

mental health AIDS

A Quarterly Update from the New England HIV Education Consortium and the New England AIDS Education and Training Center Volume 3(1), Fall 2001

Biopsychosocial Update

HIV Prevention News

About Women & Men

What factors contribute to unsafe sex? Crepez and Marks (2001), based on a meta-analysis of 34 studies, surprisingly conclude that

the current body of empirical research ... does not provide compelling support for the hypothesis that negative affect (i.e., depressive symptomatology, anxiety, anger) is associated with increased sexual risk behavior. As such, the findings suggest that expanding clinical intervention efforts to reduce negative

mental health AIDS is a quarterly update originally developed with the support of the Biopsychosocial Learning Center on AIDS at the University of Miami School of Medicine. With this issue, *mental health AIDS* has found a new home: the New England HIV Education Consortium (NEHEC) and the New England AIDS Education and Training Center (NEAETC), projects sponsored regionally by the Office of Community Programs, University of Massachusetts Medical School.

The format for this publication reflects a systems-oriented approach to the understanding of health and disease. In this model, HIV mental health treatment planning considers not only the psychiatric and psychological aspects of infection, but the biological, social, and spiritual aspects as well, so that treatment may be offered from a "biopsychosocial" perspective. Additionally, a "systemic" model of this type reinforces the use of the provider-client relationship in delivering health and mental health care.

The contents of this "Biopsychosocial Update" are organized as follows:

- o HIV Prevention News, with current information on issues of risk and response to a variety of subpopulations disproportionately affected by HIV;

affect among sexually active people, although worthy from the standpoint of improving mental health, may not be a cost-effective strategy for reducing sexual transmission of HIV. (p. 297)

These authors are, however, quick to observe the methodological and conceptual limitations of this literature and offer recommendations for improving research design to clarify the relationship (if any) between negative affect and unsafe sex.

Taking a different tack, Oncale and King (2001) surveyed 954 undergraduates and

- o HIV Assessment News, focusing on current understandings of the HIV counseling and testing process as well as baseline mental health evaluation for people living with or affected by HIV; and
- o HIV Treatment News, organized within a "biopsychosocial" framework and highlighting current findings on medical, psychiatric, psychological, psychosocial, and spiritual aspects of care for people living with or affected by HIV.

The update is interspersed with two types of sidebars:

- o "Building Blocks," which summarize recent major conferences and meetings that address HIV-related prevention, assessment, and/or treatment concerns; and
- o "Tool Boxes," which contain practical information and resources for the frontline provider of HIV-related prevention, assessment, and/or treatment services.

I provide a wealth of information in this update for the diverse audience receiving training through the NEHEC and the NEAETC. Feel free to explore the contents, taking what will be of use to you in your work. And thank you for the contribution you are making to improve the lives of people living with HIV and AIDS.

—Abraham Feingold, Psy.D., Editor

found that 30% of the men and 41% of the women reported that a sexual partner has tried to dissuade them from condom use during intercourse, while 17% of the men and 14% of the women reported that they have tried to dissuade a sexual partner from condom use during intercourse. The most frequently cited reason for dissuasion was that "sex feels better without a condom." The authors suggest that clinicians address concerns regarding physical gratification as well as disease and pregnancy prevention when discussing condom use with clients.

Dutch researchers (Yzer, Siero, & Buunk, 2001) followed 94 men and women who engage in casual sex and found that condom use – or, more particularly, *not* using condoms – could be predicted by past use. According to the authors, this suggests a strong habitual component to condom use (as distinguished from intentionality) and an intervention challenge, since habitual behavior is difficult to change. One option is to begin safer sex education in advance of sexual initiation so that condom use can *become* a habit. For people habituated to not using condoms, the authors suggest the formation of "implementation intentions" by:

presenting a realistic description of the

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context in which people may have sex with new partners, and then urging people to make detailed plans specifying how and when they would ensure safe[r] sex. ...Such plans, based on consciously thinking in specific details about future safe[r] sex, are likely to be salient in the behavioural setting, making the behaviour less automatic. (pp. 419-420)

Finally, Kalichman et al. (2001a) randomly assigned 332 men and women living with HIV to one of two conditions: a five-session safer sex group intervention (focused on the development of behavioral skills, increasing confidence in one's ability to practice risk-reduction behaviors, increasing intentions to change behavior and developing strategies for doing so) or a five-session health-maintenance support group. Six months post-intervention, they found that participants in the behavioral risk-reduction group engaged in less unprotected intercourse and more condom use and were less likely to transmit HIV to an HIV-negative or status-unknown partner than those who did not receive the intervention.

About Women

Catz, Meredith, and Mundy (2001) conducted interviews with 80, mostly African-American, women receiving HIV outpatient care and found that 35% had engaged in unprotected intercourse or were diagnosed with a sexually-transmitted disease (STD) in the six months preceding the interview. Of these women, 61% reported that their partners were HIV-negative or of unknown status and 11% did not disclose their own HIV status to at least one partner during that period, highlighting the need to enhance communication and sexual negotia-

tion skills among women living with HIV. While only 5% of these women indicated the belief that safer sex was unimportant in the context of antiretroviral-related reductions in viral load, 15% reported that they practice safer sex less often since initiating antiretroviral treatment and 40% now see AIDS as a less serious threat than in the past. Catz and colleagues conclude that diminished disease severity may exert a greater influence on the employment of protective behaviors than beliefs regarding reduced infectivity and that clinicians working with women living with HIV stay attuned to changes in sexual behavior that may accompany reductions in viral load and improving health, educate women about the importance of avoiding reinfection with HIV and/or exposure to other STDs, and identify and address potential barriers to maintaining safer sexual practices.

While previous studies have focused on tailoring risk-reduction messages to women based on partner type (steady or casual), other factors must also be considered when talking to women about prevention. Posner, Pulley, Artz, Cabral, and Macaluso (2001) surveyed 1,159 women, mostly young and African-American, attending STD clinics and found that STD history appears to exert an influence on condom use behavior with steady partners and may suggest a more tailored approach to counseling based on psychosocial factors associated with condom use that differ by STD history. While greater belief in one's ability to negotiate and use condoms, greater condom use convenience, and higher frequency of requests for condom use were all associated with greater use among women regardless of STD history, greater perceived norms for condom use among peers, a

heightened perception of HIV risk, and greater perceived need for use of condoms in long-term relationships were associated with increased use for women with an STD history. For women who had not experienced an STD, increased condom use was associated with factors such as briefer relationships, less violence within relationships, and lifetime drug use.

