

# mental health AIDS

A Quarterly Update from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) Volume 6, Issue 3 – Spring 2005

## Biopsychosocial Update

### HIV Prevention News

#### About Women

Do **hierarchical messages** (i.e., prevention options presented by decreasing order of effectiveness) offer women more choices without diminishing either their perception of the primary method's efficacy or their willingness to use it? To find out, Miller, Murphy, Clark, Hamburger, and Moore (2004) randomly assigned 112 African American and Mexican American women at risk for HIV to groups receiving one of two *onetime only* HIV prevention messages: "use male condoms"; or "use male condoms; if not, use female condoms; if not, use spermicide."

Compared with women in the male-condom-only condition, a significantly smaller percentage of women who received the hierarchical message perceived male condoms as highly effective against HIV. Women currently not using male condoms who received the hierarchical ... message were less likely to consider using male condoms in the future. Among current male condom users, however, the hierarchical message did not influence intent to use male condoms. These data point to the need [to examine] both the intended and unintended effects of hierarchical health care messages. (p. 509)

bakht (2004), who studied 155 African American, 153 European American, and 149 Latina women residing in Los Angeles County over a 2-year period, also urge careful examination by clinicians when responding to client need. HIV-positive women in their multi-ethnic sample (65% of the total) were more likely to report "more posttraumatic stress, chronic stress, negative health behaviors, drug use, and psychiatric history than HIV-negative women. European American and African American women were more likely to report a history of sexual trauma than Latina[s, and] history of trauma, ethnicity, drug and alcohol use, homelessness, and being HIV-positive were associated with greater likelihood of engaging in high-risk sexual behaviors, with history of trauma increasing the likelihood of engaging in [such] behaviors by 5.1%" (p. 405).

These results underscore the importance of considering multiple demographic and psychosocial risk factors in predicting and understanding the sources of variance in risky behaviors. They also suggest the need for tailoring sexual health programs to the unique needs of ethnic subgroup[s] of women who are impacted by [HIV]. This is particularly true for Latina and African American women who, despite sharing socioeconomic deprivation, appear to experi-

ence different risk pathways, with Latinas ... more likely to be infected within stable relationships, while the African American women were more socioeconomically marginalized and reported experiencing a heavier burden of early trauma. (p. 414)

With regard to early trauma, Wyatt et al. (2004) randomized a multi-ethnic sample of 147 women living with HIV to one of two conditions: an 11-session, "gender-specific, culturally congruent 'Enhanced Sexual Health Intervention (ESHI)' that was designed to reduce sexual risk and increase HIV medication adherence in HIV-positive women with histories of **childhood sexual abuse**" (CSA; p. 454) or an attention control condition. "This intervention integrated well-established components of sexual abuse treatment with successful elements of HIV interventions in both content and format" (p. 455) and was of-

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Paxton, Myers, Hall, and Javan-

ferred in both English and Spanish. In particular, “[t]he intervention offered cognitive strategies of sexual decision-making while managing symptoms associated with CSA (i.e., dissociation, depression, anxiety, and trauma symptoms) that are hypothesized as possible barriers to effective risk reduction” (p. 459). Wyatt and colleagues found that

[w]omen in the ESHI condition reported greater sexual risk reduction than women in the control condition. Although there were no differences between women in the ESHI and control groups on medication adherence, women in the ESHI condition who attended 8 or more sessions reported greater medication adherence at posttest than control women. The findings provide initial support for this culturally and gender-congruent psychoeducational intervention for HIV-positive women with CSA, and highlight the importance of addressing the effects of CSA on sexual risk reduction and medication adherence in preventive interventions for women. (p. 453)

In fact, by incorporating strategies to reduce victimization into HIV prevention interventions, clinicians may be able to help women apply new skill sets beyond the original

targeted behaviors. Theall, Sterk, and Elifson (2004) assessed **post-intervention victimization** among 333 female African American drug users who completed an HIV risk-reduction intervention. They found reductions in emotional, sexual, and physical abuse in the 6-month period following enrollment, particularly among women participating in the “enhanced” intervention. They observe that

culturally appropriate, woman-tailored, and theoretically based interventions may be effective at enhancing not only HIV preventive behavior among African American women who use illegal drugs, but also the likelihood of decreased victimization. Teaching women to stand up for themselves, to solve conflict, and to negotiate to achieve their goals should not be limited to main HIV risk behaviors such as unsafe drug use and sex. Instead, women should be encouraged to apply these skills to all aspects of their lives. (p. 406)

#### **About Men**

El-Bassel et al. (2004) analyzed data from a random sample of 322 men attending a methadone maintenance treatment program and found couple drug involvement to be directly related to **male psychological dominance** (i.e., “psycho-

logical maltreatment of women by their male partners in intimate relationships” [p. 433]) and sexual HIV risk behavior. Male psychological dominance was also found to be directly related to physical intimate partner violence (IPV) and sexual HIV risk behavior. Among their recommendations, El-Bassel and colleagues reason that establishing a nonjudgmental, trusting atmosphere will enable drug-involved men “to discuss sensitive issues related to how relationship power dynamics affect their control over when drug use and sex occur and whether or not condoms are used. ... HIV ... prevention strategies need to help men and their sexual partners raise awareness of how their process of sexual decision-making leads to unsafe sex, helping them to identify how power imbalances in their relationship and their drug-involvement as a couple [contribute] to unprotected encounters” (pp. 437-438).

#### **About Men Who Have Sex With Men**

In Puerto Rico, Toro-Alfonso and Rodríguez-Madera (2004) surveyed a convenience sample of 302 gay men, 49% of whom reported that they had a steady relationship partner. Many respondents reported **violence in their relationships** (48% reported emotional violence, 26% physical violence, 27% sexual violence), and there was “a positive correlation between being anally penetrated without a condom, the need to please the partner, and being HIV positive” (p. 47). The authors suggest that “the manner in which violence is constructed and perceived in men may be related to vulnerability for violence and possibly HIV infection” (p. 47). Consequently, “[i]nterventions for domestic violence among gay men and men who have sex with men [MSM] should ... [be] addressing issues of power, examining intergenerational violence

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and problem-solving skills. Interpersonal and structural obstacles for the development of healthy relationships should be carefully considered and include[d] in all prevention interventions ...” (p. 55).

