

mental health AIDS

A Quarterly Update from the AIDS Education and Training Centers (AETC) National Resource Center Volume 5(1), Fall 2003

Biopsychosocial Update

HIV Prevention News

About Women

How do women make decisions about whether or not to use condoms with a main partner? Drawing data from 1,938 sexually-active women in five U.S. cities, Semaan, Lauby, O'Connell, and Cohen (2003) examined factors associated with perceiving advantages ("pros") and disadvantages ("cons") to condom use, along with the decisional balance (standardized pros score minus standardized cons score) achieved by these women. Lower pros scores were associated with a history of sexually transmitted diseases (STDs) or with income from a partner or spouse during the preceding year; by contrast, higher pros scores were associated with income from public assistance during the preceding year. Lower pros scores in conjunction with a negative decisional balance score were associated with older age, living with a partner or spouse, or binge drinking during the preceding 30 days. A positive decisional balance score was associated with income from a job during the preceding year. Higher cons scores were associated with having multiple sex partners during the preceding six months or HIV risk based on perceptions of behavior of the main partner.

While their analysis could explain only a small proportion of the variance (suggesting that other factors may weigh more heavily in how women make decisions about whether or not to use condoms with a main partner), Semaan and colleagues suggest that these results "can inform our work in HIV prevention on whether to focus on the pros, the cons, or both to obtain positive decisional balance scores and increase condom use in situations that warrant protective behaviors" (p. 54).

Wilson et al. (2003) interviewed 258 HIV-positive and 228 HIV-negative women attending prenatal clinics in four U.S. states six months postpartum and found few differences between these groups regarding reproductive attitudes and sexual behaviors (e.g., rates of pregnancy following delivery, perceived emotional reactions to a pregnancy, intentions to terminate an unplanned pregnancy). According to the authors, "[s]exual behaviors resume shortly after birth for a majority of both HIV-infected and uninfected women. Consequently, pregnancy and the immediate postpartum period present an important opportunity for delivering risk reduction, family planning, and HIV-related messages" (p. 612).

About Adolescents

Newcomb, Locke, and Goodyear (2003) studied a community sample of 904 Latina adolescents, primarily of Mexican-American descent, in Los Angeles County. They found that maltreatment during childhood was associated with later risky sexual behavior (i.e., more partners, less frequent condom use, more frequent intercourse, and less testing for HIV) and that several factors (e.g., psychological distress, drug use, general self-efficacy) mediated the relationship between these earlier experiences and HIV risk behavior in adolescence. "Treatment and prevention efforts designed to screen for and reduce the impact of childhood maltreatment and reduce [p]sychological [d]istress and [d]rug [u]se ... are likely to decrease the risk of HIV acquisition and transmission in young Latina women" (p. 232), conclude the authors.

In a prospective study, Hutchinson, Jemmott, Jemmott, Braverman, and Fong (2003) followed 219 sexually experienced,

urban, African-American and Latina adolescents receiving medical care over a three-month period and found that

higher levels of mother-daughter [sexual risk] communication were associated with fewer episodes of sexual intercourse and unprotected intercourse among adolescents. ... [F]indings support the notion that mothers who communicate with their daughters about sex can affect their daughters' sexual behaviors in positive ways ... [and] lend support for the design and implementation of family-based approaches to improve parent-adolescent sexual risk communication as one means of reducing ... HIV-related sexual risk behavior among inner-city adolescent females. In addition, condom use self-efficacy ... was found to act as a mediator of these protective effects on the occurrence of unprotected intercourse. (pp. 105-106)

About Substance Users

Bowser, Word, Stanton, and Coleman (2003) studied 592 out-of-treatment injecting drug users (IDUs) and found that

the extent of HIV risk-taking in adult

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hood was highly and positively related to (a) the number of close-family-member deaths participants experienced as youth, (b) the extent to which respondents effectively mourned sudden family losses, (c) the extent to which those lost were emotionally close to the respondent, and (d) whether or not the respondent attended the funerals of lost relatives. ... These findings give credence to the importance of (a) unexpected deaths experienced early in life, and (b) related, inadequate mourning, as factors in progressively higher adult HIV risk-taking. They suggest that treatment for such individuals and their families should involve grief work dealing with unresolved losses within the family of origin. In addition, prevention efforts may have to [move] toward both more focused and more family-based methods of outreach and engagement. (p. 291)

In a study involving 109 IDUs (10% of whom were HIV-positive) meeting DSM-IV criteria for major depressive disorder, dysthymia, or substance-induced mood disorder of at least three months' duration, Stein, Solomon, Herman, Anderson, and Miller (2003) found that the greater the severity of the depression, the greater the frequency of injection risk behavior. Stein and colleagues reason that if the severity of depression can be reduced, this may also reduce the rate of high-risk injection behaviors.

Tun, Celentano, Vlahov, and Strathdee (2003) interviewed 338 HIV-positive and 593 HIV-negative IDUs in Baltimore. In the former group, unprotected sex was associated with the perception that HIV is less likely to be transmitted when taking highly active antiretroviral therapy (HAART), while needle sharing was associated with safer injection fatigue. In the latter group, needle sharing was also associated with safer injection fatigue, while unprotected sex was associated with safer sex fatigue. Tun and colleagues encourage clinicians to educate IDUs regarding the need to continue safer sexual and injection practices in the context of HAART and to address risk-reduction fatigue among those who have been engaging in safer behaviors.

Do enhanced interventions with drug users result in greater risk reduction than "standard" interventions? Hershberger, Wood, and Fisher (2003) randomized 1,362 out-of-treatment drug users (injectors, crack cocaine smokers, and "smoking injectors") to one of two conditions: a nine-session enhanced cognitive-behavioral intervention conducted over a four-month period or a two-session, National Institute on Drug Abuse (NIDA) standard condition (HIV education and skills building, counseling and testing, and referral for other services). "The most notable result of this study is the almost complete absence of differences between the enhanced and standard interventions on postintervention [reductions in drug- and sex-related risk] behaviors, but almost

universal differences in behavior between pre- and postintervention, regardless of intervention or for that matter, drug user type" (p. 236). In other words, regardless of the intervention or the type of drug(s) used, reductions in most risk behaviors were observed.

What, then, are the intervention features that contribute to risk reduction with this population? Dutch investigators (van Empelen et al., 2003) reviewed 17 studies that evaluated interventions designed to change sexual behavior among drug users and found that only five discerned significant reductions in unsafe sexual behavior that could be attributed to the intervention. Importantly, individual interventions were found to be generally ineffective; "[m]ore successful programs featured several of the following elements: use of multiple theories and methods, inclusion of peers and rehearsal of skills. Moreover, the community-level interventions showed the importance of sustainability. The most successful intervention methods were modeling, skill building and social support enhancement. These methods are generally derived from the Social-Cognitive Theory or the Diffusion of Innovations Theory" (p. 1593).