What about women resuming sexual activity subsequent to long-term monogamous relationships? Based on interviews with seven white, well-educated women, Rich (2001) concludes that women reentering the sexual arena may benefit from supportive group work that serves to enhance self-esteem following a separation or divorce. Moreover, she indicates that women in this situation must be educated about and internalize their risk for HIV and STDs, and would benefit from role-playing condom use negotiations to generate and rehearse scripts that are both appropriate and effective with new partners.

About Substance Users

El-Bassel et al. (2001) studied 273 sexually-active men receiving methadone maintenance and found that more than one-third reported perpetrating physical abuse and 15% reported administering severe physical abuse on an intimate partner during the preceding 12-month period. These perpetrators of partner violence were also more likely to engage in sexual- and needle-sharing risk behavior than their nonviolent counterparts, potentially placing that partner at risk for HIV. The authors see methadone clinics as key settings in which to screen for partner violence and HIV risk and to launch HIV prevention interventions addressing both issues.

What is the role of culture in HIV prevention activities? Dushay, Singer, Weeks, Rohena, and Gruber (2001) assigned 669 African-American and Puerto Rican street-recruited drug users to either a standard intervention or an enhanced, short-term, culturally sensitive HIV prevention program. Interestingly, the interventions appeared to be equally effective in reducing high-risk behaviors; participants who entered drug treatment following the interventions did,

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Building Block

Highlights from the 2001 National HIV Prevention Conference

The 2001 National HIV Prevention Conference was held in Atlanta, Georgia, from August 12-15. This conference, uniquely dedicated to HIV prevention efforts, focused on such areas as behavioral interventions, vaccine development, the monitoring of the epidemic, the development of tests for rapid and reliable assessment of HIV status, and easier and more timely access to treatment. Highlights, culled from a variety of news sources, are included below:

o According to new government figures released at the conference, the sharp decline in the number of Americans progressing to and dying from AIDS may be over. Health officials voiced concern as well about high rates of risky behavior and HIV infection among young gay men and low-income African-American women. Conversely, perinatal transmission of HIV plunged by 84% between 1992 and 1999 as a result of expanded HIV testing and treatment for pregnant women. Likewise, HIV infection rates among injecting drug users in New York City fell from 50% in 1990 to 20% in 2000; this drop was attributed to needle exchange programs (Okie, *Washington Post*, 8/13).

o Contrasting with previous findings, researchers in San Francisco now report that, *statistically*, the chance of becoming infected with HIV through unprotected receptive oral intercourse with a man (i.e., taking the penis in the mouth) is near zero (*Associated Press*, 8/14).

o Approximately 40% of people living with HIV do not learn of their serostatus until about 12 months before being diagnosed with AIDS. These "late testers" not only forgo treatment that can prolong life, but can also infect others with HIV. Moreover, physicians who generally offer high-quality health care may overlook HIV risk behaviors and not offer appropriate counseling (Brown, *Washington Post*, 8/15).

o Two new vaccines appear to be effective in preliminary studies involving transmission of simian immunodeficiency virus (SIV), which results in an AIDS-like disease among primates (Hitt, *Reuters Health*, 8/15).

o Two recent surveys illustrate that prejudice against people living with HIV and misconceptions regarding how HIV is transmitted remain "common" in the U.S., particularly among men and older adults (Hitt, *Reuters Health*, 8/15).

--Compiled by Abraham Feingold, Psy.D.

however, show further reductions in risk behavior. Based on these findings, these researchers conclude that short-term, HIV risk reduction interventions of all types may be used to engage drug users and to get them into drug treatment, itself a longer-term HIV prevention strategy.

Along these same lines, Prendergast, Urada, and Podus (2001) conducted a meta-analysis of 18 studies that used a "treatment-comparison group" design to evaluate HIV risk-reduction interventions for individuals enrolled in drug treatment. The authors found that, while drug treatment alone has been associated with reductions in HIV risk behaviors, interventions targeted specifically at such behaviors, when delivered within a drug treatment program, appear to have an impact over and above that of the drug treatment itself. Intervention characteristics associated with increased effectiveness include: using six or more techniques within the intervention, presenting an intervention of greater intensity, delivering such an intervention later in the course of drug treatment or during metha-

done maintenance, having separate sessions for men and women, using a lecture format, providing training in coping skills and self-control, and offering group counseling and discussion by peers.

Williams et al. (2001) evaluated the use of a brief, HIV risk-reduction educational intervention on a diverse, multicultural sample of 7,733 drug users who were not in treatment and found that participants reduced both needle use and sexual risk behaviors following the intervention. Based on these findings, the authors suggest that

drug users can be triaged into risk reduction interventions that vary in intensity based on their level of needle risk.

In an environment of scarce resources, community-based, brief educational HIV risk reduction strategies may prove sufficient as a stopgap prevention measure for low needle risk drug users. High frequency injectors, who are least likely to benefit from a brief intervention, can be triaged into treatment slots reserved for them. (p. 39)

Interestingly, while drug users in this study did not necessarily increase their consistency of condom use, they were willing and able to exercise other forms of sexual risk reduction (e.g., declining sex, reducing numbers of partners, engaging in behaviors other than intercourse, or reducing the number of occasions they had sex while using drugs). In fact, within these parameters, sexual risk behaviors were reduced to a *greater* extent than were needle-use risks, suggesting that brief, community-based, educational interventions may have greater effectiveness in reducing some sexual risk behaviors among drug users than was previously believed.

Expanding on the notion of "personal" risk reduction strategies, Metsch, McCoy, Wingerd, and Miles (2001) interviewed 92 active crack and injecting drug users (IDUs) and discerned a number of "personal" strategies employed instead of, or in addition to, condoms. While the employment of *any* strategy suggests that drug users are cognizant of sexual risk, their choice of strategy may, unfortunately, be based on misconceptions about warding off infection (e.g., overt cleanliness – a lack of visible dirt – in a partner is equated with health, a "safe" partner can be identified by certain sociodemographic or behavioral characteristics). Such beliefs may afford a false sense of security among users and must be identified and corrected by clinicians. Importantly, Metsch and colleagues note that *individuals engaging in high-risk sexual behaviors may feel free to ignore recommended practices because they are taking "precautions" that they personally believe to be effective.* They encourage clinicians to capitalize on drug users' desire for self-protection, but to redirect efforts toward more reliable methods of protection.