Denning and Camp smith (2005) analyzed multistate interview data from a diverse sample of 970 HIV-positive MSM who had a single steady male sex partner with negative or unknown serostatus. They found that 278 (29%) reported unprotected anal intercourse (UAI) in the year prior to the interview. While the vast majority of men reduced their sexual risk behavior following an HIV-positive test result, among the 674 men in the total sample who knew their positive serostatus for the full year before their interview, 144 (21%) had UAI. In this latter group, factors associated with UAI were heterosexual self-identification, use of crack cocaine, no education after high school, and having a partner with unknown serostatus. According to Denning and Camp smith, these findings underscore the need to incorporate prevention activities

into all health services that HIV-positive MSM routinely receive, such as primary care, case management, mental health counseling, and substance abuse treatment. ... Prevention programs should also help HIV-positive MSM develop the communication skills needed to disclose their HIV serostatus to their partner and to negotiate safe[r] sex with him. In addition, interventions should emphasize the importance of counseling and voluntary HIV testing for an HIV-positive man’s steady sex partner. MSM who have lower educational levels or who identify as heterosexual require more intensive prevention outreach and intervention. This is true for some racial/ethnic mi-

nority MSM as well. Although race and ethnicity were not independent predictors of UAI in our study population, the factors found to be predictive of UAI were much more prevalent among Black, Hispanic, and American Indian/Alaska Native men. (p. 156)

To learn more about disclosure practices, Gorbach et al. (2004) interviewed 55 MSM living with HIV (24 in Seattle, 31 in Los Angeles) who attended a sexually transmitted disease (STD) clinic and reported either a recent STD or UAI with a partner whose serostatus is negative or unknown. They found that “disclosing one’s HIV status to sexual partners is complicated and dependent on multiple and often competing emotional, situational, and legal factors; consequently few men ... had a consistent pattern of disclosing. The themes identified suggest ... avenues for potential intervention, but also illustrate how complex **promoting disclosure** is likely to be among MSM” (p. 516). Regarding disclosure,

o Those who were “unlikely to disclose” saw HIV as “nobody’s business,” were in denial about their own HIV status, had a low viral load, feared rejection by HIV-negative partners, saw sex as “just sex,” used drugs, and had sex in public places.

o Those who “might disclose” considered the type of sex that was practiced and whether partners asked about serostatus or disclosed first.

o Those who were “likely to disclose” had feelings for their partner, felt responsibility for their partner’s health, and feared legal prosecution if they did not disclose and their partner became infected.

It should be noted that many re-

ported the use of nonverbal or indirect disclosure methods (e.g., leaving HIV medications where a partner could see them; sporting tattoos with a “+” symbol). Also important was men’s subscribing to the “don’t ask, don’t tell” doctrine (i.e., placing responsibility on the partner to inquire about HIV status and presuming that those who do not ask must also be positive).

Gorbach and colleagues conclude that “HIV positive MSM’s decision to disclose their HIV status to sex partners is ... influenced by a sense of responsibility to partners, acceptance of being HIV positive, the perceived transmission risk, and the context and meaning of sex. Efforts to promote disclosure will need to address these complex issues” (p. 512).

Expanding on this complexity, van Kesteren, Hospers, Kok, and van Empelen (2005) summarize interviews conducted with 30 Dutch gay men living with HIV in an effort to understand more about their **perspectives on sexuality and sexual risk behavior**. They found that most of their sample engaged in less sexual activity following HIV diagnosis for several reasons.

First, most [men] struggled with the altered meaning and consequences of unprotected sex. Whereas unprotected sex before diagnosis was directly related to risks to their own health, after diagnosis unprotected sex is mainly associated with the risk of transmitting the virus during sexual intercourse. This realization diminished the enjoyment of sex for most [men] and left them feeling anxious and tense. Second, many ... suffered from sexual problems because of physical complaints brought on by the treatment regime or HIV itself. Third,

*(Biopsychosocial Update is continued on Page 6)*

## **Tool Box**

### **Addressing Historical Trauma Among African Americans as an HIV Intervention**

Klonoff and Landrine (1999) conducted a door-to-door written survey involving 520 black adults in 10 randomly selected middle- and working-class census tracts in San Bernardino County, California. Nearly 27% of respondents agreed with the statement, "HIV/AIDS is a man-made virus that the federal government made to kill and wipe out black people." An additional 23% of respondents were undecided about this statement. Importantly, endorsement of this belief was unrelated to age or income, but was associated with higher levels of education. "Blacks who agreed that AIDS is a conspiracy against them tended to be culturally traditional, college-educated men who had experienced considerable racial discrimination" (p. 451).

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*"During 2000-2003, more than half of new HIV/AIDS diagnoses in 32 states were among blacks, although blacks represented only 13% of the population of those states."*

— Centers for Disease Control and Prevention, 2005, p. 89

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More recently, Bogart and Thorburn (2005) conducted a telephone survey regarding HIV/AIDS conspiracy beliefs and their relation to condom attitudes and behaviors with a random national sample of 500 African Americans between the ages of 15 and 44. The HIV/AIDS conspiracy beliefs presented to respondents were based on earlier research studies. A selection of these beliefs follows:

- o A lot of information about AIDS is being held back from the public. (58.8% of respondents agreed "somewhat" or "strongly")
- o There is a cure for AIDS, but it is being withheld from the poor. (53.4%)
- o HIV is a man-made virus. (48.2%)
- o People who take the new medicines for HIV are human guinea pigs for the government. (43.6%)

- o The government is telling the truth about AIDS. (37.0% overall; 31.6% among male respondents)<sup>1</sup>

- o AIDS was produced in a government laboratory. (26.6% overall; 30.5% among male respondents)

- o AIDS was created by the government to control the black population. (16.2%)

- o AIDS is a form of genocide against blacks. (15.2% overall; 20.7% among male respondents)

- o HIV was created and spread by the CIA. (12.0% overall; 16.1% among male respondents)

- o The medicine that doctors prescribe to treat HIV is poison. (6.8% overall; 8.6% among male respondents)

- o The medicine used to treat HIV causes people to get AIDS. (6.0%)

- o Doctors put HIV into condoms. (1.6% overall; 4.0% among male respondents)

Consistent with prior research, these investigators found that "between 1% and 60% of the respondents endorsed specific conspiracy beliefs about HIV/AIDS. Few respondents endorsed the most extreme beliefs, such as 'Doctors put HIV into condoms.' The greatest proportion of respondents endorsed beliefs about the government's role in withholding a cure for AIDS or information about the disease itself" (p. 216).