About Men Who Have Sex with Men

Halkitis, Parsons, and Wilton (2003) conducted a brief survey with an ethnically diverse convenience sample of 518 gay and bisexual men recruited from gay neighborhoods in New York City and found that 86% of those sampled were familiar with the term "barebacking" (i.e., intentional unprotected anal intercourse) and that 45.5% had engaged in this behavior during the preceding three-month period, with HIV-positive men twice as likely as HIV-negative men to report barebacking. Although reported bareback sex was largely seroconcordant, serodiscordant pairings were also reported. From an emotional standpoint, these men associate barebacking with feelings of intimacy, connectedness, and masculinity. According to the men surveyed, such behavior is fueled by the availability of sexually-oriented chat rooms and other forms of communication on the Internet, advances in HIV treatment, emotional fatigue related to the epidemic, as well as the increased

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popularity of "club drugs." Halkitis and colleagues encourage clinicians to actively assess the relative safety of clients' sexual encounters and to educate clients regarding the health implications of unprotected anal intercourse.

Remien, Wagner, Dolezal, and Carballo-Diéguez (2003) examined psychological distress in a convenience sample of 75 HIV-discordant male couples assessed during the pre-HAART era. They also compared distress levels of the HIV-positive and the HIV-negative members of the couple and sought to identify "partner" factors that might be linked with distress experienced by individuals within the relationship. In comparison with the general population, distress levels for both the HIV-positive and the HIV-negative sub-groups were in the mild to moderate range and associated with general relationship satisfaction, sexual satisfaction, a coping style characterized by avoidance and self-blame, and support from one's partner. Since it would appear that aspects of the relationship are associated with distress in individual members of the couple, Remien and colleagues believe that "couple-focused" clinical interventions can be of great benefit to HIV-discordant couples.

In HIV and AIDS, specifically, it is important to work clinically with the many challenges these couples face at the dyadic level to strengthen the partnership, rather than only referring each partner to his or her separate support group or individual therapy. HIV-discordance makes the issues that typically confront any couple particularly complex and multifaceted. Barriers to open communication in the couples are exacerbated, for instance, by the often overwhelming fear of HIV transmission, illness progression and future loss. Therapeutically, it is important to validate the emotional concerns of both partners and help the members of the couple see that the concerns of both partners are legitimate and that there are unique concerns associated with being in an HIV-discordant couple. Findings ... suggest the importance of strengthening couple-level support, sat-

From the Block Us Helping Us

Founded in 1987, Us Helping Us, Inc. (UHU) is the only organization in the Washington, DC metropolitan area specializing in HIV prevention and support services for "black same gender loving men" as well as male-to-female transgender persons. While the organization offers HIV counseling and testing for the larger community, it delivers its case management, prevention case management, support group, "Down Low" help line, "DL online," corrections discharge planning, holistic health seminars, complementary medicine, and mental health services exclusively to its target population.

In 1998, UHU began delivering mental health services through a referral and voucher system involving clinicians in the community. Under the current initiative, the organization is working to increase recruitment and service provision for its current client base by offering individual and group psychotherapy, case management, telephone hotline counseling, and peer support groups *on-site* at program offices in the Anacostia section of Washington, DC.

The Principal Investigator is Ron Simmons, Ph.D.; the Program Director is Larry W. Ferguson, LICSW. For more information, please call 202/546-3861 or visit www.ushelpingus.com.

– Compiled by the MHHSC
Program Coordinating Center

isfaction and cohesion to reduce distress and increase individual feelings of wellbeing. It may also be important to help couples increase their sexual satisfaction within the relationship without incurring increased risk of transmission of HIV and other [STDs]. (p. 534)

About Women & Men

The difficulty of maintaining safer sexual behavior over time is reflected in a study by Gore-Felton et al. (2003), who sampled a diverse group of 179 men and women living with HIV or AIDS and found that the longer an individual reported having known of his or her positive serostatus and the greater an individual's use of emotion-focused coping strategies, the greater the likelihood that he or she reported contracting an STD following the diagnosis of HIV infection. The interaction between these vari-

ables was also significant, in that the *less* time that elapsed following the diagnosis of HIV infection and the more emotion-focused coping strategies were utilized, the greater the likelihood of reporting an STD. Thus, in addition to tailoring interventions to manage specific stressors associated with time since HIV diagnosis, bolstering problem-focused coping strategies may reduce sexual risk behavior and consequent STDs.

HIV Assessment News

HIV Counseling & Testing

Hightow et al. (2003) compared matched samples of 101 individuals newly-diagnosed with HIV and 411 individuals found to be HIV-negative who received HIV testing while visiting an STD clinic in the rural southeastern U.S. Overall, 55% of those sampled did not return for HIV posttest counseling and test results; non-return was associated with African-American race and a history of non-return for test results. These findings reinforce the need to address the importance of HIV posttest counseling prior to testing in an effort to improve the rate of return.

In comparing health beliefs of 80 current or former street drug users who received oral HIV testing with 75 who had not, Clair, Singer, Huertas, and Weeks (2003) discovered that "receiving oral HIV testing can lead to an increased belief in the possible transmission of HIV through saliva" (p. 579). "This problematic outcome suggests the importance of enhanced HIV counselling among participants in oral HIV testing" (p. 575).

Psychiatric Assessment

Conigliaro, Gordon, McGinnis, Rabeneck, and Justice (2003) evaluated 881 veterans living with HIV (99% male, 54% African-American) and found diagnoses of alcohol abuse or dependence as well as current "hazardous" drinking to be common within this cohort. "At the same time, health care providers were more likely to miss excessive alcohol consumption in those patients with undetectable viral load, high CD4 cell counts, lack of clinical hepatitis, and normal liver enzyme levels. [These] results strongly suggest that health care providers should screen all HIV-positive patients for

risky alcohol consumption rather than only suspecting it in those for whom antiretroviral therapy fails or those with obvious liver disease" (pp. 523-524).

In a sample of 174 cocaine abusers seeking drug treatment, 35.1% of whom met diagnostic criteria for antisocial personality disorder (ASP), Ladd and Petry (2003) found that those with an ASP diagnosis reported greater alcohol, legal, and psychiatric problems, as well as higher rates of risky sexual behavior, when compared to those who did not have this diagnosis. Ladd and Petry recommend that clinicians "evaluate cocaine abusers entering treatment programs for ASP, as it is an important indicator of poorer psychiatric functioning, increased legal difficulties, and greater HIV risk. ... [P]sychiatric care and the use of [contingency management] treatment strategies

[(i.e., providing monetary-based incentives when drug abstinence is objectively verified)] may improve outcomes of these patients" (p. 329).