Similarly, Sherman and Latkin (2001) surveyed a convenience sample of 703 cocaine and opiate users and found that 40% reported consistent condom use with sexual partners in the preceding three months; consistent use was associated with the individual being HIV-infected, not living with the sexual partner, and not being financially interdependent, reflecting the more generic challenge of introducing condoms into a

committed relationship with a primary sexual partner. Since drug users living with HIV were inclined to protect their partners from infection or reinfection with HIV, clinicians can build upon concern for the partner's well-being and work to enhance communication and negotiation skills related to condom use in both individual and couples' treatment.

About Men Who Have Sex with Men

Wolitski, Halkitis, Parsons, and Gómez (2001) surveyed 240 men (69% men of color) living with HIV and found that many were aware of and utilizing untested barrier methods (e.g., nonoxynol-9 (N-9), female condoms, and "double bagging," or the use of two male condoms simultaneously) in efforts to reduce HIV transmission risk during anal intercourse. While these alternatives require further investigation, clinicians should actively discourage the use of products containing N-9, which may increase the risk of HIV transmission.

Researchers in the Netherlands (Davidovich et al., 2001) studied 144 gay men who seroconverted over a 17-year period and discovered that "young gay seroconverters [men 30 years of age or less] today are more likely to have contracted HIV from a steady partner than from a casual partner, compared with early in the AIDS epidemic and compared also with older gay seroconverters" (p. 1303), who are more likely to have been infected by a casual partner. Clinicians working with younger gay men in steady relationships may want to pay attention to sexual behavior within those relationships, assess potential risk, and reinforce prevention messages.

Purcell, Parsons, Halkitis, Mizuno, and Woods (2001) surveyed 456 HIV-positive men who have sex with men (MSM) – primarily men of color – and found: 1) high rates of substance use; 2) higher rates of substance use among those engaging in risky sexual behavior with casual partners; 3) greater transmission risk among men who frequently use inhaled nitrites ("poppers"), cocaine/crack, and amphetamines; and 4) greater likelihood of unprotected insertive anal intercourse among men using poppers and alcohol before or during

sex and greater likelihood of unprotected receptive anal intercourse among men using poppers and non-injecting drugs before or during sex with casual partners. These researchers also discerned that many MSM living with HIV who use alcohol or drugs "do so selectively and purposefully in the context of sexual encounters" (p. 196). They suggest that clinicians assess substance use among MSM living with HIV, refer for treatment as appropriate, and help these men to understand how and why they use particular drugs before and during sex.

One answer may come from McKirnan, Vanable, Ostrow, and Hope (2001), who interviewed 139 African-American and 112 white gay and bisexual men and found that men who frequently combine drug use with sex (as distinguished from those who infrequently do so or those who use alcohol alone) do so to enhance their sexual experience and to "escape" (cognitively) from awareness of HIV risk; these thoughts and behaviors, in turn, are associated with sexual risk behavior. Like Purcell and colleagues, McKirnan and colleagues encourage clinicians to examine the motivation among gay and bisexual men for combining drugs or alcohol with sex as part of any sexual risk-reduction intervention.

About Adolescents

According to the National Campaign to Prevent Teen Pregnancy (Kirby, 2001), which reviewed 250 studies on sex education programming, programs that teach teens how to avoid pregnancy and HIV infection do not increase sexual activity and some even *decrease* it. According to the report, effective sex education programs clearly assert that abstinence is the safest choice for teens, but that those who are sexually active must take steps to protect themselves against pregnancy and STDs, including HIV.

On the heels of this report, Lee and Fleming (2001), who examined case reports from 25 U.S. states with confidential HIV reporting, announced that, while HIV diagnoses among women of reproductive age decreased slightly between 1994 and 1998, HIV diagnoses among women between the ages of 15 and 19 attributed to IDU increased by 90% and diagnoses attributed

to heterosexual contact increased by 117% during the same period. Lee and Fleming support the dissemination of culturally sensitive HIV prevention messages among young women prior to their initiating drug and sexual risk behaviors.

Similarly, Miller and Whitaker (2001) interviewed 907 mothers of teens between the ages of 14 and 17 and found that those who talk to their teens about condoms generally have more knowledge regarding sexuality and HIV, greater skill and comfort in discussing sex, and less conservative attitudes regarding adolescent sexuality than those who do not engage in such conversations. Miller and Whitaker believe that clinicians should provide parents with the information and skills needed to discuss sexuality and condom use before sexual activity begins, since parental communication can have an impact on teen risk-taking behavior, as well as referral to communication skills programs.

In a study of 522 sexually-active African-American female adolescents, DiClemente et al. (2001) observed that 8% carried condoms with them. While such preparedness would presumably be associated with prevention behaviors, DiClemente and colleagues found *no* differences in self-reported condom use, self-reported STDs, or biologically substantiated STDs between those who carried condoms and those that did not. They conclude that teen prevention programs "based on multiple strategies and goals in the context of individual, family, and community influences may be more likely to promote safer sexual behavior among high-risk adolescent females" (p. 447) than simply carrying condoms.

Elze, Auslander, McMillen, Edmond, and Thompson (2001) assessed 167 15- to 19-year-olds (33% white, 67% nonwhite) preparing for independent living following foster care and found recent HIV risk behaviors to be associated with the severity of sexual abuse experienced in childhood, underscoring the need for programming that targets impulsive and/or aggressive tendencies found among sexually abused youth that may impede the adoption of safer sexual practices.

Finally, Murphy et al. (2001) followed 323 adolescents living with HIV across 15 clinical sites over a 15-month period and found depression and anxiety to be associated with the continuation of high-risk sexual behavior. Moreover, these researchers believe that these teens may be self-medicating with alcohol and marijuana to deal with their psychological distress and encourage clinicians to assess psychological distress, substance use, and related health risk behavior among teens living with HIV.

About the Severely Mentally Ill

Stoskopf, Kim, and Glover (2001), utilizing hospital discharge data on 378,710 individuals in South Carolina, determined that people living with severe mental illness (SMI) are 1.44-times more likely to also be diagnosed with HIV/AIDS when compared with the general population. While no differences between racial groups were noted, women were more likely to be dually diagnosed than men and people with substance abuse or depressive diagnoses were also more likely to be diagnosed with HIV/AIDS.