Findings further suggest that HIV/AIDS conspiracy beliefs may act as a barrier to HIV prevention, particularly among black men. "Men held stronger conspiracy beliefs than did women, and endorsement of conspiracy beliefs was associated with more negative attitudes toward using condoms and less consistent condom use among men but not among women" (p. 217).

Given the highly disproportionate impact of HIV on the black community, these beliefs bear further examination

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<sup>1</sup> All differences noted for male respondents were statistically significant.

both from the historical perspective as well as the psychological.

### **The Shadow of Tuskegee**

The government-sponsored Tuskegee Syphilis Study was conducted between 1932 and 1972. Over this 40-year period, 399 African American men from Macon County, Alabama, were denied effective treatment for syphilis for the purpose of documenting the natural history of the disease. It is "the longest nontherapeutic experiment on human beings in medical history" (Thomas & Quinn, 1991, p. 1498).

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*"Conspiratorial theories are particularly endemic in Black America. These theories are historically embedded and often stem from persistent mistreatment and inequality, beginning with the institution and practice of slavery."*

— Parsons, Simmons, Shinhoster, & Kilburn, 1999, p. 216

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Not surprisingly, "[t]he Tuskegee Syphilis Study continues to cast its shadow over the lives of African Americans. For many Black people, it has come to represent the racism that pervades American institutions and the disdain in which Black lives are often held" (Gamble, 1997, p. 1777). Conspiracy beliefs about HIV/AIDS are rooted in this social and historical context.

### **Transgenerational**

#### **Transmission of Trauma and Grief**

In their pioneering studies involving American Indians, Brave Heart and DeBruyn (1998) describe the monumental losses of life, land, and culture experienced by peoples native to the Americas as a result of European contact and colonization. They contend that descendants of these native peoples, in response to these losses, suffer from historical unresolved grief. "Like children of Jewish Holocaust survivors, subsequent generations of American Indians also have a pervasive sense of pain from what happened to their ancestors and incomplete mourning of those losses" (p. 68). Compounding this legacy,

[p]resent generations of American Indians face repeated traumatic losses of relatives and community members through alcohol-related

accidents, homicide, and suicide. Domestic violence and child abuse are major concerns among American Indian communities throughout the country. Many times deaths occur frequently, leaving people numb from the last loss as they face the most recent one. These layers of present losses in addition to the major traumas of the past fuel the anguish, psychological numbing, and destructive coping mechanisms related to disenfranchised grief and historical trauma. (pp. 68-69)

What are the theoretical frameworks used to explain transgenerational transmission? Brave Heart and DeBruyn contend that self-destructive behaviors in historically traumatized peoples are reflective of "internalized aggression, internalized oppression, and unresolved grief and trauma" (p. 70). The aggression and oppression are, in turn, acted out against the self and others like the self (i.e., fellow group members).

Brave Heart and DeBruyn also point to the concept of "identification with the aggressor." Through this identification, the individual "incorporates the harshness of the aggressive authority figure, which may be projected onto others with ensuing hostility" (p. 70). As Brave Heart and DeBruyn see it, "the high rates of depression ..., suicide, homicide, domestic violence, and child abuse among American Indians can ... be attributed to these processes of internalized oppression and identification with the aggressor induced by historical forces ..." (p. 70).

*"Many ... have suggested that blacks have developed a profound distrust of whites in response to ... racism and that such distrust is purposefully taught to successive generations ... and so ... may have important implications for black health. Others have speculated that such racism has led blacks to be particularly distrustful of AIDS-related information and interventions ..."*

— Klonoff & Landrine, 1999, p. 451

Referencing the African American experience, Apprey (1999) reaches a similar psychoanalytic conclusion regarding what he describes as *transgenerational haunting*, defined as "the

transfer of destructive aggression from one generation to the next. In such a transfer we may witness a shift from suicide in one generation, murder in the next, followed by, let us say incest or physical abuse in a subsequent generation, and so on and so forth. It is as if the injured group has accepted the message that they do not deserve to live and therefore must die by one form or another. ... Here the [trajectory] toward one's death remains the same but ... the form of reducing oneself to nothingness, changes from one generation to the next" (p. 134).

While theoretical in nature, the concepts of historical trauma and historical unresolved grief have recently received preliminary empirical support (Whitbeck, Adams, Hoyt, & Chen, 2004) and will surely be topics of continuing inquiry.

*"Healing takes on many dimensions. The body, mind, spirit, and relationships to one's family and community are all involved in the healing process. Healing in one dimension is incomplete without the others. Integration of positive, healthy habits into daily patterns of life should be the ultimate goal."*

— Tully, 1999, p. 42

### **"Overturning the Received 'Poison' of History"**<sup>2</sup>

Perspectives on the therapeutic induction of a healing process are, for the most part, consistent across writers in this field.

Bogart and Thorburn stress the importance of bringing conspiracy beliefs out into the open when conducting HIV prevention interventions.

Based on the large number of individuals who endorsed HIV/AIDS conspiracy beliefs ..., it is important for ... practitioners to integrate such beliefs into safer sex education messages targeting African Americans, especially black men . ... Further, to the extent that conspiracy beliefs stem from general mistrust of the US government and health care system, interventions that encourage frank dialogue about conspiracy beliefs in the context of historical and current racial

<sup>2</sup> Apprey, 1999, p. 139

discrimination may have the greatest prospect for success. ... In this way, we can begin to overcome barriers, such as conspiracy beliefs, that are obstacles to the ready acceptance of prevention messages and the subsequent practice of safer sexual behaviors. (p. 218)

Building on these recommendations, Apprey suggests that "[i]n working with aggrieved communities and pooled communal memories that continue to have destructive impact on the present, a description of shared communal injury must include: a) *the fact of historical injury*; b) the *potential for transformation* of that history; and c) a constant reminder that each person, family, or ethnic group must know *the motivation behind the historical injury* caused by the transgressor" (p. 135).