HIV Treatment News

Medical Care

Readers of *mental health AIDS* may recall the Winter 2003 **Tool Box** detailing structured treatment interruptions (STIs). Lawrence et al. (2003) recently reported on the largest randomized, prospective clinical trial of STI to date, involving 270 individuals with multidrug-resistant HIV and viral loads > 5000 copies/mL, who received either an immediate change in antiretroviral regimen or a change following a four-month STI. Study recruitment was halted prematurely when it was found that disease progression was more common in the treatment-interruption group than in the group

that changed medications immediately. The authors conclude that "in patients with multidrug-resistant HIV infection, it is best to continue treatment with an optimized antiretroviral regimen and avoid the use of treatment interruption" (p. 845).

Based on findings from a recent clinical trial demonstrating a high rate of early virologic non-response among therapy-naive adults receiving once-daily three-drug combination therapy with lamivudine (3TC or Epivir®), abacavir (ABC or Ziagen®) and tenofovir (TDF or Viread®), health care providers have been advised that this combination of medications "should not be used as a triple antiretroviral therapy when considering a new treatment regimen for naive or pre-treated patients" and that "[a]ny patient currently controlled on therapy with this combination should be closely monitored and

Tool Box

Articles of Interest

Copenhaver, M., Avants, S.K., Warburton, L.A., & Margolin, A. (2003). Intervening effectively with drug abusers infected with HIV: Taking into account the potential for cognitive impairment. *Journal of Psychoactive Drugs*, 35(2), 209-218. HIV-positive substance users may enter treatment "with some degree of cognitive impairment in domains that could impede their ability to learn, retain, and execute HIV preventive behaviors" (p. 209). The authors offer practical strategies that can be incorporated into prevention interventions with such individuals.

Cruess, D.G., Evans, D.L., Repetto, M.J., Gettes, D., Douglas, S.D., & Petitto, J.M. (2003). Prevalence, diagnosis, and pharmacological treatment of mood disorders in HIV disease. *Biological Psychiatry*, 54(3), 307-316. "This review highlights ... studies that have examined prevalence rates of mood disorders in HIV+ individuals, characteristics of HIV disease that influence the diagnosis and psychopharmacologic treatment of mood disorders, including complex interactions with antiretroviral medications, as well as the available evidence regarding the efficacy of agents used to treat depression and mania in the context of HIV disease" (p. 307).

Douaihy, A.B., Jou, R.J., Gorske, T., & Salloum, I.M. (2003). Triple diagnosis: Dual diagnosis and HIV disease, Part 1. *The AIDS Reader*, 13(7), 331-332, 339-341.

"This review highlights the features of sub-

stance abuse-psychiatric illness and its association with changes in antiretroviral therapy use, adherence, and HIV treatment outcomes. ... Service delivery ... models based on '1-stop shopping' should be ... put into practice ... to optimize clinical outcomes" (p. 331).

Douaihy, A.B., Jou, R.J., Gorske, T., & Salloum, I.M. (2003). Triple diagnosis: Dual diagnosis and HIV disease, Part 2. *The AIDS Reader*, 13(8), 375-382.

"This review highlights the psychiatric, psychosocial, and substance use treatment issues relevant to the care of patients with triple diagnosis. A discussion of the various psychosocial and psychopharmacologic strategies stresses the importance of integrating medical, psychiatric, and substance use interventions" (p. 375).

Emler, C.A., & Vallee, C.M. (Eds.). (2002). Special issue: HIV/AIDS in adults 50 and over. *Journal of Mental Health & Aging*, 8(4), 263-363.

"The articles presented in this special issue ... represent both qualitative and quantitative research, emerging models for service delivery with various subpopulations, and overviews of special subpopulations such as HIV and older women" (p. 265).

Forsyth, B.W.C. (2003). Psychological aspects of HIV infection in children. *Child & Adolescent Psychiatric Clinics of North America*, 12(3), 423-437.

"This article reviews what is known about the psychological effects of the HIV epidemic on children and adolescents in the United States and other developed countries and presents

suggestions for optimal interventions" (p. 423).

Godin, G., Gagné, C., & Naccache, H. (2003). Validation of a self-reported questionnaire assessing adherence to antiretroviral medication. *AIDS Patient Care & STDs*, 17(7), 325-332. Canadian researchers introduce a five-item self-report questionnaire developed to assess antiretroviral nonadherence.

Inungu, J., Beach, E.M., & Skeel, R. (2003). Challenges facing health professionals caring for HIV-infected drug users. *AIDS Patient Care & STDs*, 17(7), 333-343.

To assist clinicians in addressing treatment challenges posed by IDUs living with HIV, the authors summarize four models of behavior change (the Health Belief Model, the Theory of Reasoned Action, Social Cognitive Theory, and the Transtheoretical Model).

Johnson, R.L. (Ed.). (2003). What youth need: Adapting HIV care models to meet the lifestyles and special needs of adolescents and young adults. *Journal of Adolescent Health*, 33(Suppl. 2), 1-65.

This supplement presents lessons learned from five Ryan White CARE Act Special Projects of National Significance focusing on youth that were conducted between 1996 and 2000.

Leserman, J. (2003). HIV disease progression: Depression, stress, and possible mechanisms. *Biological Psychiatry*, 54(3), 295-306.

Leserman "summarizes the large body of evidence examining whether depression and stress may have an impact on immune- and

considered for modification of therapy" (FDA, 2003a).

With regard to the coadministration of atazanavir (ATZ or Reyataz™), the first once-a-day protease inhibitor (PI) approved for marketing, and TDF, findings from three clinical trials clarify that "[c]linicians should use caution when administering unboosted ATZ [(i.e., ATZ alone, without a second PI)] with [TDF]. Unboosted [ATZ] may be less effective due to decreased [ATZ] concentrations in patients taking [ATZ] and [TDF]. As a result the coadministration of unboosted [ATZ] with [TDF] may lead to loss or lack of virologic response and possible resistance to [ATZ]" (FDA, 2003b).