What can be done to reduce behavioral risk in this population? In a pilot study, Williams, Donnelly, and Proesher (2001) evaluated the impact of an HIV cognitive-behavioral skills training intervention on "readiness for change" among 50 men and women hospitalized for SMI. They found that, while seemingly helpful in increasing readiness to change risky behavior, the intervention affected subgroups differently, offering insight into findings by Stoskopf and colleagues noted above. Men, as well as inpatients with mood disorders or a substance abuse diagnosis, were more likely to indicate that they had already begun to modify their behavior ("action"); inpatients with psychotic disorders demonstrated increasing contemplation of behavior change, though they were not yet ready to change behavior ("contemplation"); women, as a group, appeared most vulnerable, as they only first began to recognize risk and contemplate behavior change following completion of this program ("precontemplation"). While it is not clear that these changes will result in behavior change over the long-term, the authors recommend offering risk-reduction interventions, in con-

junction with substance abuse treatment, to psychiatric inpatients and coordinating these services with outpatient follow-up.

Rosenberg et al. (2001) assessed a diverse sample of 275 people living with SMI and, not unexpectedly, found that many engaged in substantial levels of high-risk behavior, particularly sexual risk. Substance use disorders as well as a male homosexual orientation were found to be most strongly associated with both sexual and drug risk behaviors. While findings are limited due to convenience sampling and the lack of comparison with a non-SMI group, Rosenberg and colleagues conclude that specific aspects of mental illness thought to be related to risk behavior (e.g., psychiatric diagnosis, post-traumatic stress symptoms) appear to play less of a role in risky behavior among people living with SMI than previously believed and, like Williams and colleagues, suggest that integrated treatment for substance abuse and SMI may be key to reducing HIV risk in this population.

HIV Assessment News

HIV Counseling & Testing

In an interesting study, Vernon, Mulia, Downing, Knight, and Reiss (2001) interviewed 67 low-income drug users recruited from the street to explore patterns of repeated HIV testing in this community and found that those interviewed did not generally engage in testing behavior in connection with *current* risk behavior. Rather, these respondents: 1) anticipated an eventual positive test result, regardless of past negative test results and an absence of current risk behavior; 2) believed that there was a 10-year window period, during which time the virus remains undetectable; 3) utilized repeated HIV testing as a routine form of healthcare; and 4) viewed testing as a means of exercising control over HIV.

Clearly, respondents were confusing the 10 years of infection preceding the emergence of HIV disease with the "window period" between infection and the development of HIV antibodies, and were therefore using HIV testing as a type of "screening procedure" associated with other types of chronic illness (e.g., hypertension). While this misconception resulted in regular use of HIV

testing services, it may also cause drug users to ignore *current* risk, believing that current behavior is unrelated to risk for infection. Vernon and colleagues suggest that clinicians working with drug users in communities hard-hit by HIV: 1) clarify confusion regarding "window periods"; 2) shift focus to current risk behavior; 3) reinforce the understanding that one may remain uninfected despite known exposure to HIV and/or years of risky behavior, but that does not guarantee that one will remain uninfected; and 4) capitalize on the use of HIV testing services as a form of self-care and employ testing as a linkage into other types of healthcare and social support.

Avants, Warburton, and Margolin (2001) surveyed 94 IDUs living with HIV upon entry into methadone maintenance and found that those who relied on avoidance coping strategies following HIV testing also reported high levels of *recent* HIV risk behavior as well as poor health at the time of entry into treatment. By contrast, more adaptive coping strategies were associated with perceived support in the religious/spiritual realm as well as an internal health locus of control. The authors encourage the provision of coping skills assessment and training when referring IDUs for HIV testing, with particular focus on spiritual and religious beliefs and related coping strategies for those testing positive.

Pugatch and colleagues conducted two studies involving the provision of HIV testing in acute inpatient substance abuse treatment facilities. In the first (Pugatch et al., 2001a), the focus was on detoxification centers. Of 66 study participants, 97% indicated that they thought HIV testing should be available during detox; 89% reported that they would manage equally well or *better* should they receive a positive test result while in the facility compared with elsewhere and most preferred oral fluid (Orasure®) testing or other rapid testing technologies, although 59% indicated that the type of test offered would not affect their willingness to test. Most (85%) expressed interest in seeing a physician within a few days of a positive test result, suggesting that HIV testing is acceptable and even desirable among people receiving inpatient

Tool Box

Reproductive Decision-Making, Parenthood, and Survival in the Era of HAART

A recent *New York Times* article (Villarosa, 2001) profiled women living with HIV electing to become pregnant, a decision that was less common only a few short years ago. At that time, HIV-positive women were faced with a one-in-four chance of passing HIV along to their unborn child. With the development of highly active antiretroviral therapy (HAART), however, a woman can reduce the risk of transmitting the virus to about 2%. HAART has also improved the prognosis for potential parents. As a result, a small but increasing number of men and women living with HIV are deciding to have children.

Who Wants Children and Why?

To explore the desire and intent to bear children among people living with HIV, Chen, Phillips, Kanouse, Collins, and Miu (2001) interviewed a nationally representative sample of 361 men and 377 women receiving HIV medical care. They found that 28% of the men and 29% of the women interviewed desired children and, of these individuals, 59% of the men and 69% of the women expected to have at least one child in the future. [In fact, 12% of these women had already conceived a child

after learning that they were HIV-positive.] Those who desired a child were generally younger, had fewer children at the time of the interview, and reported better health than those not desiring children. Interestingly, *desire was not related to clinical measures of HIV progression.*

"I went through thinking I was going to die, to then considering surrogacy and adoption and then finally considered the possibility of actually getting pregnant. After all that, to now have a healthy baby after all that we went through is truly a miracle." – Jill

(Villarosa, 2001, p. 7)

Siegel and Schrimshaw (2001) interviewed 51 women living with HIV (mostly women of color) regarding their reasons for wanting to have a baby. They found that, while their reasons were similar to those of other women in their child-bearing years (e.g., partner's desire for children, having missed out on bringing up her other children, believing that childbearing would offer completeness and a sense of fulfillment), their "justifications" for wanting to have a child were largely HIV-specific (e.g., other women with HIV were giving birth to healthy children, zidovudine [Retrovir® or AZT] would reduce the risk of transmission, God would protect the child, being young and "healthy" would preclude transmission). Siegel and Schrimshaw advocate for

the empowerment of women living with HIV to make fully informed decisions regarding pregnancy by correcting misconceptions that may be used to justify pregnancy (e.g., transmission cannot be prevented simply by being young or feeling healthy) as well as carefully exploring a women's reasons for wanting a child, with particular focus on her desire for children apart from those of her partner and the risks of not acceding to her partner's wishes.

Safeguarding Child and Family Now and In the Future

Chen and colleagues point out that men and women living with HIV who desire and expect to have children require "counseling and services to minimize the likelihood of HIV transmission to their partners and children and to help them meet the formidable challenges of undertaking parenthood while living with HIV" (p. 152).