If clinicians emphasize only the urgency of remembering history, ... patients ... only get more angry. There is, as it were, a repeat of the experience of history in affective form. If clinicians only emphasize the will to change and bypass history, ... clients ... experience a sense of woundedness once again. They hear the voice of the transgressor saying that their history of devastation does not matter. However, by considering the wounds of the living, as it were, together with the will and responsibility to transform the received injury, one gets to transform the toxic ... into [the] positive ... (p. 136)

In his view, just as destructive aggression can be transmitted transgenerationally,

[t]here is the potential to transform structures of behavior transgenerationally. In the creative arts and expressive therapies, various opportunities for dramatizing and transforming the storied texts of trauma exist.

In art therapy, narrative of who one is, where one is, and where one sees oneself as going in life

(Tool Box is continued on Page 6)

some [men] reported that sexual problems were related to negative feelings about their physical appearance ... . Personal HIV-related risk seemed to play a less important role in sexual problems ... . Although most were aware of the risk of HIV superinfection and STDs for their own health, only half ... reported that they were motivated to practice safer sex to protect themselves. (p. 162)

van Kesteren and colleagues go on to observe that "the majority of participants ... felt responsible for the health of their sex partners. It seemed that both moral concerns ('unprotected sex is wrong') and social concerns (avoidance of

blame by others) played a key role in their resolve to practice safer sex with both steady and casual or anonymous sex partners. Only a small minority ... claimed to take no personal responsibility for safer sex and reported that engaging in safer sex practices depended on what a sex partner wanted" (p. 162).

Importantly, while most men articulated a sense of personal responsibility to engage in safer sex, contextual factors seem to influence the consistency of their actual sexual behavior. These included:

- o Partner type, with men feeling less personal responsibility for safer sex with casual or anonymous partners who are "aware of

the risks they might be taking" (p. 163) or with a seroconcordant partner, either steady or casual;

- o Perception of the partner's behavior (i.e., feeling less responsibility toward partners who do not initiate condom use or exert pressure for unprotected sex); and

- o Partner characteristics, with partner attractiveness enhancing feelings of responsibility and partner similarity in appearance and background diluting feelings of responsibility.

van Kesteren and colleagues offer these recommendations to clinicians serving MSM living with HIV:

First, because many [men]

can be the subject of drawing, painting and sculpting. Various degrees of transformation are potentially there to be grasped and negotiated.

In dance therapy, a clinician can explore with a client where in one's body the traumatic pain is stored ... .

In psychodrama and/or in drama therapy, life themes can be portrayed, staged, enacted, extended and transformed in the context of negotiating how one can be both separate from and yoked to one's family.

Horticultural therapies can use plants to indicate how one plant gives life to another. (pp. 139-140)

Turning to more traditional forms of talking therapy, Apprey has this to say:

There are many clinical methods for understanding and transforming the impact of historical trauma and reinventing the self in the clinical process. However the approach advocated here requires that regardless of what clinical

method of intervention is chosen, a particular strand must run through the process of treatment to [produce] durable and meaningful change. This strand ... includes understanding ... the way that particular suffering is memorialized by the victimized group and subsequently reenacted by generations to come. In technical terms there must first be many profiles of understanding of the historical injury. Then there must be an understanding of how the aggrieved community has stored in [its] communal memory those psychological hurts, those feelings of humiliation and changing historical accounts of the actual injuries. Subsequently those sedimentations of historical grievances are enacted within the transference in the clinical situation where the grievances are not only staged, but re-staged, distorted or extended. Then comes the most decisive obligation the clinician has towards the ... client or community that is attempting to transform itself. That ... obligation is to ... constantly engag[e] the mandate to die or destroy oneself in order to find new and more flexible forms of adaptation. In short, to know death is to put it back where it belongs in history as well as knowing how victims

may unconsciously house so much bitterness that they may uncannily carry out their own extinction without knowing it and without the assistance of their historical enemy. (p. 140)

Focusing as well on modifying destructive patterns, Tully (1999) references the work of Judith Herman (1992), positing that "since the core experience of trauma is disempowerment and disconnection, recovery is based upon reconnection to one's own power and to the fellowship of others ..." (p. 31). She goes on to identify components of African American culture that buffer the effects of trauma and support healing. These include:

- o Religious faith and/or deep spirituality, which offer connection to "a powerful identity" (e.g., God, Allah) and, ultimately, reconnection to the power within;

- o The communication of ideas, feelings, and social commentary through music (e.g., "the blues," rap, hip-hop) and storytelling (in forms that range from humorous to hard-hitting), inventions that repeat and allow others to bear witness to oppression but also serve to reframe trauma stories, rendering them more manageable; and

reported sexual problems after diagnosis with HIV, it is crucial that HIV-preventive interventions for HIV-positive MSM not only target the health-promoting behavior of using a condom every time during anal intercourse but also address ... sexual dysfunction in HIV-positive MSM ... Moreover, HIV prevention programs should include clear and specific information about ... the risk of HIV superinfection and the relationship between undetectable viral load and HIV transmissibility. Failure to meet the information needs of HIV-positive MSM might result in continued confusion about HIV-related risk and might lead some people to discount the relevance of preven-

tion messages ... In addition, specific attention should be paid to the issue of personal responsibility for safer sex. ... It seems essential to enhance skills and self-efficacy to handle risk pressure and to negotiate condom use by means of, for example, instruction and modeling ... A possible way to address sexuality and safer sexual behavior in practice [is] brief counseling techniques that have been effective in improving sexual functioning in cancer patients. Typically those interventions focus on (a) assessing sexual problems; (b) providing information on the impact of the illness on sexual drive, behavior, body functioning, and body image; and (c) giving reassurance to

the participant (and his partner), improving their communication and finding alternative ways of expressing affection ... The techniques of motivational interviewing ... can [also] be useful to target safer sexual practices of HIV-positive MSM.

[Additionally, s]timulating the development of social networks by encouraging helpful relationships that enhance safer sex norms might be a very powerful tool in promoting safer sexual behavior ... (pp. 164-165)

Lightfoot, Song, Rotheram-Borus, and Newman (2005) assessed the influence of partner characteristics and risk status on sexual behavior among 217 young MSM receiving

o Dedication to family and to the community, through which members experience support and commonality.

In Tully's words, "[t]he beauty, complexity, and variety in African American experiences and cultural forms are a treasure. Understanding these elements and incorporating them into interventions may provide a means to create a meaningful, healing connection. These cultural forms are evidence of the many ways people have sought to claim their right to live fully. Helping professionals can facilitate the unique processes that individuals and communities make for themselves to address their problems" (p. 39).