Finally, two intriguing studies investigating HIV disease prognosis have recently been reported:

o The Antiretroviral Therapy (ART) Cohort Collaboration (2003) analyzed 13 North American and European cohort studies involving 9,323 antiretroviral-naïve adults who initiated HAART and received follow-up care for at least six months. They conclude that baseline CD4 cell counts and viral load measures are poor prognostic indicators. Rather, "prognosis depends on levels of CD4 and [viral load] 6 months after the start of HAART, rather than change in the levels of these markers since the start of treatment. ... In other words it matters what CD4 cell count and viral load a patient arrives at, but not where the patient was when starting HAART. This should be seen as a positive message, which might help to motivate patients to adhere to treatment regimens" (p. 685).

o Farinpour et al. (2003) presented find-

ings from the Multicenter AIDS Cohort Study (MACS), which includes men living with HIV in four U.S. urban centers:

In this 13-year, prospective study of 1,231 HIV-seropositive men, general intellectual functioning, age, and somatic symptoms of depression, at baseline, were found to be significant predictors of HIV disease progression and survival. Older age at baseline was associated with a more rapid progression to dementia and death. ... IQ estimates were associated with a more rapid disease progression (AIDS and dementia) and somatic symptoms of depression was [*sic*] associated with shortened survival. In addition, age, IQ, and somatic symptoms of depression, had an additive effect with an increase in the number of risk factors associated

disease-related parameters in HIV disease [and] finds substantial evidence that chronic depression and stressful events may affect HIV disease progression" (p. 295).

Lyon, M.E., Trexler, C., Akpan-Townsend, C., Pao, M., Selden, K., Fletcher, J., Adlestone, I.C., & D'Angelo, L.J. (2003). A family group approach to increasing adherence to therapy in HIV-infected youths: Results of a pilot project. *AIDS Patient Care & STDs*, 17(6), 299-308. In this small pilot study that involved 23 African-American youth and their family members ("treatment buddies") in alternating family/youth education sessions and youth-only education sessions over a 12-week period, 91% of the youth self-reported increased adherence to antiretrovirals following the intervention.

Lyon, M.E., & Woodward, K. (2003). Nonstigmatizing ways to engage HIV-positive African-American teens in mental health and support services: A commentary. *Journal of the National Medical Association*, 95(3), 196-200. Lyon and Woodward describe "a hospital/adolescent-clinic based model for providing support services and for increasing medical adherence among HIV positive inner city African-American adolescents" (p. 196).

Marín, B.V. (2003). HIV prevention in the Hispanic community: Sex, culture, and empowerment. *Journal of Transcultural Nursing*, 14(3), 186-192.

Marín contends that marginalization (including poverty, racism, and homophobia) as well as cultural factors (e.g., machismo, sexual silence)

impede HIV prevention and discusses Latino-specific empowerment interventions.

McNeil, J.I. (2003). A model for cultural competency in the HIV management of African American patients. *Journal of the National Medical Association*, 95(2 Suppl. 2), 3S-7S. McNeil presents the BESAFE model for cultural competency suggested by the National Minority AIDS Education and Training Center. "BESAFE is a framework that uses culturally pluralistic content and perspectives based on ... six core elements: Barriers to health care, Ethics in cultural competency, Sensitivity of the [p]rovider, Assessment appropriate to a cultural determination, Facts related to ethnocentric physiologic differences, and Encounters" (p. 4S).

Orsulic-Jeras, S., Shepherd, J.B., & Britton, P.J. (2003). Counseling older adults with HIV/AIDS: A strength-based model of treatment. *Journal of Mental Health Counseling*, 25(3), 233-244. "This article outlines a strength-based assessment and treatment model applicable for the mental health counseling of those aging with HIV. By focusing on the specific areas of life where clients are functioning effectively, this model works to decrease attention to pathology and stigma and, subsequently, works to empower clients to concentrate on areas of their lives that are controllable" (p. 233).

Price, S., & Goyette, J. (2003). Role of the psychiatrist in the care of patients with hepatitis C and HIV/AIDS. *Psychiatric Quarterly*, 74(3), 261-276.

Price and Goyette "describe the varying roles

psychiatrists have in caring for ... patients [with hepatitis C and HIV/AIDS] in the various settings of their work" (p. 261).

Ramírez García, P.R., & Côté, J.K. (2003). Factors affecting adherence to antiretroviral therapy in people living with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care*, 14(4), 37-45.

Ramírez García and Côté "present an in-depth review of the literature and ... enumerate the factors that link adherence behavior to the individual, the treatment, the illness, and the relationship with the health professional" (p. 37).

Selwyn, P.A., & Forstein, M. (2003). Overcoming the false dichotomy of curative vs palliative care for late-stage HIV/AIDS: "Let me live the way I want to live, until I can't." *Journal of the American Medical Association*, 290(6), 806-814. Through a case study involving a man with late-stage HIV disease, Selwyn and Forstein highlight "the importance of a treatment plan that integrates curative or disease-specific interventions ... and symptom palliation, to overcome the false dichotomy that limits the effectiveness of either paradigm" (p. 807).

Skevington, S.M., & O'Connell, K.A. (2003). Measuring quality of life in HIV and AIDS: A review of the recent literature. *Psychology & Health*, 18(3), 331-350.

Skevington and O'Connell review 303 articles on HIV-related quality of life published between 1995 and May 2000 and offer guidance on choosing instruments for different purposes.

--Compiled by Abraham Feingold, Psy.D.

with accelerated disease progression and shortened time to death. These findings remained consistent, despite controlling for baseline CD4 and HIV medication use. ... The results provide strong evidence that in addition to serologic markers and HIV medication effects, general intellectual functioning, age, and somatic symptoms of depressed mood influence disease course and survival in measurable years [and] need to be taken into account in gauging disease prognosis and in planning therapeutic regimens. (pp. 663-666)

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Neuropsychological Impairment

The 200-item Paced Auditory Serial Addition Task (PASAT) is sensitive to many types of cognitive dysfunction but underutilized in clinical settings due to its length and the frustration it evokes in clients as items become more difficult. Employing demographically-corrected norms for 50- and 100-item versions of the 200-item PASAT with a clinical sample of 786 adults living with HIV, Diehr et al. (2003) conclude that "the short forms of the PASAT are significantly less distressing to the patient and have equivalent clinical accuracy when used to detect impairment, although some accuracy may be lost when using the 50-item form with higher-functioning individuals" (p. 584).

