642).

About Women

Klein, Elifson, and Sterk (2008) “examined the relationship between **depression** and HIV-related **risk behavior** practices in a sample of 250 ‘at risk,’ predominantly **African American women** living in the Atlanta, Georgia metropolitan area” (p. 167) who were recruited for this study through a chain-referral (“snow-

¹ The winning meta-intervention: “While you are waiting, you have the choice to speak with a certified HIV-prevention counselor. The counseling session provides information about HIV and condom use. It will also help you figure out your risk for HIV infection. The point of the counseling session is to provide you with the most current information, not to influence your opinion or make you use condoms if you don’t want to. [Would you be interested?]” (p. 640).

ball”) sampling approach. “As predicted, condom-related attitudes were related to HIV risk behaviors, and depression, in turn, was found to have a strong association with women’s attitudes toward using condoms” (p. 179). Indeed, depression emerged as a key mediating variable: “the more depressed women were, the more opposition they tended to have toward using condoms, and the more opposed they were regarding condom use, the greater their involvement in HIV risks tended to be” (p. 180). With an eye toward intervention, Klein and colleagues reason that

because of its saliency as a mediating variable, understanding the factors underlying such women’s levels of depression is crucial, since alleviating these antecedent influences is likely to lead ultimately to reduced behavioral risk. Accordingly, . . . [the investigators] examined the factors that heighten women’s risk for experiencing depressive symptoms and discovered several such factors. They were low

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levels of religiosity, less closeness with family members, less support from family members during the formative years, childhood sexual abuse [(CSA)], childhood emotional abuse, greater financial difficulties, and more problems stemming from illegal drug use. (p. 184)

With these factors in mind, the investigators offer a number of recommendations for intervention, including:

- (1) heightening faith community involvement and religious participation to decrease depression;
- (2) working with women whose familial bonds are in need of strengthening to combat depression;
- (3) providing mental health and counseling services to women who were emotionally and/or sexually abused during their formative years . . . to help these women to recover from unresolved issues that may be fueling depression;
- (4) assisting "at risk" women who need training in money management issues to minimize their risk for depression;
- and (5) helping women drug abusers to receive treatment for their drug problems to combat their depression and lower their HIV risk. (p. 168)

According to Holden et al. (2008), "studies suggest that **depression may moderate intervention effi-**

cacy among affected persons because of impaired information processing, failure to recognize risk, or inability to change behavior" (p. 898). Holden and colleagues explored this possibility in connection with their own cognitive-behavioral intervention, Project SAFE, which significantly reduced behavioral risks and reinfection with chlamydia, gonorrhea, syphilis, and/or trichomonas among participants when compared to controls in a randomized controlled trial (Shain et al., 1999).

The investigators stratified a sample of 477 Mexican- and African American women (249 intervention, 228 controls) from San Antonio, Texas, who participated in the original study according to their level of depressive symptoms at baseline as determined by Center for Epidemiologic Studies Depression (CES-D) Scale scores, and evaluated differences in behavioral risk and reinfection between groups at 6- and 12-month follow-ups. Holden and colleagues found that Project SAFE "worked at least equally well among depressed compared to nondepressed women, particularly in that depressed women appeared to make changes earlier, for a greater time and to a greater extent than nondepressed women" (p. 902).

In accounting for these findings, the investigators observe that

although some studies have

shown that depression can interfere with information processing, they have also noted that negative messages are more likely to be interfered with than positive messages. . . . In this case, SAFE provided positive messages achieved through focused intragroup discussion, role play and other activities which empowered women to change relational and other psychosocial aspects of their lives. It provided women with a more constructive way to recognize risk and make decisions regarding relationships and sexual behavior. Through workshop sessions, SAFE emphasized the positive gains to be achieved by sexual risk reduction (e.g., selectivity in relationships) and encouraged self-efficacy (e.g., active condom use negotiation) among participants. It appears that participants may have used knowledge and skills imparted by SAFE to make changes that they believed would reduce behavior risks despite feeling depressed. Perhaps the intervention imparted a sense of control which is often thought to be lacking among depressed persons, resulting in reduced interference with participant information processing. (p. 903)

In short, "depressed study women did as well and in certain aspects better than their nondepressed counterparts," according to Holden and colleagues, who conclude that "depressed women were amenable to changing their behavior given the impetus of the Project SAFE intervention and the empowerment it conferred" (p. 903).

About Men Who Have Sex With Men

Rosser et al. (2008) "sought to identify predictors of **HIV disclosure** and serodiscordant unprotected anal intercourse (SDUAI) among HIV-positive men who have sex with men

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(MSM)" (p. 925). The investigators recruited 675 MSM living with HIV in six United States HIV epicenters. Rosser and colleagues intentionally over-sampled MSM of color living with HIV (74%) and men who engaged in unprotected anal intercourse (UAI) in the preceding year. Survey findings "showed 30 and 31%, respectively, of participants disclosed to none or some of their secondary sex partners in the last 90 days. Greater disclosure to secondary partners was associated with having fewer sexual partners, being extremely out as MSM,² longer HIV diagnosis, knowledge of CD4 count, detectable viral load and being white. Disclosure to all secondary partners was associated with lower SDUAI" (p. 925). According to the investigators, these findings suggest that "future intervention programs should encourage consistent serodisclosure to secondary sexual partners and promote outness and comfort with sexual orientation within a community-appropriate approach" (p. 928).

What might be a community-appropriate approach when working with MSM of color? Williams et al. (2008) conducted a randomized clinical trial comparing "the effects of two 6-session interventions, the Sexual Health Intervention for Men (S-HIM), guided by social learning theory and aimed at decreasing high-risk sexual behaviors, number of sexual partners, and depressive symptoms, and a standard health promotion control (SHP)" (p. 763). The investigators recruited **137 gay- and non-gay-identifying African American and Latino men**, a sample that included MSM as well as men who have sex with both men and women (MSMW).

² Rosser et al. (2008) note that "the degree of being 'out' about one's sexual orientation has been associated with improved mental health adjustment . . . and may serve as behavioral rehearsal for coming out as HIV-positive" (p. 925) and that "being out about one's sexuality may serve an important function of gaining greater social support overall for men in the study" (p. 928).

Moreover, all study participants had a history of CSA and were also living with HIV. Study participants were further characterized by the investigators as "middle-aged men who were poor, undereducated, and predominantly single, lacking both primary or long-term partners and family support" (p. 769).

The experimental intervention, the S-HIM, was adapted from an evidence-based intervention designed originally for HIV-positive women with histories of CSA, modified in accordance with qualitative research conducted with gay- and non-gay-identifying African American and Latino MSM living with HIV. In this adapted intervention,

choices regarding sexual behaviors and consequences were discussed within a culturally congruent social context, specifically for HIV-positive ethnic men. General topics included (1) the influence of gender and ethnicity (i.e., the meaning of being an African American or Latino man); (2) early socialization regarding gender and culture, as well as adult experiences (i.e., being gay/bisexual versus heterosexual within the African American and Latino communities, having male and/or female partners; having early and/or unwanted sexual experiences); (3) the stigma of HIV, particularly within African American and Latino communities; (4) the Keeping Males in a Healthy Place (KMNHP) concept to problem solving (i.e., Know about the problem, eMotions – identify how you feel, Need to deal with the problem, Holding you back from changing, and Plan); (5) the ability and skills to improve psychological well-being and self acceptance/esteem by addressing personal experiences of depression; and (6) strategies for recognizing triggers and for coping with these problems. (p. 766)

Although Williams and colleagues "did not require the men to disclose their abuse history or with whom they have sex, the focus of the intervention was on the sexual histories of participants and their link to current cognitive, affective, and behavioral patterns. The impact of CSA on personal decision-making was emphasized throughout the session as an important link between past traumatic experiences, HIV infection, and current functioning. Emphasis was placed on problem-solving strategies and communication skills training" (p. 766).

In the control condition, the SHP intervention

addressed health issues, including certain cancers, hypertension, diabetes, and heart disease, all of which are common among ethnic minority men, but did not specifically focus on sexual behavior. . . . The SHP intervention was structurally similar to the S-HIM, consisting of six 2-h psychoeducational sessions that included discussions, interactive exercises, role-playing, and games (e.g., using the relaxation and feelings thermometer, identifying and rating your health risks, negotiating self-exercise regimes, planning diets and the food pyramid matching game, etc.). (p. 766)

The findings were intriguing, for "while the S-HIM curriculum more directly addressed sexual risk and depression and provided participants with skills to examine cognitive, affective, and behavioral patterns than the SHP, both interventions may have produced benefits" (p. 769). More specifically, "the sample as a whole reported reductions in sexual risk behaviors and number of sexual partners from baseline to post-test, and from the 3 to 6 month follow-ups, although the decrease in sexual risk behavior from baseline to post-test

was significant only for S-HIM participants. No significant differences between conditions were reported for depressive symptoms, but the total sample reported a significant decrease at 6 months” (p. 763).