Speaking to the centrality of community, the underlying premise in Brave Heart and DeBruyn's healing model "rests on the importance of extended kin networks which support identity formation, a sense of belonging, recognition of a shared history, and survival of the group" (p. 70).

Similarly, Stephens et al. (1997) urge clinicians to "[e]mphasize the benefit that risk-reduction practices have for the community" (p. 86). "For the group or individual counselor, ... positive results may be obtained if health promotion and maintenance through

safer sex practices can be used to give African American males health alternatives, reduce stress, and support individual decision making. Paying strict attention to ... the importance of linking HIV/AIDS prevention as a form of giving back to the community, may instill the importance of health care and HIV prevention among this group" (pp. 87-88).

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HIV care in New York, Los Angeles, Miami, or San Francisco. Of these young men, 62% reported multiple partners during the preceding 3 months and 34% engaged in unprotected sex during the same period. The investigators found that study participants generally decide whether to use a condom on the basis of their perception of their partner's risk for infection (i.e., they practice safer sex with partners not known to be HIV-positive and do not use condoms with partners they believe to be infected). A similar decision-making process was noted among the 26% of study participants with only one sexual partner, 28% of whom engaged in unprotected sex. These findings concern the authors, "because it is questionable whether the youth can truly know a partner's risk or HIV status or rely on a regular partner to be monogamous. Furthermore, these young men are putting themselves at significant risk for infection with an STD, which could have detrimental effects on their own disease progression" (p. 67).

Lightfoot and colleagues contend that interventions targeting young MSM living with HIV "need to focus on techniques of acquiring information from sexual partners to make a more informed decision [regarding condom use]. Interventions should also reinforce the altruism that [these men] feel toward protecting their partners. Consequently, there is a need to develop prevention strategies that involve couple-oriented and social network models" (p. 67). For those having unprotected sex with seroconcordant partners, "interventions ... must include education about transmission risk for STDs and the detrimental impact of other STDs on their own disease progression" (p. 67). The authors conclude that, "although these young men continue to have unprotected sex, they are making important decisions to

protect themselves and others. Prevention programs must focus on promoting good decisions" (p. 67).

This advice extends to **negotiated safety** (NS), investigated by Guzman et al. (2005) in their survey of a diverse community sample of 340 HIV-negative MSM in San Francisco. "NS relationships were defined as those in which HIV-negative men were in seroconcordant primary relationships for > 6 months, had [UAI] together, and had rules prohibiting [UAI] with others. Adherence to NS was determined from self-reported sexual behavior in the prior 3 months. Presence of an agreement with NS partners to disclose rule breaking was also determined" (p. 82). Within this sample, Guzman and colleagues found that 22% of men were engaged in a seroconcordant primary relationship of at least 6 months' duration. Of this group, 50% had a relationship including NS; 39% had no UAI with primary partners; and 11% engaged in UAI with primary partners, but had no rules proscribing UAI with other men. Among the 38 men in an NS relationship, "29% violated their NS-defining rule in the prior 3 months, including 18% who reported [UAI] with others, and 18% reported [an STD] in the prior year. Only 61% of NS men adhered fully to rules and agreed to disclose rule breaking" (p. 82).

Guzman and colleagues conclude that, "[a]lthough NS was commonly practiced among HIV-negative men in seroconcordant relationships, some men violated NS-defining rules, placing themselves and potentially their primary partners at risk for HIV infection. Prevention efforts regarding NS should emphasize the importance of agreement adherence, disclosure of rule breaking, and routine [STD] testing" (p. 82). They further concede

that "[u]ntil further data are collected from studies of US MSM regarding their NS relationships, including factors associated with agreement rule breaking, caution should be used in endorsing NS as an alternative risk reduction strategy to condom use for US HIV-negative men in seroconcordant relationships" (p. 85).

Finally, Huebner, Rebchook, and Kegeles (2004) surveyed a convenience sample of 538 young adult gay and bisexual men who were HIV-negative or untested and not engaged in monogamous relationships at baseline, and surveyed them again 18 months later. "In the cross-sectional data, **treatment optimism** [about highly active antiretroviral therapy (HAART)] was associated with the 2-month cumulative incidence of [UAI] with non-primary partners; however, this effect was observed only among men who felt highly susceptible to HIV infection. Longitudinal analyses revealed that treatment optimism did not predict subsequent UAI, but UAI did predict later treatment optimism" (p. 1514). The authors conclude from their findings that "although risk and treatment optimism are related, the association may be more complex than previously thought. Whereas some prior research has implied that optimism drives subsequent risky sexual behavior, [these] data indicate that optimism is just as likely to follow from past risk behavior" (p. 1518).

#### **About Women & Men**

Exploring gender differences in HIV risk behavior, Kenagy and Hsieh (2005) analyzed survey data from 122 **male-to-female** (MTF) **transgenders** and 62 female-to-male (FTM) transgenders. Notably, "[c]ompared to MTFs, FTMs were significantly less likely to have used protection the last time they had sex and significantly more like-

ly to have engaged in recent high risk sexual activity. The gender difference existed even after controlling for demographic variables, AIDS knowledge, perceived AIDS knowledge, perceived effectiveness of condom usage, perceived susceptibility to AIDS and self-esteem” (p. 195). Acknowledging that the generalizability of these findings is limited because of the sampling techniques involved and the oversimplification of gender identity into only two categories, Kenagy and Hsieh nonetheless urge clinicians to assess sexual activities thoroughly to identify HIV risk behaviors, review safer sexual practices, and encourage HIV testing among FTM transgenders so that informed decisions regarding sexual activities can be made.

#### **About Adolescents**

Kowal and Blinn-Pike (2004) surveyed 297 Midwestern high school students with an **older biological sibling** under the age of 30. They found that “when sibling discussions about safe[r] sex practices take place in concert with parent-adolescent conversations about sex, adolescents reported less risky attitudes about appropriate sexual behavior for people their age and higher levels of self-efficacy for communicating with partners about condom use and for buying and using condoms. [They] did not find similar results with regard to adolescents’ perceived ability to refuse sex” (p. 382). Kowal and Blinn-Pike also note that “sibling discussions about sex were more likely to occur when adolescents report positive relationships with their older siblings. ... Further, [they] found that when sibling relationship quality was relatively high, discussions about sex were equally likely to take place *regardless of whether adolescents perceived their older siblings to have risky or conservative sexual attitudes* [italics added]” (p. 382).