Adding emphasis to conclusions drawn in a **Tool Box** from the Summer 2003 issue of *mental health AIDS*, Canadian investigators (Carter, Rourke, Murji, Shore, & Rourke, 2003) examined the relationship between subjective cognitive complaints and neuropsychological (NP) test performance in 160 men who were primarily white and well-educated. They found that "cognitive complaints predicted [NP] skills, independent of the effects of depressed mood and medical symptoms on cognitive complaints, suggest[ing] that increased cognitive complaints are associated with poorer [NP] performance. Although mood and medical symptoms contributed to cognitive complaints, the relationship between cognitive complaints and [NP] skills was not solely due to their influence" (p. 415). Carter and colleagues point out that "increased

cognitive complaints can reflect [NP] impairment even in individuals who are depressed or medically symptomatic [italics added]. In clinical practice, it appears that a correction factor for the degree of depressed mood or medical illness is not required when assessing whether cognitive complaints are associated with [NP] performance. Nevertheless, individuals with depressed mood or increased medical symptoms are also more likely to report [NP] difficulties" (p. 415).

In Italy, Tozzi et al. (2003) examined the impact of HIV-associated cognitive impairment, as measured by a battery of 17 NP tests, on health-related quality of life (HRQoL) in a sample of 111 people living with HIV. They found that the one-third of participants demonstrating cognitive impairment reported a lower quality of life across all domains measured (physical health, mental health, pain, physical functioning, cognitive functioning, role functioning, social functioning, energy, health distress, general health perceptions, and overall quality of life).

Impairment in different cognitive abilities, such as fine motor functions, memory, mental flexibility, concentration and speed of mental processing, and visuospatial and constructional abilities, was also associated with reduced HRQoL. Poor performance in the Digit Symbol Test was the strongest predictor of poor HRQoL in multivariable analyses controlling for CD4 count, previous AIDS diagnosis, receiving HAART, and drug abuse. ... We also found that the extent of cognitive impairment was related to mental health summary scores, physical health summary scores, self-reported measures of cognitive functioning, and overall quality of life. (p. 649)

The authors recommend that clinicians conduct a systematic assessment of cognitive functioning as part of routine clinical assessment to identify NP impairment as well as possible reductions in HRQoL and intervene with antiretrovirals that cross the blood-brain barrier should impairment be discerned.

In a detailed examination of perinatally HIV-

infected children who displayed pronounced cognitive declines even while experiencing virologic, immunologic, and clinical stability on a PI-containing HAART regimen, Tamula, Wolters, Walsek, Zeichner, and Civitello (2003) found that the treatment regimen provided to these children did not contain zidovudine (ZDV, AZT or Retrovir®) or did so in a lower than optimal dosage. Cognitive functioning was stabilized or improved when AZT was introduced at the highest recommended dosage in two of these four children. As suggested by Tozzi et al. above, Tamula and colleagues observe that adding a central nervous system (CNS) penetrating drug, such as AZT, to a HAART regimen may partially reverse HIV disease in the CNS in children as well as adults and recommend that clinicians monitor cognitive functioning in HIV-infected children through repeated NP assessment.

Alternative Medicine

Shor-Posner et al. (2003) conducted a randomized, double-blind, placebo-controlled trial of nutritional chemo-prevention with selenium (a biological antioxidant; 200 µg/day) over a 12-month period on 32 male and 31 female drug users living with HIV and found that participants who received selenium reported reductions in anxiety (both state *and trait*) and an increase in vigor when compared to participants who received the placebo. No impact was observed on depressive symptomatology or level of distress. The authors conclude that "[selenium therapy may be a beneficial treatment to decrease anxiety in HIV+ drug users who exhibit a high prevalence of psychological burden" (p. 56).

Adherence to Treatment

Tesoriero et al. (2003) conducted one baseline and two follow-up interviews with 435 individuals participating in one of New York State's HAART adherence support programs and found that, while at any of the three interviews, no more than 35% of these clients were nonadherent, 54% missed one or more doses in at least one of the three interviews. *This translates into a misclassification of between 19% and 28% of clients at each interview, since these clients were actually nonadherent when viewed longitudinally.* With this knowledge and

additional data analysis, the authors emphasize that

tracking adherence over time is necessary to more accurately assess the adherence-related behaviors of HIV-infected individuals. ... The periodic assessment of potential barriers to adherence (e.g., housing status, stress, drug and alcohol use) also appears important For at least some clients, it may be the instability in these factors, rather than simply their presence or absence, that contributes to nonadherence. If this is true, more detailed investigation into the factors affecting or producing instability in adherence barriers is needed; as the pathway to increasing client adherence may ultimately be an indirect one, requiring interventions aimed at increasing stability in the life factors that correlate with adherence.” (pp. 491-492)

Following up on an earlier cross-sectional study (Mellins et al., 2002), Mellins, Kang, Leu, Havens, and Chesney (2003) interviewed mothers living with HIV – 97 of 128 original study participants – eight to 18 months after their initial follow-up interview. “Supporting our baseline findings, this follow-up study found that HIV-infected mothers with poor mental health status at baseline were less likely to adhere to their medication regimens and medical appointments at the second follow-up. Also, participants with a current drug or alcohol abuse diagnosis at baseline were less likely to adhere to medications” (p. 413). As before, the authors stress the need to integrate mental health and substance abuse treatment into medical service delivery for women living with HIV to increase both access and adherence to the current standard of HIV care.

Within a sample of 48 perinatally HIV-infected children and their adult caregivers, Dolezal, Mellins, Brackis-Cott, and Abrams (2003) discerned a low level of concordance in reports of antiretroviral adherence, particularly in cases involving older children who assumed greater responsibility for managing their medications. The authors observe that “asking about adherence prob-

lems from both the child and the caregiver ... raises awareness for both about the proper medication regimen and potential barriers to adherence It also provides an opportunity to encourage the adult to

From the Block PROTOTYPES

PROTOTYPES, a non-profit organization established in 1986, assists approximately 10,000 women and their families each year through 24 community services locations throughout Southern California. Case management; substance abuse treatment (residential, outpatient, and day treatment); day treatment mental health services; HIV/AIDS education, prevention, outreach and intervention; child and adolescent services; domestic violence counseling; peer support; counseling/psychosocial support; childcare; housing assistance; thrift stores; and transportation are among the services provided.

PROTOTYPES/WomensLink, founded in 1994 and based in Inglewood, California, is a program designed by women for women living with HIV/AIDS in Los Angeles County. WomensLink operates as a consortium of PROTOTYPES, LA/USC County Hospital, the Southern California Women's Interagency HIV Study (WIHS), and Childrens Hospital Los Angeles. The target population includes Caribbean, African and African-American women as well as monolingual and bilingual Hispanic/Latina women. Ninety percent of the women served have a history of substance use; trauma histories and concurrent medical conditions (hepatitis C, diabetes, hypertension) are also common. The women are diverse with regard to sexual orientation and partner/family participation is encouraged.