Speaking to the significant findings regarding sexual risk reduction in the experimental intervention, the investigators conjecture that the “sexual decision-making skills provided in the S-HIM may have helped the men to reduce sexual risk behaviors and number of sexual partners immediately. However, the use of these skills may fluctuate over time, and participants may benefit from ongoing support for change. This may include booster sessions to maintain effects over time” (p. 769).

In the view of the investigators, one reason for the reduction in depressive symptoms among participants in the two study conditions may be that “the weekly group format of both interventions . . . provided social support that helped to alleviate social isolation contributing to symptoms of depression. Social support may be an important variable to incorporate in interventions for participants who endure a triple stigma of being HIV-positive and an ethnic and sexual minority. . . . The support of other group members who were facing similar issues may have served as a buffer against rejection and racial and health stigma for these men” (p. 769). With regard to the mix of participants in this study, the investigators question whether “it is possible that psychosocial issues for MSM and MSMW are significantly different and that . . . [this] intervention did not **target issues most pertinent to the MSMW subculture**” (p. 770).

On this point, Wheeler, Lauby, Liu, Van Sluytman, and Murrill (2008) administered audio computer-assisted self-interviews to 596 black MSM and 226 black MSMW in New

York City and Philadelphia. Their data

showed that Black MSM were more likely to be at risk for HIV infection than black MSMW. Black MSM were also more likely than Black MSMW to report engaging in receptive UAI, to be HIV-positive, and to have unrecognized HIV infection. . . .

MSMW were more likely to be older than MSM and less likely than MSM to disclose their same-sex behavior to at least one person. There was also evidence of different economic status and life experiences between MSMW and MSM. MSMW reported lower annual incomes than MSM, less education, and were less likely to be employed. In addition, MSMW were more likely than MSM to report recent exchange sex activity [for money, food, or drugs], recent substance use, being arrested twice or more times in their lifetime, and that their income supports more than one person. . . . Although Black MSMW in . . . [this] sample were more likely than Black MSM to report commercial sex work activity and a history of arrests, they were less likely than Black MSM to report a history of forced sex.

There were several common **correlates of UAI among Black MSMW and Black MSM** in . . . [this] sample. The strongest correlate for either insertive or receptive UAI among both groups of men was engaging in exchange sex. The next strongest correlate of UAI shared among the men . . . was homosexual or gay identity. Homosexual[-] or gay[-]identified men in . . . [this] sample were more likely to engage in unprotected receptive sex, the riskiest behavior associated [with] HIV infection. However, homosexual or gay, bisexual, or heterosexual identity did not predict

unprotected insertive anal sex among MSMW or MSM in . . . [this study].

There were also unique correlates for insertive or receptive UAI for each group of men. Among Black MSMW, reporting drug use in the past 3 months was associated with less insertive UAI. . . . Compared with only one unique correlate among MSMW, there were many more correlates of UAI specific to Black MSM. Disclosure of sexual activity was related to insertive anal sex. . . . In terms of receptive UAI, Black MSM who were born in the US were more likely than Black MSM who were not to engage in receptive UAI. . . . Ever being forced to have sex was also associated with receptive UAI among Black MSM in . . . [this] sample. Last, younger age was associated with greater rates of both insertive and receptive UAI among Black MSM. . . .

The degree of congruence between sexual identity and sexual behavior among men in . . . [this] sample was fairly high. Most MSMW . . . identified as bisexual and most MSM . . . identified as homosexual or gay. However, a significant number of MSMW identified as heterosexual (24%) and a significant number of MSM identified as bisexual (25%). (pp. 703-705)

According to Wheeler and colleagues, findings from this study highlight “the need for specific HIV prevention interventions targeting Black MSMW as distinguished from Black MSM” (p. 697). For men in both of these groups,

data from . . . [this] study strongly suggest that interventions address the role of economic survival and self-sufficiency. Among Black MSMW, . . . [these] data

point to a need for increased attention to the influence of the criminal justice system, familial obligations and substance use. For MSM, interventions should also incorporate components that address the effects of forced sexual experiences. Additionally, for MSM . . . [sampled in this study], significant correlates of UAI included being born in the US, being homosexual or gay identified, and disclosing this identity to others. These findings call into question approaches to sexual behavior and sexual identity integration often employed in HIV prevention interventions. . . . [These findings instead suggest] that interventions must consider more culturally specific approaches to work with Black MSM and MSMW in these areas. Such approaches would build on behaviorally oriented models of prevention intervention to also include components that address the roles and influences of economic, cultural, and social variables. (p. 705)

Fields, Malebranche, and Feist-Price (2008) report on the high **prevalence and context of CSA among Black MSM** “across 3 independent qualitative studies. Semistructured one-on-one interviews were conducted with 87 Black MSM across 3 cities (Rochester, NY, *n* = 28; Lexington, KY/Atlanta, GA, *n* = 30; and Atlanta, GA, *n* = 29). A combined CSA prevalence of 32% (28/87) was found among the 3 [convenience] samples, despite variation in geographic location, mean age, and sexual identification” (p. 385). The investigators also found that the “CSA experiences often involved older male relatives and were prolonged and repetitive in nature” and that “many viewed their current same-sex desire as rooted in their CSA experiences.” Moreover, “descriptions of depressive symptoms, social isolation, suicidality, ‘acting out,’ and other adverse men-

tal health responses were common” (p. 388). As Fields and colleagues see it, these findings underscore “the need for earlier screening of CSA. . . . Moreover, alcohol use, exchanging sex for money, and physical violence were commonly reported details of these experiences. This described context of CSA among the Black MSM . . . highlights essential issues of poor mental health that may be going unaddressed” (p. 389).

Of interest in this regard is a study by Arreola, Neillands, Pollack, Paul, and Catania (2008), who assessed the **differential effects of forced, consensual, and no childhood sexual experiences** (i.e., before the age of 18 years) on health outcomes among a probability sample of 2,506 adult MSM who self-identified as gay or bisexual and resided in one of four large American cities: Chicago, Los Angeles, New York, and San Francisco. The investigators found that “the forced sex group had the highest levels of psychological distress, substance use, and HIV risk. There were no differences in rates of depression and suicidal ideation between the consensual- and no-sex groups. The consensual- and forced-sex groups had higher rates of substance use and transmission risk than the no-sex group. The forced-sex group, however, had significantly higher rates of frequent drug use and high-risk sex than the consensual group” (p. 246). According to Arreola and colleagues, these findings

suggest that, for gay and bisexual men, distinguishing forced from consensual childhood sexual experiences is critical to understanding mental health and transmission risk outcomes, and may provide a deeper understanding of the conditions under which substance use places men at risk. . . . The finding that forced sex was significantly riskier than consensual sex [for mental health and transmission risk outcomes],

however, indicates that we must pay special attention to the unique effects of forced childhood sexual experiences on mental health and transmission risk outcomes among gay and bisexual men. For these men, it may be that two different trajectories emerge from childhood sexual experiences, one related to the psychological sequelae of forced sex and the other to the correlates of consensual, but early, sexual initiation. (p. 250)

Arreola and colleagues “recommend that research move toward a more mature understanding of childhood sexual experiences that includes the subjective experience of childhood sex. In particular, it appears that at least for gay/bisexual men, the subjective experience of being coerced is particularly salient in predicting and differentiating mental health and transmission risk outcomes” (p. 251). The findings also point to the importance of conducting “more nuanced evaluations of childhood sexual experience characteristics themselves in order to better understand the nature of these experiences. For example, severity and duration of childhood sexual experiences will help to differentiate those likely to need more intensive interventions, such as individual psychotherapy, from those who may not” (p. 251).

According to Johnson, Carrico, Chesney, and Morin (2008), “**internalized heterosexism (IH)**, or the internalization of societal antihomosexual attitudes, has been consistently linked to depression and low self-esteem among gay men, and it has been inconclusively associated with substance use and sexual risk in gay and bisexual men” (p. 829). With data from a sample of 467 gay-identified men living with HIV, Johnson and colleagues found support for “a model in which IH appears to be linked to greater HIV transmis-

Tool Box

Books & Articles

Davey, M.P., Duncan, T.M., Foster, J., & Milton, K. (2008). Keeping the family in focus at an HIV/AIDS pediatric clinic. *Families, Systems, & Health, 26*(3), 350-355.

"As the subdiscipline of medical family therapy grows, collaborative partnerships between family therapy programs and HIV/AIDS clinics represent a promising opportunity to systemically address the medical, intrapersonal, and interpersonal issues that often arise when a family member is coping with the diagnosis and treatment of HIV/AIDS. This article highlights a successful collaboration between Drexel's Couple and Family Therapy Program and a Pediatric and Adolescent HIV/AIDS clinic at St. Christopher's Hospital for Children. The authors describe a brief history of St. Christopher's Pediatric and Adolescent HIV/AIDS clinic and its transition from a more traditional nonfamily therapy model to one that is systemic. An illustrative case example and lessons learned about developing successful collaborations with HIV/AIDS clinics are presented" (p. 350).