With regard to the former, Siegel, Lekas, Schrimshaw, and Johnson (2001) explored factors related to the willingness of the 51 women previously described to take AZT during pregnancy. Interestingly, most held reservations about AZT use during pregnancy related to fear of toxic side effects on mother and/or child, fear of drug resistance, believing that AZT is not necessary among "healthy" women, and having previously given birth to a healthy child without

detox, provided that HIV clinical care is also readily available.

In the second study, Pugatch et al. (2001b) focused on an acute inpatient substance abuse treatment facility serving youth between the ages of 18 and 25. In all, 74% of those offered HIV testing (150 of 204) accepted it, and all preferred Orasure® testing. Although 64% of those tested learned their results, return rates were low (9%) among those who did not receive results during treatment and required a follow-up appointment. While testing appears feasible in this setting, particularly if results can be made available during treatment, those at greatest risk for infection may refuse testing, as was found here; "having been recently tested" was the most common reason for refusal. The authors suggest that motivational interviewing may promote increases in HIV repeat testing among substance abusing youth who decline an offer of testing in the context of ongoing sex- and drug-related risk behavior.

On the subject of return rates, Lazebnik, Hermida, Szubski, Dieterich-Colón, and Grey (2001) retrospectively evaluated 285 adolescents who consented to anonymous HIV testing in an urban, free, teen clinic and found that only 42% returned for test results and posttest counseling. Characteristics associated with return included: 1) the specific seeking of HIV testing; 2) carrying private health insurance; and 3) having unprotected sex while using alcohol or drugs. Given the low rate of return and noting that, aside from unprotected sex while using alcohol or drugs, no other risk factors were associated with return, Lazebnik and colleagues suggest employing confidential testing and follow-up (for those who do not return for results) within the clinic setting to ensure the receipt of results and posttest counseling by teens who consent to testing.

Peralta, Constantine, Deeds, Martin, and Ghalib (2001) surveyed 277 teens and young adults (237 were African-American)

about preferences following the presentation and demonstration of six HIV antibody collection and testing methods (three involving saliva, two involving blood [fingerstick], and one involving urine) and found that these teens had a clear preference for a noninvasive procedure (the collection of saliva) and a rapid result response time when submitting to HIV antibody testing. Tailoring testing methods to the teen audience will (hopefully) promote the early identification of HIV status.

In Scotland, Salt, Davidson, and Harvey (2001) compared 66 adults in genito-urinary medicine clinics (predominantly heterosexual) planning for or having had HIV testing to 129 with no intention to seek testing and found that, while perceived risk was the strongest predictor of testing, *perception* of risk and *actual* risk were not correlated, in that two-thirds of those not seeking testing reported at least one risk factor for HIV; these individuals were also less likely to see testing as beneficial. The au-

the use of AZT. Willingness to take AZT during pregnancy was associated with believing that a mother "owes it" to her child to take AZT, having a positive relationship with the treating physician, knowing others who took AZT during pregnancy, and having personal experience with AZT use during an earlier pregnancy. While here, again, the authors support client education and fully informed decision-making, they suggest that clinicians work in a respectful manner to reduce potential barriers and promote factors that appear to heighten willingness to take AZT during pregnancy.

*"I really expect to see my kids graduate from high school, go to college and give me some grandchildren. Being a mother is an experience I'm grateful that I didn't have to miss." – Marcya
(Villarosa, 2001, p. 7)*

With regard to the latter, Lee and Rotheram-Borus (2001) studied 307 parents living with HIV (81% female, 45% Latino, 34% African-American) to identify survival trends. Interestingly, the 56% of parents in this sample who survived the study period (median = 28 months) had higher levels of anxiety and depression at baseline that decreased over time, while parents who died reported lower levels of anxiety and depression at baseline that remained constant, indicating that a change (i.e., reduction)

thors believe that HIV testing might be encouraged by reframing testing messages to underscore benefits lost by not testing, including protection of one's partner and access to early medical intervention.

Psychiatric Assessment

Bing et al. (2001) surveyed a nationally representative sample of 2,864 adults receiving HIV medical care in 1996 and found that nearly *half* screened positive for a psychiatric disorder (i.e., major depression, dysthymic disorder, generalized anxiety disorder, or panic attacks), 26% reported illicit drug use (other than marijuana) during the preceding 12-month period, and more than 12% screened positive for drug dependence. The rate of psychiatric disorders was four- to eight-times higher than in the general U.S. population and associated with number of HIV-related symptoms, illicit drug use and dependence, heavy use of alcohol, and lack of employment or disability. Contrary to earlier studies, sexual orientation was *unrelated* to screening posi-

in emotional distress may enhance survival among parents living with HIV. Additionally, Lee and Rotheram-Borus found that those who had *more* children, coped by seeking social support, and were sexually active (i.e., had a partner) survived longer, highlighting the importance of social networks, including partners and children, to survival. Responsibility to and for others may serve as an additional incentive to survive; as the authors amusingly conclude, "parents are constantly challenged to adapt to their children's shifting needs and developmental capacities. Perhaps children actually help keep parents alive, not just young" (p. 1308).

A Startling Reminder

While the prospect of childbearing and extended parenthood for men and women living with HIV is a heartening development, such decision-making requires the fundamental knowledge of one's HIV status. In this regard, a sobering bit of news comes from Lansky, Jones, Frey, and Lindegren (2001), who collected data from 9,159 women nationwide and found that the percentage of women receiving testing for HIV increased from 41% in 1994 (prior to the 1995 dissemination of U.S. Public Health Service guidelines advising counseling and voluntary testing for all pregnant women) to 56% in 1999. While this increase in testing is encouraging, the upshot is that *44% of pregnant women in the U.S. are still not receiving HIV testing.*

itive for a psychiatric disorder in the HIV population and women had only a slightly higher rate of anxiety and depression than men, though rates of dysthymic disorder were much higher for women than for men. While all these disorders can reduce quality of life and interfere with medication adherence, they are also treatable. Bing and colleagues urge clinicians to identify those at risk and offer care to those diagnosed with psychiatric disorders.

HIV Treatment News

Medical Care

Researchers have concluded that short-term increases in viral load that occur in individuals who previously achieved an undetectable viral load (i.e., < 50 copies/mL) while taking antiretrovirals do not necessarily indicate that treatment is failing and that a change in regimen is needed. Havlir et al. (2001) reviewed data on 241 people receiving highly active antiretroviral therapy (HAART) who were followed for approximately 16 months and another group of 13

Clearly, increased effort is required to encourage women to receive HIV counseling and testing during pregnancy, thereby maximizing the chance to offer antiretroviral therapy both to reduce the risk of perinatal HIV transmission and to improve the health and survival of the mother-to-be.