PROTOTYPES/WomensLink gives women with HIV/AIDS access to the full array of PROTOTYPES services and provides linkage to, and support for, medical treatment for HIV. Under the current initiative, WomensLink is expanding its mental health program. Services include individual and group psychotherapy, psychiatric care, peer health advocacy, child mental health services, family strengthening, and spiritual counseling.

The Principal Investigator is Vivian B. Brown, Ph.D.; the Project Director is Annette “Chi” Hughes, M.S.W. For more information, please call 310/641-7795 or visit www.prototypes.org.

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monitor the child's adherence even in situations where the child has primary responsibility for taking his own medication” (p. 359).

Russell et al. (2003) interviewed 57 people living with HIV/AIDS regarding factors that affected their medication taking. Barriers to medication taking included perceptions, psychoemotional issues, provider or clinic issues, interpersonal factors, and factors related to disease and its treatment, while *facilitators* included motivation, routines, factors of faith, and the influence of others. Of note was the observation that participants who perceived themselves as adherent to their treatment regimen related many instances in which they were not. “An important question to ask patients on each encounter, then, is not if they take their medications, but rather how they take them” (p. 58), assert the authors. They recommend that clinicians make specific inquiries regarding adherence barriers for each individual client at each clinical encounter to work meaningfully to reduce or eliminate the influence of such barriers. They go on to say that “it is just as important for health care providers to inquire about the things that facilitate patients' medication taking as it is to ask about why they don't take their medicines. The simultaneous strengthening of specific facilitators, combined with the elimination of barriers, provides a patient-specific model for individualizing medication-taking practices and, ultimately, may lead to improved health care outcomes ...” (p. 58).

On the question of outcomes, Bangsberg et al. (2003) assessed drug resistance and antiretroviral adherence (the latter through unannounced pill counts) in 148 low-income individuals living with HIV in the inner-city and on stable therapy over a six-month period. While high levels of adherence were associated with treatment longevity and viral suppression, in a subset of 57 individuals who had difficulty achieving an undetectable viral load, new drug resistance was associated with treatment longevity *and* adherence based on pill count. Extrapolating from these findings, the authors estimate that 23% of all drug resistance at the population level occurs in the top fifth of adher-

ence rates (92% - 100%) and over 50% occurs in the top two-fifths of adherence rates (79 - 100%); "[t]he net effect at the population level is that a high proportion of drug resistance mutations are in patients with high levels of adherence. ... [Collective] findings suggest that the greatest risk for resistance is in patients with high levels of adherence and incomplete viral suppression, and this relationship is strongest for PI-based therapy" (pp. 1930-1931). The authors point out, however, that "levels of adherence too low to generate drug resistance are also too low to delay AIDS progression or death. Conversely, high levels of adherence, even with drug-resistant virus, will likely provide more clinical benefit than either low levels of adherence or no treatment. Consequently, the goal remains for patients and providers to strive for exceptional levels of adherence both to delay progression to AIDS and death and to achieve reliable and durable viral suppression in order to limit the development of drug resistance as much as possible" (p. 1931).

Serostatus Disclosure

Kalichman, DiMarco, Austin, Luke, and DiFonzo (2003) interviewed 331 men and women living with HIV – a sample of convenience – regarding HIV-status disclosure to friends and family and its relationship to social support. They found disclosure to be selective, with participants disclosing more often to friends than family and, within family, to mothers and sisters more than to fathers and brothers. Those who disclosed reported that they experienced greater social support within those relationships and, further, the authors noted that such social support may serve as a buffer against depressive symptoms. For these reasons, Kalichman and colleagues encourage clinicians to "assist people living with HIV-AIDS [to] reduc[e] disclosure-related stress, mak[e] effective disclosure decisions, and maximiz[e] the potential positive outcomes that can occur with HIV-status disclosure" (p. 331).

Coping, Social Support, & Quality of Life

Continuing on the topic of support, Schrimshaw (2003) studied a racially and ethnically diverse convenience sample of 146 women living with HIV in New York City

and found that

unsupportive interactions from family [had] a direct negative effect on depressive symptoms, regardless of the presence of unsupportive interactions from other sources. In contrast, unsupportive interactions from a lover/spouse and from friends ... interact[ed] with one another, such that the presence of high levels of unsupportive interactions from either single source or both sources was detrimental. ... [This] interaction demonstrates that the presence of either unsupportive friends *or* an unsupportive lover/spouse is sufficient for high levels of depressive symptoms[, though] the presence of high rates of unsupportive social interactions from both sources resulted in no appreciable difference in the level of depressive symptoms. (pp. 309-310)

Since any one source of unsupportive interactions is associated with depressive symptomatology, Schrimshaw recommends that clinicians "focus intervention efforts on all three relationship sources. At an individual level, therapeutic interventions with HIV-infected women may serve to help them cope with negative feelings evoked by unsupportive interactions, particularly from individuals close to them. Interventions may also serve to empower women to discuss their feelings with individuals who are unsupportive or ending these unsupportive relationships. ... Interventions with [social] network members may serve to address the reasons for their unsupportive behavior or provide skills on how to provide more effective support" (p. 311).

In an effort to identify women living with HIV who may be at risk for mental health and substance abuse problems, Sherbourne, Forge, Kung, Orlando, and Tucker (2003) analyzed data from 847 women within a nationally representative sample of 2,864 adults receiving HIV medical care in 1996. They found that 55% of these women presented with a probable psychiatric condition; risk factors included younger age, symptomatic HIV disease, the use of avoidant coping strategies, greater conflict with others, previous physical abuse, the

Tool Box

Comparing Cross-Sectional and Longitudinal Studies of HIV-Serodiscordant Mother-Child Dyads

Young, uninfected children of HIV-infected mothers have been the subject of numerous research studies. While most research to date has been cross-sectional, clinicians are now benefitting from longitudinal studies of these mother-child dyads. In some cases, longitudinal research bears out findings from cross-sectional investigations; in other cases, findings contrast and may alter clinical recommendations. A selection of recent findings and their clinical implications follow.

Are the Kids Alright?

Hough, Brumitt, Templin, Saltz, and Mood (2003) studied child psychosocial adjustment through surveys and interviews with 147 low-income, urban, primarily African-American mother-child dyads in which the mother was infected with HIV and her school-aged child was not. In order of importance, the factors found to affect the child's adjustment were: mother's HIV-associated symptom distress, mother's emotional distress, social support available to the child, the child's coping strategies, and the quality of the mother-child relationship. According to the authors, "in addition to ... assess[ing] both the mother's and child's need for ongoing social support, HIV-positive mothers and their children are in need of interventions that specifically address the development of effective coping skills. The mother's use of passive tension-reducing coping was found to have a deleterious effect on her level of emotional distress, which was a direct predictor of the child's psychosocial adjustment problems. [Also], the strong significant relation between maternal emotional distress and child psychosocial adjustment problems points to the need for comprehensive psychological assessment and treatment components in the care protocol of HIV-positive mothers" (p. 652).