Douaihy, A., Hilsabeck, R.C., Azzam, P., Jain, A., & Daley, D.C. (2008). Neu-

ropsychiatric aspects of coinfection with HIV and hepatitis C virus. *AIDS Reader, 18*(8), 425-432, 438-439.

"This review summarizes . . . what is known about the neurocognitive and psychiatric aspects of HIV/HCV coinfection and discusses the clinical implications and challenges in working with coinfecting persons. An integrated, flexible, and interdisciplinary team approach model for treating patients who are coinfecting is presented with specific recommendations for clinicians working with this population" (p. 425).

Fisher, J.D., Amico, K.R., Fisher, W.A., & Harman, J.J. (2008). The Information-Motivation-Behavioral Skills model of antiretroviral adherence and its applications. *Current HIV/AIDS Reports, 5*(4), 193-203.

"The Information-Motivation-Behavioral Skills (IMB) model of HAART [highly active antiretroviral therapy] adherence can be used to understand the dynamics of HAART adherence and to intervene with patients to promote more optimal levels of adherence. This article reviews the core hypotheses of the IMB model of HAART adherence and describes available correlational and experimental evaluations of the model, outcomes of adherence intervention trials that applied the model, and IMB model-based interventions

that are currently under evaluation. It then explores one potential promising application of the model that uses a protocol . . . [that] could be incorporated into clinical practice as a valuable tool in working with patients individually" (p. 193).

Foley, J., Ettenhofer, M., Wright, M., & Hinkin, C.H. (2008). Emerging issues in the neuropsychology of HIV infection. *Current HIV/AIDS Reports, 5*(4), 204-211.

"This article provides an overview of our current knowledge of HIV-associated neuropsychological abnormalities, with an emphasis on the most recent attempts to classify cognitive impairment within Western and developing societies, the emergence of diverse cognitive presentations in the post-HAART era, factors that moderate the development or impact of HIV-related neurocognitive and functional deficits, and the neurophysiologic consequences of infection" (p. 204).

Nwoye, A. (2008). Memory and narrative healing processes in HIV counseling: A view from Africa. *Contemporary Family Therapy: An International Journal, 30*(1), 15-30.

"Although psychotherapists are desperately needed, most of those in Africa have not been given sufficient

sion risk and nonadherence to HIV medications indirectly via increased negative affect and more regular stimulant use. These findings are unique in the focus on identifying potential pathways between IH and an increased risk of infecting others with HIV, and with the increased likelihood of poor disease management through nonadherence to prescribed medications" (p. 835).

Regarding intervention, Johnson and colleagues point out that

there is a clear recognition of the importance of social stigmatization and IH in the guidelines for clinical therapeutic work with gay men (American Psychological Association, 2000). . . . In implementing these guidelines, the incorporation of cognitive-

behavioral techniques to challenge heterosexist beliefs has been identified as a strategy when working with gay men in psychotherapeutic settings. . . . Other approaches – such as gay affirmative therapy . . . , affirmative cognitive-behavioral therapy . . . , and acceptance and commitment therapy . . . ; all of which involve addressing negative beliefs about one's sexuality – may have a positive impact on HIV transmission and disease self-management among gay men living with HIV. Incorporating intervention content targeting the reduction of IH may further enhance the efficacy of demonstrated coping interventions with HIV-positive gay and bisexual men. . . . Such intervention content may include problem solving

about productive disclosure of sexual orientation and HIV status, identifying and accessing support resources in the gay community, and specific techniques (such as identifying and modifying cognitive antecedents related to IH) that trigger affective states (such as depression). Further, the current findings suggest potential applications for addressing and reducing IH in the context of substance abuse treatment, in particular for the pervasive problem of stimulant abuse in the gay community. (pp. 835-836)

Golub, Rosenthal, Cohen, and Mayer (2008) interviewed 104 MSM who were prescribed **non-occupational post-exposure prophylaxis** (NPEP) following sexual exposure to HIV. The

training in HIV counseling. In addition, access to specific models of healing for those traumatized by the news of infection with HIV disease is hardly available. Memory healing processes, which are essential in grief work in Africa, can be combined with ritual theory within a narrative framework to provide a model for bringing healing to clients traumatized by the news of HIV infection" (p. 15).

Pyne, J.M., Asch, S.M., Lincourt, K., Kilbourne, A.M., Bowman, C., Atkinson, H., & Gifford, A. (2008). Quality indicators for depression care in HIV patients. *AIDS Care, 20*(9), 1075-1083. "In this paper we report the results of an expert panel conducted in March 2006 to construct a set of valid and feasible quality indicators for detecting and treating depression in patients with HIV" (p. 1076). "The quality indicators identified in this study can be used to evaluate and improve the quality of HIV depression care" (p. 1081).

Rabkin, J.G. (2008). HIV and depression: 2008 review and update. *Current HIV/AIDS Reports, 5*(4), 163-171. "This review addresses the methodologic difficulties in determining depression prevalence, major findings regarding rates of disorder and corre-

lates among different segments of the HIV community, effects of depression on HIV illness progression, psychopharmacologic and psychotherapeutic treatment findings, and behavioral effects of depression, such as its impact on medication adherence, employment, and risk behavior. Finally, the article summarizes international studies of depression prevalence in developing countries and the challenges regarding cross-national diagnostic definitions and measures" (p. 163).

Rohleder, P. (2008). Challenges to providing a support group for HIV-positive prisoners in South Africa. *British Journal of Guidance & Counselling, 36*(3), 277-285.

"This paper looks at the challenges to providing a support group for HIV-positive prisoners. The author's experience of attempting to provide a support group highlights two key challenges: organisational issues which lead to disruptions for the group; and challenges to ensuring confidentiality, a core ethical principle in HIV counselling" (p. 277).

Sayles, J.N., Hays, R.D., Sarkisian, C.A., Mahajan, A.P., Spritzer, K.L., & Cunningham, W.E. (2008). Development and psychometric assessment of a multidimensional measure of in-

ternalized HIV stigma in a sample of HIV-positive adults. *AIDS & Behavior, 12*(5), 748-758.

"The goal of this study was to develop and evaluate a . . . [multidimensional] measure of internalized HIV stigma that captures stigma related to treatment and other aspects of the disease among sociodemographically diverse [persons living with HIV/AIDS]. We developed a 28-item measure of internalized HIV stigma composed of four scales based on previous qualitative work. . . . This measure should prove useful to investigators examining . . . the role of stigma in HIV treatment and health outcomes, and evaluating interventions designed to mitigate the impacts of stigma on [persons living with HIV/AIDS]" (p. 748).

Vance, D.E., Moneyham, L., Fordham, P., & Struzick, T.C. (2008). A model of suicidal ideation in adults aging with HIV. *Journal of the Association of Nurses in AIDS Care, 19*(5), 375-384. "The purpose of this article is to synthesize the HIV and gerontology literatures by providing a model of the factors contributing to depression and suicidal ideation in adults aging with this disease" (p. 376).

— Compiled by
Abraham Feingold, Psy.D.

investigators found that "21% of participants reported unprotected sex during NPEP, and 11% reported unprotected sex with HIV-positive or HIV status unknown partners" (p. 852). In univariate analysis, several psychosocial variables

were associated with high-risk behavior during NPEP, including: risk-taking in the 6 months prior to NPEP, loss of loved ones to HIV, depression, prevention fatigue, and engagement in the HIV care system. In multivariate testing, HIV engagement – defined as receiving services from an HIV-related organization, donating money to or volunteering for an HIV-related cause, and/or reading HIV-related magazines and web sites – emerged as the strongest predictor of unpro-

tected sex during NPEP and the only significant predictor of unprotected sex with an HIV-positive or status unknown partner during NPEP. (p. 857)

As Golub and colleagues see it,

the prevalence of unprotected anal sex with partners of any status underscores the importance of combining the use of NPEP with behavioral interventions that promote risk-reduction practices. . . . Behavioral interventions designed to accompany NPEP traditionally stress the maintenance of risk reduction behavior after completion of the regimen. These data suggest that interventions are needed that specifically address the psychosocial factors that might make maintaining risk

reduction difficult during the 28-day NPEP period. (p. 857)

Moreover, clinicians who intervene "should not assume that those most engaged with HIV/AIDS service organizations are less likely to engage in risk behavior" (p. 852).