Turning to intervention, the authors observe that

younger siblings may learn from their older siblings that it is appropriate and important to talk to parents about sex. Older siblings also may help parents begin and sustain conversations with adolescents about safe[r] sex practices and educate parents about appropriate terminology. Older siblings are in the unique position of being able to explain to parents the sexual situations that their younger siblings are likely to encounter and the potential barriers to safe[r] sex practices that they may experience. Parents who are more aware of the realistic problems and issues their children face are better able to provide them with pertinent and timely information. (p. 383)

Kowal and Blinn-Pike further observe that “older siblings who care about their younger siblings may provide them with information about safe[r] sex practices regardless of their own views about the importance of safe[r] sex for adolescents in general” (p. 383). With sibling relationship quality appearing to serve a protective function, the authors encourage clinicians to provide caring older siblings “with tools and information about how to protect their brothers and sisters from potential risk” (p. 383) and to integrate older siblings into existing programs focused on adolescent’s responsible sexual behavior, “so they too learn about their important role in the development of their younger siblings’ attitudes about and self-efficacy for safe[r] sex practices” (p. 383).

Psychiatric care can also serve a protective function. Brown, Houck, Hadley, and Lescano (2005) studied 293 adolescents receiving intensive psychiatric treatment.

They found that “being female, being Caucasian, having been sexually abused, and reporting less impulse control were predictive of **self-cutting**. Further analysis found that those who self-cut were three and a half times more likely to report infrequent condom use than those who did not self-cut, even after the analysis controlled for sexual abuse history and HIV prevention self-efficacy” (p. 216). These investigators go on to observe that “[s]elf-cutting frequently raises clinicians’ concerns about a patient’s potential for suicidal behavior and drug use. However, the strong relationship between self-cutting and sexual risk behavior observed in this study suggests that treatment providers must consider a range of risk behaviors in treatment planning, recognizing that impulsivity and affect dysregulation may take many forms. Self-cutters appear particularly vulnerable to harm given the association with impulsivity, hopelessness, and sexual risk behavior” (p. 218). For this reason, Brown and colleagues encourage clinicians to assess sexual risk behaviors carefully among teens who engage in self-cutting.

#### **About Substance Users**

Kalichman and Cain (2004) studied a convenience sample of 453 STD clinic attendees (313 men, 140 women) over a 6-month period and found that, for men, **sensation seeking** (i.e., the inclination to seek optimal stimulation and take behavioral risks) predicted unprotected intercourse 6 months later. “Sensation seeking also predicted **alcohol outcome expectancies** [i.e., the expectation that the sexual experience would be enhanced by drinking alcohol], which predicted alcohol use in sexual contexts 6 months later, which in turn predicted unprotected sex” (p. 367). Kalichman and Cain further determined that alcohol outcome expect-

tancies mediated the relationship between sensation seeking and alcohol use in sexual contexts. Importantly, "[t]hese findings replicate previous research, with the prospective design confirming directional hypotheses and supporting causal conclusions" (p. 367). Noting several methodological limitations, the authors still suggest that this study

supports the conclusion that alcohol outcome expectancies serve as a cognitive mechanism through which sensation seeking influences sexual risk-related alcohol use. Unlike sensation seeking and other personality dispositions, alcohol expectancies may be amenable to change, therefore offering a potential inroad into behavioral intervention. ... Cognitive and motivational counseling approaches ... include cognitive-restructuring strategies that can address expectancies that alcohol enhances sexual outcomes. Effective counseling for risk-related alcohol use can be integrated into existing counseling services offered by ... mental health clinics. (p. 372)

In another study focusing on alcohol use, Matos et al. (2004) explored the association between **alcohol intoxication** and HIV risk behaviors in 557 street-recruited heroin and cocaine injecting drug users (IDUs) from "semi-rural" areas of Puerto Rico. "Findings ... suggest that, among drug injectors, the association between alcohol intoxication and both injection and sexual risk behaviors is straightforward" (p. 233); after adjustment, specific risk factors include sharing needles, sharing cotton, engaging in sex with a casual or paying partner, and trading sex for money or drugs. While these findings diverge from those of earlier studies involving different cohorts of IDUs, Matos

and colleagues reason that "HIV prevention programs, to be effective, must address alcohol intoxication and its relation to injection and sexual risk behaviors as a central issue in HIV prevention among drug injectors" (p. 229).

Williams and Latkin (2005) interviewed a community sample of 332 current and former drug users from inner-city Baltimore on three occasions between 1997 and 2002 and found that high levels of **depressive symptoms** appeared to be *causally related* to sexual activity with multiple partners, as well as engaging in sex with IDUs and crack users. "Results suggest that depressive symptoms are a major contributing factor to sexual risk behavior, and therefore, at minimum, depression should be assessed [by clinicians]. ... The stress of high crime and poor living conditions may also contribute to depressive symptoms" (pp. 72-73).

On this point, Latkin, Williams, Wang, and Curry (2005) surveyed 701 IDUs from the same community (95% African American, 66% male, 21% HIV-positive) and found, *among men only*, that "psychological distress is higher in more **socially disordered neighborhoods**, that distress leads to greater injection frequency and equipment sharing, and that injection frequency predicts equipment sharing" (p. 96). Latkin and colleagues stress that "[d]epressive symptoms could be targeted for interventions; however, without reducing the neighborhood stressors it is doubtful that this would be a sustainable approach" (p. 99).

Extending their line of research on methamphetamine (meth) users, Semple, Patterson, and Grant (2004) explored condom use "stage of change" in a sample of 181 HIV-negative, **heterosexual meth users**: 89 in the contempla-

tion stage of change and 92 in the preparation stage of change.<sup>1,2</sup> They report that

[s]exual risk behavior was highest among those in the contemplation stage of change. When compared with those in the preparation stage of change, contemplators were more likely to be never married, more likely to have an STD, consumed larger amounts of meth and other illicit drugs, had lower scores on self-efficacy and outcome expectancies for condom use and negotiation of safer sex practices, and had less positive social norms in relation to AIDS preventive behaviors. ... [In contrast,] the preparation stage of change was associated with increased self-efficacy for condom use, stronger social norms regarding condom use, and reduced occurrence of [STDs]. (p. 391)

Observing these differences between groups, Semple and colleagues point to factors "that appear to be important in terms of helping meth users, who are in the early stages of change, to adopt condom use behaviors" (p. 399).