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- Compiled by Abraham Feingold, Psy.D.

individuals on HAART who were followed for more than four years and found that "intermittent viremia" (i.e., an increase in viral load to > 50 copies/mL, followed by a return to undetectable levels) occurred in 40% of the first group and 46% of the second. In almost all cases, there was no evidence of "virologic failure" (i.e., a sustained increase in viral load to > 200 copies/mL). Expanding on this theme, Hermankova et al. (2001) followed 20 adults and children on HAART for more than two years and found that continuing treatment appeared to suppress the development of *new* drug-resistant viral mutations, even in those who experienced intermittent viremia. As Havlir et al. observe, "[u]nnecessary regimen switching may result in disruption of a [client's] medication routine, toxic effects from new drugs, and premature discarding of useful drugs" (p. 178).

What practices have been associated with disease progression among MSM? Vittinghoff et al. (2001) followed 370 gay and bi-

sexual men living with HIV over a period of 18 years and found increased risk of progression to AIDS and death to be associated with: 1) frequent use of hallucinogens; 2) frequent use of cocaine; and 3) unprotected receptive anal intercourse with ejaculation, practices about which clinicians may counsel avoidance.

According to Reuters Health (2001), Indian drug maker Cipla, Ltd. has released a new pill: Triomune-LNS, a three-in-one combination of stavudine (d4T or Zerit®), lamivudine (3TC or Epivir™), and nevirapine (NVP or Viramune™). A one-month supply will cost about \$38.00, a five- to six-fold decrease in the cost of these medications if purchased separately; additionally, the pill burden is reduced from six pills to two pills each day.

More good news on the topic of pill burden: Mole, Schmidgall, and Holodniy (2001) conducted a pilot study of a once-daily, four-drug antiretroviral regimen – indinavir (Crixivan®), zidovudine (Retrovir™), didanosine (ddI or Videx®), and lamivudine – over a 24-week period with the assistance of 10 antiretroviral-naïve or minimally experienced individuals living with HIV. The regimen appears to offer strong viral suppression with limited toxicity and does so within a more manageable dosing schedule; more extensive evaluation will be conducted on this formulation.

Albrecht et al. (2001) studied 195 nucleoside-experienced individuals and found that treatment that involved a four-drug regimen containing the protease inhibitor (PI) nelfinavir (Viracept™) and the non-nucleoside reverse transcriptase inhibitor (NNRTI) efavirenz (EFV or Sustiva®) plus two nucleoside reverse transcriptase inhibitors (NRTIs), at least one of which was new, resulted in a higher rate of viral suppression at Weeks 16, 40, and 48 than three-drug regimens containing only the PI or the NNRTI. In an accompanying editorial, Montaner and Mellors (2001) stress “the importance of prescribing, whenever possible, at least two drugs of new classes for patients who have already received treatment, so as to increase the likelihood of a sustained virologic response” (p. 453).

On the subject of efavirenz, Spanish investigators (Blanch et al., 2001) followed 31 people living with HIV who were prescribed an antiretroviral regimen containing EFV over a 12-week period. EFV has been associated with neuropsychiatric side effects (e.g., feelings of “disengagement” and nightmares; to a lesser extent, increases in the severity of previously-diagnosed depression, apathy, agitation, emotional lability, euphoria, hallucinations, and psychosis) and, indeed, four (13%) participants in this preliminary study needed to discontinue EFV as a result of psychiatric side effects. Those who continued on the regimen for the full 12 weeks demonstrated a reduction in psychological distress, with no apparent impact on quality of life. The reporting of neuropsychiatric side effects was associated with lower educational levels; feeling better, both physically and psychologically, at baseline than in the past; and suffering more distress related to physical complaints. The authors encourage screening for mental status, physical and psychological distress, and quality of life before initiating treatment with EFV.

Psychiatric/Psychological/ Psychosocial/Spiritual Care Neuropsychiatric Impairment

Coscia et al. (2001) assessed 43 children living with HIV and found that the creation of a mentally stimulating home environment is associated with a reduction in the negative impact of poverty on cognitive functioning in these children and that this association is more pronounced during advanced stages of HIV disease. The authors suggest that clinicians work to enhance parenting skills and aid in the acquisition of cognitively stimulating toys for the home to enhance the cognitive skills of children living with HIV.

Access to Care

Lehrman, Gentry, Bonacci Yurchak, and Freedman (2001) studied HIV case management activities among 28 agencies and 588 clients. Nearly 9,000 clients needs were identified, and nearly 80% of these were service needs. While more than 72% of needed services were arranged, about 13% of these services were never utilized by clients. The authors suggest that case

managers may benefit from training in: 1) the assessment of client readiness and desire for services; 2) promoting “buy-in” to service acquisition on the part of clients; and 3) supporting follow-through on services that have been arranged.

Turner et al. (2001) evaluated the receipt of antiretroviral medications among a nationally representative sample of 2,267 adults receiving HIV medical care and found that drug abuse-related factors (i.e., drug dependence, severe drug abuse, and IDU as an HIV risk factor) were associated with less likely use of antiretrovirals than the presence of a mental disorder. In fact, those receiving mental health treatment were over 50% more likely to report use of HAART than those not receiving such care.

What proportion of people living with HIV access mental health services? Utilizing this same nationally representative sample, Burnam et al. (2001) drew data on 2,864 adults receiving care in 1996 and estimated that 61.4% of such adults used mental health or substance abuse services over a six-month period. Services included: hospitalization (1.8%), psychiatric medications (29.6%), residential substance abuse treatment (3.4%), individual mental health specialty visits (26.0%), group mental health treatment (15.2%), outpatient substance abuse treatment (5.6%), substance abuse self-help groups (12.4%), and talking over emotional problems with medical care providers (40.3%). Socioeconomically disadvantaged individuals had poorer access to mental health outpatient care but were more likely to receive substance abuse treatment services. People living in the South were less likely to receive services, while those in the Northeast were more likely to receive services. While the magnitude of service delivery is substantial, these findings raise questions about the preparation of mental health professionals for treating individuals with complex medical and mental health needs as well as training and linkage with specialty providers for HIV primary care practitioners.