Beckerman, Heft-LaPorte, and Cicchetti (2008) took on the topic of **intentional seroconversion** in their report on a sample of 24 gay men who "were asked to identify what motivations were connected to their attempt to become seropositive. Three general variables emerged as potential indicators: (1) seeking relief from emotional HIV fatigue, (2) the wish to be closer with one's HIV[-]positive partner, and (3) the expectation to become HIV[-]positive" (p. 502).

“Although intentional seroconversion has been characterized as purposeful and conscious, it is not to say that ambivalence, fantasy, and unconscious conflicts are not at play as well in this dynamic” (p. 512), according to the investigators. Beckerman and colleagues set out the following assessment goals for clinicians working with this population, offering as well commentary on these goals:

Identify men at high risk for intentional seroconversion.

Clinicians should listen for, and inquire how their HIV[-]negative clients are coping with their HIV status. . . . If there is a pervasive sense of fatigue about HIV-related worries, or chronic fatigue about the need to practice safer sex, there could be higher risk for intentional seroconversion thoughts and behaviors.

Being HIV[-]negative, particularly for those who are involved with an HIV[-]positive partner, may also provoke feelings or fantasies of seroconverting. . . . Counseling around these issues provides the opportunity to assist the client to emotionally process . . . [his] feelings about . . . [his] partner’s positive status, and how that may transfer into fantasy or intentions to become HIV[-]positive. If this fantasy is present, clients can be assisted . . . [by: supporting] ventilation about anxiety and guilt feelings related to partner’s positive status; identifying and assisting in reframing characterological patterns of self-blame; and focusing on the diminution of distorted thought processes that have resulted in intentions to contract HIV. (pp. 512-513)

Explore underlying issues for men intent on seroconverting.

Psychological fatigue . . . can be

understood on a psychodynamic level as a possible manifestation of depression[:]. . . either situational (AIDS trauma) or characterological (depression, unresolved interpersonal issues), or both. Efforts to distinguish the origin of these thoughts and feelings should be made by the clinician, so that the underlying conflict can be identified and diffused.

If a client indicates HIV fatigue, the clinician should assess for any signs of a fatalistic mindset, low self-esteem, and/or self-destructive tendencies as correlated to risky sexual behavior. Empathy, reflective questioning, and interpretation can be used to assist the client to become aware of . . . [his] underlying psychological issues that may contribute to . . . [his] current wishes and behaviors to seroconvert. (pp. 513-514)

Promote sustained behavioral change with regard to safer sexual practices.

Clinicians . . . should engage their clients in purposeful discussion of their experiences, thoughts, feelings, and behavior related to HIV and safer sex. The clarification, amplification, and interpretation of feelings and behaviors are likely to be adjunctive in reducing behaviors aimed at intentional seroconversion.

Additionally, the client’s fantasy of seroconversion needs to be explored and gross departures from reality such as being able to be “less careful” need to be reflected back. As insight alone is not likely to be sufficient in changing behavior, the practitioner may want to utilize . . . motivational interviewing – a strategy that highlights ambivalence and cultivates self-efficacy regarding

behavior change. . . . One recommendation is that practitioners . . . [encourage clients to develop] peer support for safer sex behavior through both friendship networks and community programs.

Lastly, the clinician should be particularly aware of client-worker issues such as transference and countertransference, difference in serostatus, likeness or difference in sexual orientation, and worker self-disclosure about the aforementioned issues. . . . Given all the inherent complexities [in this work], clinical supervision has an essential role. (pp. 514-515)

About Adolescents & Young Adults

Grossman et al. (2008) “examined factors associated with high-risk adolescents’ movement toward or away from adopting **consistent condom use** behavior using the **Transtheoretical Model Stages of Change**. [A sample of 446 adolescents] . . . responded to items assessing pros and cons of condom use, peer norms, condom communication, and perceived invulnerability to HIV. Participants were categorized based on their condom use behavior using the Transtheoretical Model” (p. 913). The investigators found that “progression to consistent condom use [over a 6-month period] was predicted by continuing to perceive more advantages to condom use, reporting greater condom use communication with partners, and less perceived invulnerability to HIV. Movement away from adopting consistent condom use was predicted by a decrease in perceived advantages to condom use, increased perceived condom disadvantages, and fewer condom discussions” (pp. 913-914). Grossman and colleagues contend that findings from this study

are helpful in informing intervention development. The pros of condom use and condom com-

munication were consistent in their power to predict progression to and maintenance of consistent condom use. Notably, the pros of condom use were relatively stable for those with greater condom use across the 6-month window (i.e., Progressors and Maintainers), whereas among those demonstrating less condom use behavior over time (i.e., Non-progressors and Relapsers), the pros of condom use decreased. Among the Non-progressors and Relapsers there appears to be a shift towards the perception of condoms being less pleasurable and more of a hassle. Additionally, Condom Communication followed a similar trend whereby Progressors reported increased communication and Relapsers reported decreased communication.

Based on these findings, interventions could categorize individuals according to their baseline scores into consistent and inconsistent condom users and then tailor interventions accordingly. For those youth using condoms inconsistently, interventions should first target increasing the advantages of using condoms (e.g., lengthen duration of sexual intercourse, decrease messiness, increase female pleasure) and then promote and model skills for communication with partners about condoms. . . . For those individuals using condoms consistently, interventions might adhere to a relapse prevention model whereby the goals are to preserve positive attitudes toward condoms, maintain consistent communication with partners about condoms, and reinforce perceptions of vulnerability to HIV. (p. 921)

The investigators conclude that this study “examines a sample of high-risk youth and provides support for

the importance of improving positive attitudes and communication about condom use to influence safer sexual behaviors. These factors were found to change naturally and predicted more consistent condom use over 6 months. The findings suggest that interventions that target positive attitudes about condom use and that build skills for condom communication are likely to promote consistent condom use among adolescents” (p. 921).

Koniak-Griffin et al. (2008) evaluated a six-session, theory-based, culturally appropriate, couple-focused **HIV prevention program for Latino adolescent mothers and their male partners** (i.e., coparents). Twenty-six couples were assigned to the intervention³ and 23 couples were offered a 1.5-hour “traditional” HIV information session. Important in the study design for a community-based intervention such as this one was the decision to recruit participants

³“The HIV intervention curriculum represents an integration of strategies based on . . . [several] theoretical framework[s], specific HIV prevention strategies borrowed from an adapted form of *Be proud! Be responsible!* (Jemmott et al., 1996 . . .), and data collected through focus group discussions and individual interviews. . . . The 12 hours of content . . . built on feelings of maternal and paternal protectiveness and integrated traditional teachings based on culturally rooted concepts and on values found in the indigenous teachings and writings of the ancestors of many Chicano, Latino, and Native American people. The intervention process focused on the guiding and healing of men and women toward developing and maintaining harmony and balance in all their relationships. Facilitators used an *espejo* (mirror) process of teaching that included strategies such as storytelling, reflection, and guidance. . . . HIV-related content included (a) HIV awareness; (b) understanding vulnerability to HIV infection; (c) attitudes and beliefs about HIV and ‘safer’ sex; (d) condom use skills, refusal skills, and conflict negotiation; and (e) disease prevention. Skills-building activities were designed to increase behavioral intentions to use condoms and build perceived self-efficacy, factors believed to affect sexual risk behaviors. The intervention program was co-led by female and male facilitators who were health professionals (e.g., nurses, health educators, social workers, psychologists)” (pp. 729-730).

from community-based agencies and alternative schools rather than from health care settings, as commonly done in other studies. Findings during a 6-month follow-up period support the effectiveness of a[n] . . . HIV prevention program specifically designed for adolescent mothers and their male partners. . . . Both female and male participants in this program demonstrated safer sexual behaviors (i.e., decreased probability of unprotected sex with any episode of vaginal intercourse) than did those who received a one-session, HIV/AIDS information-only comparison condition. Similarly, participants in the intervention group showed a significant increase over time in condom use intentions compared with those receiving standard education. . . . In addition, females in both groups demonstrated a lower probability of unsafe sex . . . and higher intentions to use condoms than . . . did [their] male partners at baseline and over time. . . . Finally, both the couple-focused and brief, traditional HIV prevention program were beneficial in terms of increasing male and female participants’ knowledge of HIV/AIDS. (pp. 737-738)

The investigators stress that “intervention programs need to have flexible scheduling of classes, provide necessary supportive services such as child care, and offer incentives valued by participants” (p. 739). Koniak-Griffin and colleagues conclude that “this study provides initial evidence to support the beneficial effects of a couple-focused HIV prevention program for Latino adolescent mothers and their male partners living in the inner city” (p. 739).