These findings and recommendations are both extended and modified in important ways through a comparative, longitudinal study conducted by Forehand et al. (2002), who followed 51 HIV-positive mothers and their uninfected children (between the ages of six and 11 at baseline) and 124 HIV-negative mothers and

need for income assistance, and delaying personal medical care when caring for others. The authors recommend that clinicians: 1) initiate preventive mental health and sub-

their children over a four-year period. Across the four annual assessments conducted by the investigators comparing the former group with the latter: 1) the children of mothers living with HIV consistently reported more depressive symptoms; 2) children of HIV-infected mothers viewed the mother-child relationship as less warm and supportive during the first two assessments, while mothers in both groups reported no differences along this dimension; 3) a more positive mother-child relationship was associated with fewer child adjustment difficulties, although this held only when the reporter (mother or child) was the same on these two variables; and 4) in several analyses of maternal reports on the mother-child relationship, the relationship seemed to be *less* strongly associated with child adjustment among families with an HIV-positive mother than those with an HIV-negative mother. By and large, however, child adjustment was similar across the two groups and, here again, was associated with the mother-child relationship.

The major implications of this study are that children of HIV-infected mothers, relative to children living in the same neighborhoods but in families without maternal HIV infection, demonstrated more self-reported depressive symptoms across 4 years. Clinical interventions need to target these symptoms. Interventions for these families also should include a focus on parenting skills. Clinicians also need to be sensitive to the discrepancy in reports of children and parents about both child and parent behaviors. Finally, at least from the mother's perspective about problem behaviors, children are not functioning adaptively whether or not there is maternal HIV infection. Prevention and intervention efforts aimed at families of maternal HIV infection may falsely attribute child maladjustment to HIV alone, potentially missing other sources of stress and distress for children residing in high-risk environments. This suggests that psychosocial intervention with children of HIV-infected mothers must focus not only on difficulties associated with the infection but other stressors in the environments in which these families live, such as poverty, crime, violence, and drugs. (p. 598)

Disclosure and Its Aftermath

Contrasting with earlier cross-sectional studies suggesting that disclosure of maternal HIV sta-

stance abuse efforts at the first sign of symptomatic HIV disease (if such measures have not already been taken); 2) promote the use of more adaptive coping skills through struc-

ture did not appear to be associated with a negative impact on young children, Shaffer, Jones, Kotchick, Forehand, and the Family Health Project Research Group (2001) found that *mothers reported an increase in child behavioral problems and a decrease in the quality of the mother-child relationship following disclosure.* Their longitudinal study involved 99 inner-city African-American mothers living with HIV and one of their non-infected children between the ages of six and 11 at the time of recruitment. Interestingly, the children themselves did not report behavioral changes and indicated that they possessed greater understanding of HIV and AIDS following the disclosure. Should they elect to disclose, clinicians can help mothers living with HIV to prepare for disclosure to their children and support them through the process and its outcome.

A recent cross-sectional study echoes these findings. Pilowsky, Zybert, Hsieh, Vlahov, and Susser (2003) assessed 61 parents, primarily African-American, urban IDUs, and 79 HIV-negative children between the ages of six and 11 residing with them. Twenty-four parents were living with HIV, 10 with "apparent" infection (i.e., symptomatic disease and/or disclosure) and 14 who had not disclosed and were not experiencing medical symptoms. While the children as a group exhibited high rates of psychopathology, parental HIV infection did not appear to have a discernable impact on selected psychiatric diagnoses, competencies, or psychopathological syndromes. Children of participants with "apparent" HIV infection were, however, about eight times more likely to present with a disruptive behavior disorder than children of IDUs who were uninfected, while children whose parents were depressed (whether HIV-positive or negative) were three times more likely to present with a disruptive behavior disorder than children of parents who were not depressed. The authors conclude that "[p]arental HIV status per se does not seem to have a differential impact on the affected children. However, parental medical symptoms typically associated with HIV infection and disclosure may be associated with children's externalizing symptoms and disorders" (p. 955). They encourage clinicians to diagnose and treat depressive symptomatology in parents and facilitate access to additional supports as parents become more ill. Should parents start to appear ill or elect to disclose their HIV status, Pilowsky and colleagues en-

tured group training activities or cognitive-behavioral therapy; 3) screen women who present for care to identify any history of physical abuse; and 4) offer practical, fam-

ily-related services to ease caregiving burdens and promote access to care.

Take Mothers' Advice

On the subject of disclosure, Murphy, Roberts, and Hoffman (2003) interviewed 47 mothers who had self-disclosed their serostatus to their young child. While two-thirds did not regret this decision, regrets were identified in several areas, including preparing for the disclosure event, the timing and context of the event, what was shared and its outcome. The mothers offer the following advice to their peers who are contemplating serostatus disclosure to their young children: 1) carefully consider whether to disclose, attend a support group to prepare for disclosure, decide if it would be helpful to have a professional present to assist, and decide what you will say; 2) disclose when you are not ill and when other stressors are not unduly burdening the family; 3) do not disclose impulsively, when in a bad mood, or depressed and remain calm and matter-of-fact during the disclosure; 4) answer questions without shame or hesitation and reassure the child throughout the discussion; and 5) arrange follow-up support for the child if needed.

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ily-related services to ease caregiving burdens and promote access to care.

On the subject of families, Lester, Stein, and

Bursch (2003) followed 211 parents living with HIV and their adolescent children over a 12-month period and found that somatic symptoms in the teens persisted over time and occurred more often among female teens than male teens. Additionally, "(1) parental distress over pain predicted adolescent somatic symptoms at baseline and follow-up, (2) adolescents who experienced their parents as highly rejecting and uncaring were more likely to report somatic symptoms at follow-up, and (3) school problems, as well as parental rejection, were found to correlate with somatic symptoms at baseline but not at follow-up. ... These data support family-based prevention and treatment approaches targeting specific risk factors such as parent-child relational factors and school problems for adolescents with persistent somatic symptoms" (p. 248).