Adherence to Treatment

In the Netherlands, Nieuwkerk et al. (2001) found that only 47% of 224 people living

with HIV were *fully* adherent to their antiretroviral treatment regimen (i.e., took all medications on time and in accordance with dietary requirements) over a one-week period; less-than-full adherence was associated with "lower drug exposure" (and the potential for viral rebound and the emergence of drug-resistant strains of HIV) than that observed among those who were fully adherent. Support for maximal adherence to HIV medications is clearly needed.

Kalichman et al. (2001b) studied 112, primarily African-American, women living with HIV from the community and found that only 64% were taking antiretrovirals and that, among those who were, 46% had missed at least one medication dose in the preceding week. Women in this latter group indicated that they were less motivated to adhere and reported that they had less confidence in their ability to overcome barriers that would promote closer adherence to their regimen than women who were fully adherent. The authors recommend these approaches to assist women to improve adherence to antiretroviral medication regimens: 1) focused skills training in adherence strategies, including pill sorting, the problem-solving of potential adherence barriers, guidance in developing strategies for incorporating medications into daily routines, and regular use of reliable reminder systems (e.g., pill boxes, beepers, timers, reminder notes, date books); and 2) the introduction of self-monitoring techniques to record dosing, along with regular feedback regarding changes in viral load to motivate consistent use of medications.

A spiritual focus may also be of help. Woodward and Sowell (2001) interviewed 21 low-income, mostly African-American, women living with HIV and found that they use their spiritual lives to *enhance*, rather than to avoid, prescribed care. The authors encourage clinicians to assess the spiritual beliefs of women living with HIV and to incorporate discussion of these beliefs into a comprehensive care plan that has the potential to enhance treatment outcomes.

Lucas, Cheever, Chaisson, and Moore (2001) followed 764 individuals receiving HIV outpatient services and found that,

while former drug users and non-drug users responded similarly to treatment, *active* drug users underutilized HAART, were less adherent when taking antiretrovirals (by self-report), and displayed suboptimal virologic and immunologic responses to treatment. These findings reinforce the importance of reducing, if not eliminating, drug use among people living with HIV.

Spanish investigators (Martin et al., 2001) offered 115 men and women living with HIV (primarily IDUs) the opportunity to participate in a group educational intervention to enhance antiretroviral adherence; 74% *refused* participation in the group, citing "personal" reasons (59%) or job trouble (33%). Women with AIDS and women experiencing adherence problems were more receptive to group participation. These investigators suggest that individual adherence interventions may be preferred by some people living with HIV and that group interventions be targeted to individuals who may be more receptive to that approach.

In Italy, Murri et al. (2001) assessed adherence to indinavir- and ritonavir-based HAART among 142 people living with HIV at the time of study enrollment and again 295 to 631 days later (average time to follow-up was 441 days). They found that participants who self-reported nonadherence at baseline were 15-times more likely to remain nonadherent as those who reported adherence at baseline. Vomiting and itchy skin (medication side effects) were respectively associated with individuals being 11- and 17-times more likely to remain persistently nonadherent. Murri and colleagues conclude that self-reported nonadherence appears to be a reasonably good measure of adherence difficulties and that symptom control may help to support higher levels of adherence.

Coping Strategies

Canadian investigators (Burgoyne & Saunders, 2001) assessed self-perceived, health-related quality of life among 113 adults (primarily gay men) receiving HIV outpatient services and found that learning that one is HIV-infected affects psychological dimensions of life quality and becoming symptomatic affects most dimensions

of life quality, both physical and psychological. Burgoyne and Saunders emphasize the need for support in adjusting to an HIV diagnosis and the importance of symptom management, in concert with appropriate medical care, to maximize quality of life for people living with HIV and AIDS.

Miles, Gillespie, and Holditch-Davis (2001) followed 34 African-American birth mothers of HIV-positive children for a period of 24 months following delivery. These women, themselves living with HIV, reported a variety of physical symptoms over that period, including low energy, problems thinking and remembering, infections, and gynecological problems. They also reported moderate levels of stigma related to their HIV infection, as well as a high number of depressive symptoms. The authors conclude that special attention must be given to the physical and mental health of mothers living with HIV, particularly during the first two years following delivery, and that mind-body interventions (meditation, aerobic exercise, and biofeedback) be added into treatment plans that address depressive symptoms, feelings of stigma, fear of disclosure, lack of support, and parenting challenges among these women.

Bachanas et al. (2001) compared female caregivers of 36 HIV-positive children to those of 32 matched HIV-negative controls and found *no* difference in psychological distress between these groups. Interestingly, more than a third of each group reported high levels of distress, associated with greater use of emotion-focused coping strategies and the availability of fewer family resources. Distress in caregivers was associated with maladjustment in their children. Like Miles and colleagues, Bachanas and colleagues recommend teaching caregivers stress management skills, problem-focused coping strategies, and ways of increasing access to family resources.

By contrast, Wiener, Vasquez, and Battles (2001) surveyed 31 fathers of children living with HIV and found that over half reported high levels of parenting stress as well as psychological distress and expressed the *desire* for "gender-specific support groups, assistance with discipline, dis-

ease management, and assistance with planning for the future" (p. 353).

Pelton, Forehand, Morse, Simon Morse, and Stock (2001) interviewed 246 inner-city African-American women, 40% of whom were living with HIV, and one of their HIV-negative children between the ages of six and 11 and found that children whose mothers were not HIV-infected were more likely to have: 1) fathers who were alive and living at home; and 2) more frequent contact with their fathers, regardless of father's place of residence. Pelton and colleagues advocate for the inclusion of fathers or surrogate adult men in intervention efforts addressed to children of HIV-infected women.

Rotheram-Borus, Lee, Gwadz, and Drainin (2001) randomly assigned 307 parents (largely single, Latino or African-American drug users, either active or in recovery) living with AIDS and their adolescent children (412 in all) to either an intensive coping skills intervention (see <http://chipts.ucla.edu>) or standard care and found, over a two-year period, that the intervention greatly improved adjustment among both parents and their teens. The authors note that a coping skills intervention can help to prevent negative outcomes among teens who have a parent living with AIDS.

edu) or standard care and found, over a two-year period, that the intervention greatly improved adjustment among both parents and their teens. The authors note that a coping skills intervention can help to prevent negative outcomes among teens who have a parent living with AIDS.

Lyon and Younger (2001) surveyed 123 adults receiving HIV care in an urban infectious disease clinic and found an inverse relationship between "purpose in life" and depressive symptoms. Moreover, a reduced sense of "purpose in life" was more closely associated with depressive symptoms than laboratory markers of HIV disease progression. In addition to the routine assessment of depressive symptoms, Lyon and Younger advocate for the use of interventions that enhance existential meaning and a sense of purpose among people living with HIV as one potential route to addressing depressive symptoms.