HIV Assessment News

Psychiatric Assessment

In a study that parallels their examination of symptoms of psychologi-

cal distress experienced by African Americans seeking HIV-related mental health care (Shacham, Basta, & Reece, 2008, summarized in the [Fall 2008](#) issue of *mental health AIDS*), Basta, Reece, and Shacham (2008) examined self-reported symptoms of psychological distress presented by a convenience sample of 191 **Latinos** living with HIV/AIDS upon their self-enrollment into a publicly funded HIV-related mental health clinic in a large city in the southeastern United States. The investigators found that the men and women in this sample “presented for care with significantly lower symptoms of obsessive compulsivity, interpersonal sensitivity, and anxiety than the normative sample of the Brief Symptom Inventory. Eleven percent ($n = 21$) of this sample met the criteria for caseness . . . on the global severity index on the BSI, a general measure of overall psychological distress. However, Latinos in this sample reported higher levels of symptoms indicative of **paranoid ideation** and **somatization**” (pp. 167-168), attributed by the investigators to reasonable mistrust in response to the public debate regarding Latino immigration to the region, and a culturally sanctioned expression of psychological distress, respectively. Basta and colleagues sum it up this way: “Latinos are self-enrolling in mental healthcare services, but their presentations of levels of psychological distress are significantly different from those documented among the general population. These findings offer health professionals additional considerations that may increase the extent to which their services are responsive to the particular issues facing Latinos living with HIV” (pp. 157-158).

Neuropsychological Assessment
Rivera Mindt et al. (2008) “characterized **neuropsychological (NP) test performance of HIV+ English-speaking Hispanic participants** [who were primarily of Caribbean ori-

gin] ($n = 51$) and investigated the combined roles of sociocultural factors (e.g., ethnicity, socioeconomic status [SES] proxy, and reading level) on NP test performance among . . . HIV+ Hispanic and non-Hispanic White participants ($n = 49$)” (p. 315), all of whom presented with advanced HIV disease. Rivera Mindt and colleagues found that “HIV+ Hispanic participants with advanced disease demonstrate a pattern of [NP] sequelae that is consistent with the frontal-striatal pattern observed in HIV-induced CNS [central nervous system] disease” (p. 322). Moreover, the investigators found that “71% of the Hispanic group was globally neuropsychologically impaired, with the great majority (95%) of those demonstrating a mild to moderate level of impairment. When the Hispanic NP-impaired group was compared with the Hispanic NP-normal group, the former demonstrated the greatest deficits in the areas of processing speed, abstraction/executive functioning, fine motor skills, and learning” (p. 321). Finally, with regard to the “combined roles of sociocultural variables (ethnicity, reading level, SES) and disease progression (CD4 count) in the prediction of [NP] functioning” (p. 321), “reading level was the only unique predictor of global NP functioning, learning, and attention/working memory. In contrast, ethnicity was the only unique predictor of abstraction/executive functioning” (p. 315).

According to Rivera Mindt and colleagues,

this study’s results affirm the utility of commonly used [NP] test measures in the detection of HIV-related [NP] impairment among HIV+ Hispanic participants. However, the results also demonstrate the need for providing culturally competent [NP] evaluations as an integral part of the standard of care. Specifically, it is recommended that a compre-

hensive sociocultural evaluation (e.g., literacy, quality of education, acculturation, linguistic information, etc.) and improved normative data be utilized. Integration of such information could potentially improve the interpretation of [NP] test data, aid in making more precise cognitive diagnoses, and assist in developing culturally tailored treatment recommendations. (p. 322)

Rivera Mindt and colleagues also acknowledge that “additional research is needed to replicate and expand the current findings with larger, more thoroughly characterized Hispanic samples of English- and Spanish-speakers to better evaluate the prevalence of HIV-associated [NP] sequelae within this population and to examine the role of within[-] group variation on several sociocultural factors (acculturation, language, etc.) that may [be] associated with [NP] test performance” (p. 322).

HIV Treatment News

Medical Care

In a recent letter, Harris, Larsen, and Montaner (2008) write that “**raltegravir** [(Isentress®)] is an HIV integrase inhibitor that has demonstrated excellent antiviral activity, safety and tolerability in clinical trials. . . . We report four cases of treatment-experienced HIV-infected patients who experienced significant exacerbation of pre-existing depression temporally related to the start of raltegravir therapy” (p. 1890). The investigators conclude that, “pending further study, caution and close monitoring is advised when starting raltegravir in patients with a history of depression who are currently under treatment with antidepressant and other psychotropic medications” (p. 1891).

Spanish investigators Quereda et al. (2008) point out that “mood disorders and other neuropsychiatric disorders are common adverse events limiting

[the] tolerability of α -interferon (IFN) therapy for hepatitis C virus (HCV). Because efavirenz (EFV [or Sustiva®]) frequently produces neuropsychiatric side effects . . . [as well, the investigators] studied **the effect of EFV in the incidence of these side effects in HIV/HCV patients receiving IFN**" (p. 61). Quereda and colleagues found that

among 266 HIV/HCV patients starting a course of IFN (91% pegylated IFN) plus ribavirin, 53 (20%) received concomitant EFV and 213 (80%) did not. Most EFV patients (92%) were already on EFV before starting IFN (mean 26 months). Neuropsychiatric side effects were frequent, without significant differences between both groups (79% vs 65% . . .), and only 10 patients discontinued IFN. Mood disorders were reported more frequently in EFV patients (36% vs 23% . . .), but antidepressant therapy use was similar in both groups. The incidence of anxiety, insomnia, irritability, headache or prescription of anxiolytics or hypnotics was similar. (p. 61)

In short, the investigators found a "trend for an increased rate of neuropsychiatric side effects when EFV was used in combination with IFN-based therapies, but this did not reach statistical significance" (p. 62). Quereda and colleagues conclude that neuropsychiatric adverse events "are common among HIV/HCV-coinfected patients on IFN, but usually of mild or moderate intensity. Although concomitant EFV use may favor symptoms of mood disorder, it was not related to an increased risk for significant depression requiring specific treatment" (p. 63).

Crane et al. (2008) examined the association between lipoatrophy (decrease in fat tissue) or lipohypertrophy (excessive fat growth) and depressive symptoms among an

observational cohort of 250 men and women receiving HIV primary care services in Seattle. The investigators found a "high prevalence of body morphology abnormalities: 82% of patients had at least some degree of lipoatrophy or lipohypertrophy. Most abnormalities were mild, with 13% of patients reporting moderate-to-severe lipoatrophy or lipohypertrophy. Mean depression scores were significantly higher among patients with lipoatrophy or lipohypertrophy. Moderate-to-severe lipoatrophy was associated with dramatically higher depression scores: over double those of patients reporting no abnormalities in adjusted analyses" (p. 783). Crane and colleagues observe that "the association between facial lipoatrophy and depression suggests a simple way for providers to identify patients at increased risk for depression and suggests that treatment of facial lipoatrophy may be an important part of care of HIV-infected patients" (p. 784).

Psychiatric/Psychological/ Psychosocial/Spiritual Care Adherence to Treatment

To date, one of the most widely read *mental health AIDS Tool Boxes* has been "Addressing Historical Trauma Among African Americans as an HIV Intervention." This article appeared in the [Spring 2005](#) issue and reported on findings that conspiracy beliefs may act as a barrier to HIV prevention. Are these beliefs also associated with poorer access and adherence to HIV care and health outcomes among persons living with HIV? To answer this question, Clark, Mayben, Hartman, Kallen, and Giordano (2008) surveyed a convenience sample of 113 men and women receiving HIV primary care services at one of four publicly funded facilities in Houston, Texas, and found that

63% had at least one conspiracy belief related to the origin of HIV,

the lack of a cure for HIV infection, or the lack of a vaccine to prevent it. These beliefs were most common in black participants but were not uncommon in participants of other racial and ethnic backgrounds. . . . [The investigators] hypothesized that persons with HIV infection who harbor **conspiracy beliefs** might be less engaged in care and less healthy as a result. However, . . . [Clark and colleagues] could not document any adverse patterns of health care utilization or health outcomes associated with holding these beliefs. Compared to persons without conspiracy beliefs, persons with conspiracy beliefs had higher CD4 cell counts at diagnosis of HIV infection and higher current CD4 cell counts, but similar use of HAART [highly active antiretroviral therapy] and adherence to HAART, similar retention in medical care, and similar overall health and quality of life. (p. 757)

The investigators acknowledge that "since recruitment focused on patients in care, patients with extreme conspiracy beliefs may be underrepresented" (p. 753) in this study. Nevertheless, Clark and colleagues conclude that "efforts to improve adherence to care, including adherence to HAART and retention in care, may not need to focus in depth on combating these common beliefs" (p. 758). The investigators further reason that the "patients are able to distinguish their beliefs about the origins and treatment of HIV from their own need for health care. This is a reassuring finding since conspiracy beliefs are so common, even among the educated. Health care professionals should make a greater effort to build trusting relationships with HIV[-]positive patients in order to help patients remain in and benefit from care" (p. 758).