[T]he main goal of counseling in the contemplative stage of change focuses on helping the

<sup>1</sup> "The contemplation stage is apparent when the individual shows awareness that a true problem exists. At this stage, the individual begins to think about change but has not yet made a commitment to overcome his/her problem behavior. The contemplation stage is characterized by ambivalence toward change. ... In the preparation stage of change, motivation to change is high, and the individual begins to prepare for the changes that are forthcoming. The individual in this stage often needs assistance in identifying effective strategies that will facilitate desired behavior change" (p. 392).

<sup>2</sup> Additional information on meth use, HIV risk, and intervention may be found in **Tool Boxes** in the Spring and Summer 2004 issues of mental health AIDS.

## From the Block

### Center for Community Health, Education & Research

The Center for Community Health, Education & Research (CCHER), a nonprofit, community-based health and social services agency established in 1987, serves Greater Boston's large immigrant Haitian population from a homelike office setting in Dorchester, Massachusetts. Agency services include HIV case management, nutrition and meal delivery, housing search and advocacy, peer support, health education, and outpatient substance abuse treatment.

With funding from CMHS/SAMHSA, CCHER has opened the Alcide Center for Counseling & Family Services (ACCFs) to provide comprehensive and culturally competent mental health assessment, treatment, and consultation services to Haitian individuals and families who are living with HIV/AIDS. Housed at CCHER, the program offers an array of direct care services. These include diagnostic evaluations; crisis intervention; psychopharmacological assessment, intervention, and medication management; individual, couple, family, and group counseling; and community outreach and education.

CCHER's intervention model is holistic, focusing on cultural belief systems, attitudes, behaviors, and practices prevalent in the Haitian community. The model addresses stigmas about HIV/AIDS, mental illness, and mental health. Direct care services incorporate traditional models (e.g., cognitive behavior therapy) and nontraditional approaches, including spirituality and pastoral counseling, self-care, and stress management practices (e.g., relaxation, meditation, and cultural rituals). The model is flexible and focuses on meeting individual client needs. Services are provided in the home, hospital, clinic, and other community-based settings. Clinicians are fluent in Haitian Creole and so are able to offer linguistically appropriate mental health care to non-English-speaking Haitian clients.

The Principal Investigator/Project Director is Eustache Jean-Louis, MD, MPH; the Clinical Director is Gemima St. Louis, PhD. For more information, please call 617/265-0628 x213 or go to <http://www.ccher.org>.

— Compiled by the MHHSC Program Coordinating Center

participant resolve ambivalence toward AIDS preventive strategies. This might be accomplished by eliciting self-motivated reasons for change and enhancing the participant's self-efficacy for change. In particular, this research suggests that a focus on enhancing self-efficacy for condom use, promoting positive social norms favoring AIDS preventive behaviors, and raising awareness of STD risk, may be effective strategies for advancement from the contemplative to the preparation stage of change. (pp. 398-399)

### HIV Assessment News

#### HIV Counseling & Testing

Fitzgerald, Maxi, Marcelin, Johnson, and Pape (2004) studied

1,168 **Haitians** in Port au Prince who tested HIV-positive and returned for posttest counseling. They found that refusal to notify a sexual partner of one's positive HIV status was associated with being poor and female and holding the belief that HIV transmission can occur by magic. Interestingly, acceptance of medical referral was also associated with holding the belief that HIV transmission can occur by magic. In addition, it was associated with expressing denial at the time HIV test results were received and having clinical symptoms associated with HIV disease at the time testing was voluntarily sought. Fitzgerald and colleagues conclude that "information collected during counseling can predict patient's future adherence with

[risk reduction] counseling and medical referral. Counselors can use information such as signs of severe depression, gender, fear, economic status, magical beliefs, and denial to identify patients who are at risk for nonadherence and to adapt their counseling to respond to patient needs" (p. 662).

In another study focused on returning for HIV testing results, Desai and Rosenheck (2004) interviewed 5,890 **homeless adults with severe mental illness (SMI)** who were enrolled in a community-based, intensive case management program at baseline and again 3 months following enrollment.

Overall, 38.0% of clients were tested for HIV in the 3 months after program entry; of these, 88.8% returned to receive their test results. Likelihood of being tested was independently associated with having been tested before, more severe psychiatric symptoms and drug problems, level of worry about getting AIDS, younger age, less education, minority status, longer-term homelessness, being sexually assaulted, being arrested, and health services utilization. Among those tested, likelihood of receiving the test results was higher among those with a history of prior testing and return for results, a higher frequency of testing, and more years of education and lower among those with drug abuse problems, outpatient medical service utilization, disability, and [an STD other than HIV]. ... [F]or men, greater social support increased the likelihood of both HIV testing and receipt of results, while sexual victimization during follow-up decreased the likelihood that men would return for their HIV results. (p. 2287)

## **Building Block**

### **New Government Guidelines Extend Use of PEP**

The U.S. Department of Health and Human Services (DHHS) Working Group on Nonoccupational Postexposure Prophylaxis (nPEP) has extended the recommended use of antiretroviral postexposure prophylaxis (PEP) beyond health-care workers at risk for infection due to occupational exposure (e.g., needle-sticks). PEP is now recommended for anyone who experiences unanticipated, *nonoccupational* exposure to HIV (e.g., accident, sexual assault, isolated incidents of unprotected sex or needle-sharing).

The following recommendations are intended for the United States alone, as they might not apply in other countries:

For persons seeking care  $\leq$  72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected, when that exposure represents a substantial risk for transmission, a 28-day course of highly active antiretroviral therapy (HAART) is recommended. Antiretroviral medications should be initiated as soon as possible after exposure.

For persons seeking care  $\leq$  72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person of unknown HIV status, when such exposure would represent a substantial risk for transmission if the source were HIV infected, no recommendations are made for the use of nPEP. Clinicians should evaluate risks and benefits of nPEP on a case-by-case basis.

For persons with exposure histories that represent no substantial risk for HIV transmission or who seek care  $>$  72 hours after exposure, DHHS does not recommend the use of nPEP. Clinicians might consider prescribing nPEP for exposures conferring a serious risk for transmission, even if the person seeks care  $>$  72 hours after exposure if, in their judgment, the diminished potential benefit of nPEP outweighs the risks for transmission and adverse events.