Italian investigators (Murri et al., 2003) observed 809 people living with HIV who were, for the most part, taking HAART, over a six-month period and found that stage of HIV disease, symptoms of HIV disease, a recent hospitalization, and satisfaction with information offered by health care providers regarding HIV disease and its treatment were key determinants of physical or mental health within this sample. Importantly, all of these factors that influence HRQoL are amenable to clinical intervention.

Sexual involvement contributes to quality of life for many individuals. And yet, Siegel and Schrimshaw (2003) conducted semi-structured interviews with 63 adults living with HIV who were between the ages of 50 and 68 and found that 48% were currently celibate or had chosen celibacy following their diagnosis with HIV, with women more frequently reporting celibacy than men (78% vs. 36%). While celibacy was linked to fear of reinfection or of infecting others across genders, women also reported losing interest in sex, feeling anger and distrust towards men, and feeling the desire to focus on themselves rather than on men; by contrast, men also reported fear of stigmatization or rejection, experiencing sexual performance difficulties, and harboring negative feelings about their aging bodies. Siegel and Schrimshaw conclude that "HIV-infected older adults may be in need of intervention

to reduce or more realistically evaluate their fears of sexual involvement. Intervention goals may include helping them recognize ways they can safely become sexually involved or more therapeutic intervention [may be required] to address and alleviate their feelings of victimization. In this way, HIV-infected adults ... may be able to reestablish the psychosexual facet of their lives and perhaps improve their overall quality of life" (p. 199).

Work also contributes to quality of life for many individuals. In Los Angeles, Martin, Brooks, Ortiz, and Veniegas (2003) surveyed 1,991 people living with HIV/AIDS regarding concerns related to workforce entry and found these concerns sorting into six factors: benefit-loss concerns, work-related health concerns, and concerns related to job skills, discrimination, personal health care, and accommodations in the workplace. In general, levels of concern increased with disease progression and the amount of time since last worked. Higher levels of work-related health concerns were associated with reduced frequency of considering workforce entry; as work-related health concerns and concerns related to the loss of disability benefits increased, so did the estimated time to entering the workforce. Martin and colleagues observe that concerns appear to shift as individual move toward workforce entry, suggesting that "[i]nterventions designed to assist people with HIV/AIDS in their workforce-entry decision-making process may need to be tailored to the state of decision making. Interventions targeted at [those] considering but not committed to efforts at workforce entry may need to emphasize assessment of work-related health concerns as they relate to the decision whether or not to return to work, whereas for those who are committed, emphasis may shift to dealing with potential disability benefits loss" (p. 190).

Life planning is clearly challenging in the context of illness uncertainty. Brashers et al. (2003) conducted focus groups with 33 people living with HIV or AIDS to examine the nature of HIV-related illness uncertainty and conclude that "[u]ncertainty in illness is a complex phenomenon that can be associated with stress and anxiety (or alterna-

tively, hope and optimism). People living with HIV experience medical, social, and personal forms of uncertainty. Mental health [providers] can assist with uncertainty management by providing information, helping patients to reappraise uncertainty [(moving from threat to hope)], or by providing medication to improve anxiety or depressive symptoms" (p. 518).

From the Block HACS

Houston Area Community Services, Inc. (HACS) is a minority, non-profit, community-based agency that provides health, social, and advocacy services to individuals and families in Houston, Texas and surrounding counties. Established in 1985 as a volunteer organization addressing the needs of HIV-infected and -affected communities within Houston, HACS is now Houston's largest minority HIV/AIDS prevention and care provider.

Families Under Urban and Social Attack (FUUSA) is a community-based organization founded in 1989 in response to the community's desire to address the escalating alcohol and drug problem in Houston's Third Ward. Under the current initiative, HACS, in partnership with FUUSA, has developed an Integrated Mental Health Practice and Care Treatment Program (IMPACT).

This mental health services expansion program is designed to address the needs of both African-American and Hispanic/Latino(a) persons living with HIV. Services are offered either in one of HACS' office locations (including the Joseph-Hines Clinic, which provides free outpatient medical services for people living with HIV/AIDS), through FUUSA's substance abuse program (which is adding a mental health component), or in a client's home. Individual, couple, and group therapy to work through issues related to living with HIV, support groups, and psychoeducational groups are among the services provided.

The Principal Investigator is Joe Fuentes, Jr.; the Clinical Director is Socorro Pasco, L.M.S.W. For more information, please call 713/526-0555 or visit www.hacstx.org.

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Expanding on this theme, Thompson (2003) conducted interviews with 12 gay men with AIDS who were experiencing significant

improvement in health and functioning in the context of HAART and concludes that "long term survival with AIDS requires an exceptional tolerance for ambiguity and an ability to reconstruct the future – skills which may co-vary with economic/career opportunities, social supports and individual resilience" (p. 87). He advises clinicians to: 1) acknowledge and empathize with fear and apprehension that go along with the many uncertainties of living on HAART and help clients to address affect engendered by uncertainty; 2) acknowledge and empathize with the challenges of adhering to HAART and address adherence difficulties through cognitive and behavioral techniques; 3) help clients to construct new narratives and re-think previous identities; 4) encourage the sharing of grief, clarify that grief generated by multiple losses is rarely resolved, promote grieving of the loss of an earlier self/level of functioning/lifestyle and set realistic goals while continuing these reconstructive efforts; and 5) assist clients to "re- confront" unresolved psychological issues that were set aside in the context of serious illness and impending death.

Lastly, Moskowitz (2003) prospectively studied a pre-HAART, San Francisco household probability sample of 407 gay men living with HIV and found that those who demonstrated higher cumulative average "positive affect" scores (with positive affect defined as "the frequency of a psychological state consisting of feeling just as good as other people, feeling hopeful, feeling happy, and enjoying life in the week before the data were collected" [p. 623]) had a lower risk of death from AIDS than those who had lower average positive affect scores, even when controlling for negative affect scores, laboratory measures of disease progression (e.g., CD4 cell count, serum β_2 -microglobulin, P24 antigen) and use of antiretrovirals or when predictors were "lagged" to rule out the possibility that positive affect was simply associated with better health. Moreover, it is the ability to sustain positive affect, *regardless of co-occurring levels of negative affect*, that appeared to be associated with greater longevity in the pre-HAART era. Moskowitz designates positive affect as the "active ingredient" associated with survival and, while taking pains

not to minimize the serious individual and societal sequelae of HIV infection, reasons that, "rather than focusing exclusively on reducing negative affect, interventions should also focus on increasing opportunities to experience positive affect ... even in the most dire stressful circumstances [or when] depression and distress are significantly elevated" (p. 624).

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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 literature reviews e-mailed by Florida International University researcher Robert Malow, Ph.D. Other sources

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of information are identified when appropriate.

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

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