(Biopsychosocial Update is continued on Page 16)

Tool Box

HIV-Related Mental Health Interventions Delivered Through Telephone & Internet Technology

According to Mohr, Vella, Hart, Heckman, and Simon (2008), "one reason for th[e] . . . discrepancy between interest and failure to initiate or follow through with psychotherapy is that there are considerable barriers for many patients, including time constraints, transportation problems, caregiving responsibilities, stigma concerns, disability, or living in a rural area that lacks adequate mental health services" (p. 244). These investigators contend that "many of these barriers could potentially be mitigated through the use of the telephone in administering psychotherapy" (p. 244).

With this mindset, Mohr and colleagues conducted a meta-analysis that included 12 trials in which the telephone was used to deliver psychotherapy for depression. They found that

telephone-delivered interventions are well-received and reduce depressive symptoms. . . . [Mohr and colleagues] found significant symptom reductions across all assessment periods for patients enrolled in telephone-administered psychotherapy, compared with treatment as usual . . . ; greater reductions were found when analyses were limited to changes from pre- to postintervention. . . . Moreover, the mean attrition rate in the 12 studies reviewed was 7.5%, markedly lower than attrition found in similar face-to-face interventions (range = 14% to 65%). (in Ransom et al., 2008, 871-872)

Mohr and colleagues conclude that "telephone-administered psychotherapy can produce significant reductions in depressive symptoms" (p. 243).

HIV on the Line

For many of the reasons noted above, communication by telephone has also been embraced by providers of HIV-related services. Telephone-based interventions have been used to promote HIV transmission risk reduction

among men who have sex with men (MSM; Picciano, Roffman, Kalichman, Rutledge, & Berghuis, 2001; Roffman et al., 1997), as well as to facilitate smoking cessation (Vidrine, Arduino, Lazev, & Gritz, 2006), and the monitoring (Kalichman et al., 2007) and supporting (Reynolds et al., 2008) of antiretroviral medication adherence among persons living with HIV/AIDS.

Another line of telephone-based intervention research has focused on the treatment of depressive symptoms in men and women living with HIV, in recognition of "consistent and positive correlations between depressive symptoms and treatment nonadherence . . . , suicidal ideation . . . , more rapid progression to AIDS . . . , and mortality . . . in HIV-infected persons" (Heckman et al., 2004, p. 97). Of particular concern in this context has been the well-being of men and women who are living with HIV in rural America.

For purposes of research, Heckman et al. (2002) define rural (or "nonmetropolitan") as "living in communities of 50,000 or fewer . . . located at least 20 miles from a city of 100,000 or more" (p. 141). In characterizing their sample of intervention-seeking, nonmetropolitan persons living with HIV, "Heckman et al. (2002, 2004) found that approximately 38% of HIV-infected rural persons experienced suicidal thoughts in the past week and two-thirds reported moderate or severe levels of depressive symptoms" (Heckman & Carlson, 2007, p. 5). "These findings underscore the need for culturally contextualized mental health interventions that can reduce the physical sequelae of HIV disease, foster more adaptive coping strategies in response to HIV-related distress, and increase access to social support resources in this population" (Heckman et al., 2004, p. 98).

Eliminating Bad Connections

Heckman and colleagues (2002) reason that "cognitive therapy, which seeks to correct faulty information processing and modify or eliminate maladaptive emotions and behaviors, may

constitute a potential approach to reduce thoughts of depression, hopelessness, and suicide" among rural Americans living with HIV. More specifically,

in light of the associations among life-stressor burden, coping difficulties, and thoughts of suicide in HIV-infected rural persons, the potential for cognitive-behavioral stress management (CBSM) . . . and coping-effectiveness interventions . . . to enhance the adjustment efforts of this group warrants investigation. CBSM interventions, which enhance coping responses and emphasize relaxation techniques, health habit changes, regular rest and exercise, meditation, and breathing exercises have reduced depression and anxiety and have improved immune system functioning in HIV-infected persons. . . . Similarly, coping effectiveness training (CET) has demonstrated considerable potential to reduce stress and increase coping self-efficacy among depressed HIV-infected persons. CET, frequently implemented in small group settings, emphasizes the correct appraisal of life stressors, the optimal use of problem- and emotion-focused coping, and maximizing the use of social supports to reduce stress and assist coping efforts. Because both CBSM and CET interventions reduce stress and strengthen coping self-efficacy – two factors linked to suicidal thoughts among study participants – the efficacy of these interventions to facilitate the adjustment efforts of HIV-infected rural persons should be explored. (p. 146)

Taking this reasoning a step further, Heckman and colleagues surmise that offering CBSM and/or CET as "telephone-based mental health interventions can overcome the geographic distances separating HIV-infected rural persons, maximize confidentiality, enhance coping skills, and create systems of mutual support for HIV-infected people isolated by the stigma of their illness and the lack of support systems in their communities" (Heckman et al., 2002, p. 147).

Sorry, Wrong Number

Of course, not every clinical trial produces the expected outcome. On this point, Roffman (2007) neatly summarizes two studies of telephone-delivered behavioral support interventions for persons living with HIV – Heckman and Carlson (2007), who targeted rural residents, and Stein et al. (2007), who targeted primarily urban residents – in this way:

The . . . [299] participants in the Heckman and Carlson study, being served by AIDS service organizations at the time of study enrollment and living in rural areas, were randomly assigned to usual care, or one of two 8-session telephone group interventions: an Information Support Group (i.e., didactic content on health topics pertinent to HIV) and a Coping Improvement Group (i.e., learning strategies of stressor appraisal and enhancing coping skills). Although 71% scored at baseline in the moderate to severe range on the Beck Depression Inventory (BDI), at follow-up no treatment condition produced reductions in depression or other psychological symptoms under study. Some post-treatment improvement of limited duration (more support from friends, fewer barriers to services) was reported by Information Support Group participants.

The 177 participants in the study conducted by Stein and his colleagues had comparable BDI baseline ratings to those in the Heckman and Carlson trial (i.e., mean score in the moderate to severe range). Participants were randomized to a psycho-educational counseling approach called Family Intervention: Telephone Tracking (FITT, up to 12 calls with an interventionist over 6 months) or assessment only. Structured to include a Resource Guide, FITT focused on education, problem appraisal, and referral for services related to mood and family functioning. When participants enrolled along with their informal caregiver, they each received the same content delivered separately. Overall, depression scores were

lower at follow-up, but contrary to expectation, there were no differences in depressive symptom reduction between conditions.

In summary, the investigators of both studies report null findings and in their discussions they recognize that the process of testing innovative behavioral interventions is iterative, with each study's findings often giving rise to questions to be addressed by the next. Looking ahead, Heckman and Carlson recommend enhanced training of group facilitators (e.g., skills with telephone delivery, familiarity with contextual issues for HIV[-]positive individuals who live in rural environments), longer treatment, 24-h access for participants to information and support, and proactive attrition reduction strategies.¹ Stein and his colleagues also wonder if their intervention was sufficiently potent.² They additionally question whether an adequately powered trial might reveal the experimental condition's efficacy with certain subgroups. (p. 3)

Person-to-Person Call

Another group of investigators led by Heckman (Ransom et al., 2008) identified an interpersonal psychotherapy (IPT) intervention that showed promise in addressing depressive symptoms in persons living with HIV. IPT

treats depressive symptoms by focusing on grief, interpersonal disputes, role transitions, and interpersonal sensitivity. . . . Given the nature of stressors that confront many HIV-infected persons in rural areas, such as multiple bereavements, partner-relational conflicts, and discrimination . . . , therapeutic interventions that focus on interpersonal relations may be highly ap-

¹ Heckman and Carlson (2007) "witnessed relatively high attrition rates (particularly in participants of color and men) and the failure of 40% of participants to complete 50% or more of all intervention sessions" (p. 12).

² In the study by Stein and colleagues (2007), "the protocol was not designed to provide psychotherapy. Rather, the intervention was structured to provide education, appraisal and resolution-through-referral of problems related to mood and family functioning" (p. 17).

propriate for this group. However, the only known randomized clinical trial that tested [IPT] with HIV-infected persons was conducted with an urban sample more than a decade . . . [earlier] and used a face-to-face format. . . . It is unclear whether telephone-delivered . . . [IPT] can reduce psychiatric distress among HIV-infected persons in rural areas. (p. 872)

In the urban randomized clinical trial of 16-week interventions for depressive symptoms among adults living with HIV (Markowitz et al., 1998), "subjects randomized to [IPT] (n=24) and supportive psychotherapy with imipramine (n=26) had significantly greater improvement on depressive measures than those receiving supportive psychotherapy (n=24) or cognitive behavioral therapy ([CBT:] n=27)" (p. 452). Importantly, "high prevalences of Axis II disorders and lifetime substance abuse did not preclude successful treatment of mood symptoms" (p. 455) in this study. The investigators concluded that "depressive symptoms appear treatable in HIV-positive patients" and that IPT "may have particular advantages as a psychotherapy for patients who have experienced the significant life events of HIV infection" (p. 452).