Along these lines, Lavery, Boyle, Dickens,

Macleay, and Singer (2001) interviewed 32 Canadians living with HIV and found that 20 (63%) would pursue euthanasia or assisted suicide to end their lives, while three (9%) had decided against it and nine (28%) were undecided. Desire for euthanasia was related to: physical "disintegration" from disease symptoms, resulting in a loss of functioning and dependency on others; and "loss of community" or the "progressive diminishment of opportunities to initiate and maintain close personal relationships" resulting from abandonment by family, stigmatization, homophobia, histories of physical and/or sexual abuse, the loss of social role and function, drug addiction, and increasing social isolation. Together, these factors precipitate a perceived loss of self. Euthanasia and assisted suicide were viewed as a means of limiting this loss of self. Lavery and colleagues observe that interest in euthanasia or assisted suicide might be altered as a result of meaningful changes in the social circumstances of people living with HIV, independent of

Tool Box

Resources

Articles of Interest:

Adnopoulos, J.A., & Berkowitz, S.J. (Eds.). (2000). Children and adolescents affected by HIV/AIDS: A mental health challenge. *Child & Adolescent Psychiatric Clinics of North America*, 9(2), 267-468.

This volume offers a multi-systemic approach to working with HIV-affected children, adolescents, and their families.

Carey, M.P., Carey, K.B., Maisto, S.A., Gordon, C.M., & Weinhardt, L.S. (2001). Assessing sexual risk behaviour with the Timeline Followback (TLFB) approach: Continued development and psychometric evaluation with psychiatric outpatients. *International Journal of STD & AIDS*, 12(6), 365-375.

The authors introduce and offer evidence for the reliability and validity of the Timeline Followback (TLFB) method for self-reporting sexual risk behavior among outpatients with severe mental illness.

Halkitis, P.N., Parsons, J.T., & Stirratt, M.J. (2001). A double epidemic: Crystal methamphetamine drug use in relation to HIV transmission among gay men. *Journal of Homosexuality*, 41(2), 17-35.

Halkitis and colleagues review studies on methamphetamine, used by gay men to initiate, in-

tensify and prolong sexual encounters, and its association with HIV risk.

Huba, G.J., Melchior, L.A., Panter, A.T., Brown, V.B., Cherin, D.A., & Simmons, J. (Eds.). (2001). The next generation of AIDS patients: Service needs and vulnerabilities. *Home Health Care Services Quarterly*, 19(1-2), 1-125.

Huba and colleagues describe innovative models of HIV care serving those who have historically experienced barriers to accessing HIV prevention and treatment services. These projects were funded under the Health Resources & Services Administration (HRSA) HIV/AIDS Bureau "Special Projects of National Significance" (SPNS) Cooperative Agreement initiative.

Kalichman, S.C., & Rompa, D. (2001). The Sexual Compulsivity Scale: Further development and use with HIV-positive persons. *Journal of Personality Assessment*, 76(3), 379-395. The authors demonstrate the reliability and validity of the Sexual Compulsivity Scale when used with HIV-positive men and, preliminarily, with HIV-positive women.

Mason, S.E., & Miller, R. (2001). Safe sex and first-episode schizophrenia. *Bulletin of the Menninger Clinic*, 65(2), 179-194.

Based on experience with 68 clients, Mason and Miller use clinical examples to introduce individual and group strategies for encouraging safer sexual behavior in persons who have experi-

enced a first episode of schizophrenia.

Parker, R., & Ehrhardt, A.A. (Eds.). (2001). Through an ethnographic lens: HIV/AIDS research. *AIDS & Behavior*, 5(2), 105-191.

This special issue of *AIDS & Behavior* brings a cultural focus to HIV/AIDS research in such diverse areas as drug and sexual risk among MSM speed users, hard-to-reach heterosexual women at-risk for HIV in the inner-city, and sexual expression among women with severe mental illness.

Stenzel, M.S., McKenzie, M., Adelson Mitty, J., & Flanigan, T.P. (2001). Enhancing adherence to HAART: A pilot program of modified directly observed therapy. *The AIDS Reader*, 11(6), 317-328.

The authors describe a voluntary pilot program of modified directly observed therapy (based on the model used for tuberculosis) to increase adherence to HAART.

Internet Resources:

The Department of Health & Human Services' Office of Minority Health, with "a mission to improve the health status of racial and ethnic minority groups in the United States," has created a Web site to support the Minority HIV/AIDS Initiative, located at: http://www.omhrc.gov/omh/aids/aidshome_new.htm

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disease progression.

Hudson, Lee, Miramontes, and Portillo (2001) surveyed a convenience sample of 104 women living with HIV who reported limited social interaction with friends and family as well as a low level of perceived social support; the latter was associated with elevated levels of distress. Hudson and colleagues suggest that supportive interactions with health care providers may ameliorate some of the isolation and distress experienced by women living with HIV; support groups and health information programming may be of additional assistance to women who are socially isolated.

Waller (2001) surveyed a diverse sample of 60 urban gay men living with AIDS and found, contrary to earlier findings that social support for these men was often meager or ineffective, that both family of origin and friends may offer more support than was previously recognized. Moreover, perceived social support, particularly support from family of origin, was associated with positive adaptational outcomes (i.e., a sense of coherence, self-esteem, and psychological well-being) to illness. Waller recommends acknowledging, assessing, and actively cultivating social support from friends and family of gay men living with AIDS as part of a comprehensive care plan.

On a similarly positive note, Collins et al. (2001) interviewed 2,864 individuals receiving HIV care and found that, after testing positive for HIV, 43% had increased their physical activity, 59% had improved their diet, and 49% of cigarette smokers and 80% of substance users quit or reduced their consumption. Health behavior changes were associated with a desire to take an active role in one's HIV medical care (through information-seeking) and with active coping strategies. According to the authors, "health promotion among people with HIV is a method of self-care – an effort to cope with HIV by exerting personal control over the course of the illness" (p. 356). Although many people improve their health behavior after testing HIV-positive, more might be assisted in doing so by targeting such behaviors through education, counseling, and skills training.

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Tool Box

A Note About 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.cdcnpi.org/news/prevnews.htm>); the *Kaiser Daily HIV/AIDS Report* (<http://report.kff.org/hiv/aids/>); and periodic literature reviews e-mailed by researcher Robert Malow, Ph.D. at the University of Miami. Other sources of information are identified when appropriate.

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

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