Off the Hook

According to Markowitz et al. (1998), IPT

helps patients relate changes in mood to events in their environment and consequent changes in social roles. . . . Depression is defined as a medical illness. The therapist gives the patient a depressive diagnosis and the sick role, engages the patient on affectively laden current life issues, and frames the patient's difficulties within an interpersonal problem area: grief, role dispute, role transition, or interpersonal deficits. Strategies address these problem areas, focusing in the present on what the patient wants and what options exist to achieve this. [For the study conducted by Markowitz and colleagues, t]he manual . . . modified IPT to particular psycho-

(Tool Box is continued on Page 14)

(Tool Box -- continued from Page 13)

social concerns of depressed HIV-positive patients. Therapists told patients they had 2 medical illnesses: depression and HIV. (p. 453)

Markowitz and colleagues reason that IPT

may have particular advantages over CBT for HIV-positive patients with depressive symptoms. [IPT] connects life events to mood episodes (1) to help patients mourn life upheavals while (2) pragmatically and optimistically encouraging them to find new life goals and adjustments. Both halves of this formula seemed important to patients. Having suffered a surfeit of HIV-related life events – multiple bereavements, role disputes, and role transitions – they responded to IPT therapists’ supportive encouragement to “live out your fantasies”: to change their lives and seek whatever they desired for however much time remained to them. This seemed a tailored fit of therapy and patient. By contrast, CBT addresses patients’ exaggeration of hopeless thoughts, a relatively disadvantageous stance in treating patients with objectively negative life events. Even with optimistic cognitive restructuring and refocusing, CBT may fit HIV patients’ situations less well. . . . [The investigators] speculate that IPT may be indicated for depressive patients who have experienced recent distressing life events and are likely to experience more in the future. Patients who report few life events (the IPT “interpersonal deficits” category) may be better CBT candidates. (pp. 455-456)

Custom Calling Features

Ransom et al. (2008) conducted a pilot study to learn whether brief IPT delivered in one-to-one sessions by telephone could reduce psychiatric distress among rural men and women who were “recruited through AIDS service organizations in ten states . . . [and] met criteria for a major depressive episode (current or partial remission) or dysthymic disorder” (p. 872). The 79 study participants were “as-

signed randomly to a usual care control condition or to a six-session, telephone-delivered . . . [IPT] intervention (hereafter referred to as the teletherapy group); participants in the teletherapy group continued to receive standard services available to them in the community” (p. 871).

Although the original IPT manual outlined a 12-session intervention, Ransom and colleagues followed the original protocol but reduced the number of sessions from 12 to 6. Each teletherapy session was 50 minutes in length. The first of the six sessions

explored participants’ psychiatric symptoms, discussed the nature of depression, reviewed current interpersonal relationships, and identified a therapeutic focus for later sessions. On the basis of the [IPT] protocol . . . , each participant’s primary interpersonal concern was framed around one of four focal areas: interpersonal role disputes (for example, conflict with a partner); role transition (for example, loss of employment); grief (for example, death of a loved one); or interpersonal deficits, which was eventually relabeled “interpersonal sensitivity” (for example, chronic difficulty forming and maintaining close relationships). . . . Sessions 2 through 6 addressed the interpersonal conflict identified in the first session via exploration of participants’ perspectives, communication patterns, expectations, and adaptive coping strategies. Each participant had the same therapist for all six sessions. (pp. 872-873)

Unlike findings from studies of telephone-delivered behavioral support interventions, “results from this pilot trial suggest that brief telephone-delivered . . . [IPT] constitutes a potentially effective approach to reducing psychiatric distress among HIV-infected persons in rural areas. Participants in the teletherapy group evidenced significant reductions in depressive and psychiatric symptoms (unlike those in a time-matched control group). Moreover, nearly 30% of participants in the teletherapy group who completed the intervention reported clinically meaningful reduction

in . . . [psychiatric distress]” (pp. 875-876).

Ransom and colleagues go further, however, in commenting that even though

approximately 23% of participants in the teletherapy group showed a clinically meaningful change on the BDI-II (compared with only 8% of those in the control group), the teletherapy group’s mean BDI-II score at postintervention remained in the “moderate” level of depressive symptomatology, and participants in the teletherapy and control groups did not differ significantly at postintervention on BDI-II scores. Although the teletherapy intervention may promote clinically meaningful change among some participants, the lack of even greater reductions in BDI-II scores in this study calls into question the utility of this briefer version of the original [IPT] intervention. Perhaps increasing the number of intervention sessions would augment the intervention’s efficacy. (p. 876)

Of importance as well is the fact that

most participants (81%) were receiving concurrent mental health treatment outside of the intervention, including psychotropic medication, individual therapy, and support groups. Although no significant group differences in the use of alternate mental health treatments were found at preintervention, slightly greater proportions of participants in the teletherapy group appeared to be accessing mental health services outside of the study, compared with those in the control group. Some gains reported by participants in the teletherapy group may have been the result of these outside services and not the intervention. (p. 876)

Nevertheless, Ransom and colleagues conclude that the telephone-delivered IPT intervention “showed potential to reduce depressive and psychiatric symptoms among HIV-infected persons in rural areas. On the basis of these encouraging findings,

additional research examining this intervention with this clinical population is warranted" (p. 871).

Blue(s) Screen

Technological innovations now offer new and exciting ways for clinicians to evaluate depressive symptoms and implement interventions. Hirshfield et al. (2008), for example, assessed

the utility of screening for, and characteristics associated with, depressive symptoms in an online survey of MSM. In 2003-2004, an online cross-sectional study was conducted among 2,964 MSM from the US and Canada. Using the two-item Patient Health Questionnaire (PHQ-2),³ 18% of the study participants screened positive for depressive symptoms within the past three months. Characteristics associated with a positive PHQ-2 screen for depressive symptoms in multivariate analysis included: having less than a high school or college degree; being single (not having a primary male partner) or being married to a woman; being HIV-positive; and not having recent sex. (p. 904)

Of particular concern in this study was the finding that

a large proportion of men who screened positive for recent depressive symptoms did not report treatment from a mental health provider in the past year. These respondents were significantly

³ "The first two questions of the 9-item Patient Health Questionnaire Depression Scale (PHQ-9) comprise the PHQ-2. The PHQ-2 assesses depressed mood and anhedonia: 'Over the past three months, has there been a period of time for two weeks (or more) when you were bothered by either of the following problems: (1) When you had little interest or pleasure in doing things? and (2) When you were feeling down, depressed or hopeless?' The response options for each item are "not at all", "several days", "more than half the days" and "nearly every day" and are scored from 0-3. The PHQ-2 score ranges from 0-6, with a score of 3 considered the optimal cut-point for screening purposes" (Hirshfield et al., 2008, p. 905). Additionally, "in th[is] . . . study, the PHQ-2 was revised to inquire about any two-week period during the three months prior to the study, rather than the last two weeks" (p. 905).

less educated, black/African American/Canadian or Hispanic and less likely to have a primary care provider, compared to those who screened positive and reported mental health treatment. Conversely, men who screened negative on the PHQ-2 but who had mental health treatment in the past year were significantly more likely to know their HIV status and have a primary care provider. These findings indicate socioeconomic differences in access to care and mental health treatment among MSM online and signal a strong need to develop online mental health screening tools, as well as connection to offline assessment and intervention. Men of color and men with low socioeconomic status who use the Internet may not otherwise have access to these types of services. (p. 908)

Hirshfield and colleagues emphasize that "screening tools, such as the PHQ-2, do not replace professional assessment but, rather, serve as a means to refer people for professional assessment and help." These investigators further contend that

of MSM who have participated in online research, a considerable proportion may benefit from Internet-based interventions. They are often well-educated, insured and less likely to be exposed to offline prevention messages . . . , making them ideal targets for intervention efforts. . . . Online behavioral interventions have been developed and implemented successfully to assist with the management of . . . depression (Christensen, Griffiths, & Jorm, 2004)⁴ but such interventions have not been

⁴ Christensen, Griffiths, and Jorm (2004) evaluated "the efficacy of two Internet interventions for community-dwelling individuals with symptoms of depression – a psychoeducation website offering information about depression and an interactive website offering cognitive behaviour therapy" (p. 265) – as well as an attention control condition among 525 Internet users in Canberra, Australia, who were randomly assigned to one of these three conditions. The investigators found that "information about depression and interventions that used cognitive behaviour therapy and were delivered via the Internet

assessed in this specific population. . . .

More work is needed to assess the scope of depression and treatment needs among MSM online, as well as the feasibility of recruitment and referral for mental health services via the Internet. The Internet is clearly a viable medium to reach and screen men at-risk for depression. Additionally, the Internet presents the opportunity to raise awareness about depression and offer information about symptoms and treatment options. Assessing the scope of depression, different treatment needs and access to care for this online population is a necessary next step. (Hirshfield et al., 2008, p. 909)

Help With Rebooting

One approach to care access comes from Lai, Larson, Rockoff, and Bakken (2008), who report on user acceptance

(Tool Box is continued on Page 16)

were more effective than a credible control intervention in reducing symptoms of depression in a community sample. It was concluded that both cognitive behaviour therapy and psychoeducation delivered via the Internet are effective in reducing symptoms of depression" (p. 265).

In a later paper (Mackinnon, Griffiths, & Christensen, 2008), 6- and 12-month follow-up surveys were conducted with the original study participants. "Of 525 participants recruited, 79% completed their assigned intervention and 60% were retained at 12-month follow-up" (p. 130). The investigators found that "at 6-months follow-up, the reduction seen for the people allocated to the CBT arm remained significant, whereas that for the depression information website arm was not. At 12 months, both active interventions were statistically significantly superior to the control condition" (p. 130). Mackinnon and colleagues conclude that "there is some evidence that benefits of these brief internet interventions are retained beyond their endpoint" (p. 130).

In a recent editorial appraising this new field of CBT delivered via the Internet, Andersson and Cuijpers (2008) conclude that "online . . . CBT . . . for depression has the potential to serve as an important addition to the care of people with *mild to moderate depression* [italics added]. Although some studies show promising results, the need for proper diagnoses and human guidance must be considered when interpreting the modest effects found in studies with little or no guidance from a therapist" (p. 271).

Stress Management

Antoni et al. (2008) draw attention to the fact that "risk for developing cervical neoplastic disease [(precancerous cell growth)] is greatly increased in women infected with oncogenic [(cancer-causing)] sexually transmitted human papillomaviruses (HPVs) and who have lowered cellular immunity due to coinfection with . . . HIV" (p. 389), and that most of these women have low income and hold minority racial/ethnic status. Notably, "factors associated with promotion of HPV to cervical neoplasia in HIV-infected populations include degree of immunosuppression as well as behavioral factors such as to-

bacco smoking and psychological stress. This study examined the effects of a cognitive behavioral stress management (CBSM) intervention on **life stress and cervical neoplasia** in HIV+ minority women" (p. 389). According to the investigators,

the form of CBSM intervention tested in this study, composed of relaxation training, cognitive behavior therapy, and interpersonal skills training, delivered in ten 2-h group sessions, has previously been shown to decrease stress, impact immunologic indicators of herpesvirus activity, and decrease HIV viral load in HIV+ men, effects that appeared due

to improved relaxation skills, increased social support, decreased negative mood, and improved adrenal hormone regulation (using indices of urinary cortisol and norepinephrine). . . . Less is known about the biobehavioral effects of CBSM intervention in HIV+ women. (p. 399)

Antoni and colleagues recruited 39 African American, Caribbean Island, and Hispanic women who were living with HIV and recently had an abnormal Papanicolaou (Pap) smear. The women were randomly assigned to the 10-week CBSM group intervention or a 1-day CBSM workshop and evaluated at baseline and 9

(Tool Box -- continued from Page 15)

of the HIV TIDES (Tailored Interventions for management of **DE**pressive **S**ymptoms) program, "designed . . . to provide tailored, computer-based education on key elements and self-care strategies for depressive symptoms in persons living with HIV/AIDS" (p. 217).

Expanding on the design of this program, Lai and colleagues write that the algorithm used to tailor computer-generated responses to individual users

was based upon the results of . . . [an] initial Center for Epidemiologic Studies-Depression (CES-D) assessment [completed by the user, as well as responses to a] . . . secondary assessment (Stages of Change Questionnaire, Cognitive Event Schedule, and Social Activities Questionnaire). . . .

The 20-item CES-D . . . [constitutes] the first level [of] assessment in HIV TIDES. CES-D scores were used . . . [to prescribe] the intervention pathways because the instrument is multi-factorial[,] thus facilitating [the] tailoring of specific self-care interventions. . . . Individuals with [a] minimum level of depressive symptoms received messages to reinforce their health behaviors related to physical activity, positive thoughts, pleasant social activity, and medi-

cation adherence. Those with [a] severe level of depressive symptoms are educated with the definition of depression diagnoses and the available treatment options. They are highly encouraged to have . . . [a] psychiatric evaluation done by their clinician to confirm the possible diagnosis. For individuals with [a] moderate level of depressive symptoms, depending on the score of CES-D sub-scales, they are divided into three groups to work on increasing physical activity, practicing positive thoughts, and participating in more pleasant social activities. HIV TIDES then provides symptom education, secondary assessment, review of current status, interactive goal setting, practice planning, and the final summary of all the information provided. The users are encouraged to print the summary to keep as their personal reference and [to] discuss it with their providers. . . . [U]ser[s] can also track . . . [their] past history with HIV TIDES every time they log into the system to review their progress. (p. 218)

To study user acceptance, Lai and colleagues recruited 32 adults receiving HIV primary care services in East Harlem and the Bronx in New York City. A majority of study participants

were African American (68.8%), male (65.6%), with high school or lower education (68.7%), and in

their 40s (62.5%). Participants spent an average of 10.4 minutes (SD=5.6) using HIV TIDES. . . . [Study participants] rated the system as easy to use . . . and useful. . . . The high ratings of behavior[a] intention to use . . . suggest that HIV TIDES has the potential to be accepted and used by [persons living with HIV/AIDS]. Four factors were positively correlated with behavioral intention to use: perceived usefulness . . . , perceived ease of use . . . , internal control . . . , and external control. . . . Computer anxiety . . . , tailoring path . . . and depressive symptoms . . . were negatively correlated with behavioral intention to use. (p. 217)

Lai and colleagues summarize their findings and conclusion in this way:

Depression is associated with all dimensions of health-related quality of life for [persons living with HIV/AIDS]. Screening tools improve case finding and encourage early treatment. HIV TIDES is designed to assess users' level of depressive symptoms, identify individuals in the high[-]risk group and those who require medical attention, automatically generate tailored self-care management strategies that correspond with . . . [the] level of depressive symptoms [of persons living with HIV/AIDS] and other factors, and provide tailored messages related to symptoms,

months. The investigators

found that HIV+ women (the vast majority of whom were infected with . . . [oncogenic] HPV subtypes) who were assigned to a 10-week group-based CBSM intervention reported decreased perceived life stress and revealed lower odds of cervical neoplasia at 9-month follow-up. In addition, results revealed that the relationship between CBSM group assignment and cervical neoplasia at 9-month follow-up was especially pronounced for women with residual life stress at 9-month follow-up. Notably, given that the assessment of life stress at fol-

low-up occurred prior to the disclosure of cervical biopsy results at follow-up, the relationship between high life stress and cervical neoplasia could not be attributed to their learning of their cervical neoplasia status. Furthermore, the CBSM intervention effects on stress and cervical neoplasia appeared to be independent of cervical neoplasia at study entry, HPV type, CD4+ CD3+ cell count, viral load, and substance use. (pp. 398-399)

Although these findings are preliminary, Antoni and colleagues conclude that "CBSM may provide psychological and health benefits for

women with HIV who are at heightened risk for cervical neoplasia" (p. 399).

Coping, Social Support, & Quality of Life

Lennon-Dearing (2008) surveyed 71 women attending nine **women-only HIV support groups** conducted in Alabama, Georgia, and South Carolina, and found that

attending an HIV support group for women is associated with self-reported positive changes in members' emotional, behavioral and physical health. Specifically, . . . since participating in a women-only HIV support group,

diagnoses, and treatment options. The results of this study provide evidence of the acceptability of HIV TIDES by [persons living with HIV/AIDS]. Individuals are expected to be empowered through participating in the interactive process of exploring their mental health status and generating their self-care management plan. HIV TIDES has the potential to promote information sharing focusing on health promotion and disease prevention related to depression and to reframe the traditional patient-provider relationship. (p. 224)

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65% of group members perceived that they had reduced their [HIV] risk behaviors, 48% had become more regular in taking their medication, 67% felt less ashamed about having HIV, and 70% socialized outside of the group. These findings are meaningful because the purpose of support groups is not behavioral change, but emotional and informational support. The discovery that participants in a support group may reduce . . . risk behavior and improve . . . medical compliance and self-opinion is serendipitous; individuals may go to a support group for support and come away with more healthful behavior. (p. 37)

Lennon-Dearing suggests that “women diagnosed with HIV should be educated about the benefits of support group attendance, preferably at the time of their diagnosis” (p. 41), and referred into such groups, which “may prove to be the single most powerful psychosocial intervention for women living with HIV” (p. 42).

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Tool Box

A Note on Content

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

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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:

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