For all exposures, other health risks resulting from the exposure should be considered and prophylaxis administered when indicated. Risk-reduction counseling and indicated intervention services should be provided to reduce the risk for recurrent exposures. (p. 1)

#### **Reference**

Centers for Disease Control and Prevention. (2005). Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services. *Morbidity & Mortality Weekly Report*, 54(RR02), 1-20.

— Compiled by Abraham Feingold, Psy.D.

Desai and Rosenheck indicate that

[k]nowing whether clients have been tested previously and, if so, whether they received those earlier results will help clinicians to identify individuals who may benefit from additional and more careful follow-up. In addition, repeated HIV testing during follow-up increased the likelihood of actually getting the results and thus may prove to be a useful strategy in helping to increase HIV serostatus awareness among mentally ill homeless persons, who of ten live chaotic lives and for whom returning for test results may be a challenge. (p. 2293)

Drawing on earlier research studies and recent epidemiological

information, Holtgrave and Anderson (2004) set out to **differentiate and prioritize HIV prevention service needs** for the diversity of Americans living with HIV. These investigators estimated transmission rates for a variety of populations: those unaware of their HIV status; those aware (through HIV testing) but not yet receiving counseling; those receiving counseling and no longer engaging in behavior that puts others at risk for infection; and those receiving counseling and continuing to engage in behavior that puts others at risk for infection. They write:

The overall, annual HIV transmission rate in the US has been about 4% since the early 1990s. ... [W]e find that the transmission rate for persons unaware

of their HIV serostatus is approximately 10.79%, and for persons aware of their HIV seropositivity is about 1.73% overall. However, the latter statistic can be further disaggregated. For persons who receive HIV counselling and testing, and for whom these services are effective, the transmission rate is near 0%. For persons who do not receive counselling services as well as testing, or for whom counselling and testing [are] insufficient to induce behavioural change, the HIV transmission rate is between approximately 2% and 4%. (p. 789)

On the basis of these estimated transmission rates, along with the actual number of transmissions

and the particular populations examined, Holtgrave and Anderson offer the following recommendations for prioritizing HIV prevention services for those who are living with HIV.

First and foremost, it seems that promoting knowledge of HIV serostatus for persons living with HIV but unaware of their serostatus is critical. Second, given the effectiveness level of HIV counselling and testing for modifying HIV transmission risk behaviours, it is imperative that testing be accompanied by appropriate counselling services. Third, even though counselling and testing [have] a high effectiveness level, [they do] not work to modify transmission risk behaviours for everyone. Therefore, during the course of ongoing clinical care, it is important to monitor for incident risk behaviours and [STDs]; the occurrence of either might suggest the need for an intensification of counselling, support and other prevention services. It is clear that different persons living with HIV will have different needs for various levels and types of HIV-prevention counselling services; the intensity of the services should be matched to the real needs of the client. (p. 791)

### **Psychiatric Assessment**

Himmelhoch, Moore, Treisman, and Gebo (2004) looked at 549 people with AIDS who had never received HAART before entering medical care in an attempt to answer the following question: "Does the presence of a current psychiatric disorder in AIDS patients affect the **initiation of antiretroviral treatment and duration of therapy?**" Within this cohort, 18% were characterized as having a current psychiatric disorder, 39% were characterized as not having a current psychiatric

disorder, and 43% could not be characterized psychiatrically. Himmelhoch and colleagues report the following:

First, in a clinic offering on-site psychiatric services, among a cohort of patients with AIDS, those receiving treatment of their psychiatric disorder were 37% more likely to receive HAART and had 2.5 times the odds of being prescribed HAART for at least 6 months compared with those without a psychiatric disorder. In addition, we found that patients with AIDS who were receiving treatment of their psychiatric disorder had nearly a 40% reduction in mortality compared with those without a psychiatric disorder. These striking findings suggest that in a clinic offering on-site psychiatric services, patients with AIDS receiving treatment of their psychiatric disorders may not only be more likely to be prescribed HAART but may be more likely to reap the survival benefit by remaining on it. (p. 1460)

### **HIV Treatment News**

#### ***Psychiatric/Psychological/ Psychosocial/Spiritual Care Psychopharmacology***

In a 4-week, open-label pilot study, Rabkin, McElhiney, Rabkin, and Ferrando (2004) evaluated the efficacy of **modafinil** (Provigil®; a wake-promoting agent) for fatigue in people living with HIV. They found that 80% of 30 enrollees experienced a reduction in symptoms of fatigue and, in many respondents, symptoms of nonmajor depression. Improvements in verbal memory and executive function were also noted. While small sample size and the absence of a placebo comparison group limit the conclusions that may be drawn from this initial study, the authors "recommend that clinicians treating

HIV+ patients inquire directly about fatigue severe enough to interfere with daily activities ... and if it is identified, offer treatment" (p. 1694).

#### ***Neuropsychological Impairment***

Cristiani, Pukay-Martin, and Bornstein (2004) investigated the interaction between HIV disease stage and use of **marijuana**. They stratified 282 individuals by disease stage (i.e., HIV-negative, HIV-positive and asymptomatic, HIV-positive and symptomatic) and frequency of marijuana use (i.e., no/minimal use [ $\leq 12$  times per year] and frequent use [ $\geq 52$  times per year, with nearly daily use by many of those sampled]). They found that

frequent marijuana use may be associated with cognitive dysfunction in the context of more advanced HIV infection. Although the main effect for marijuana use only approached significance, there was a significant interaction, suggesting that frequent marijuana use was associated with greater cognitive impairment among subjects with symptomatic HIV infection. This effect appeared to be primarily related to performance on memory tasks. These results cannot be attributed to the influence of confounding variables such as depression, anxiety, or alcohol use, all of which were included as covariates in the data analysis. (p. 333)

Cristiani and colleagues conclude that, while marijuana appears to exert a "minimal" residual cognitive impact on those who are uninfected or in the early stages of HIV infection, "there is a synergistic effect of HIV and marijuana use in patients with advanced HIV disease. This is consistent with other data suggesting that the subtle effects of some conditions may

become more manifest in the setting of immunocompromise” (p. 330).

With regard to intervention, the authors reason that chronic users should be encouraged to reduce their level of marijuana consumption. “However, this may be in conflict with the management of other symptoms associated with HIV infection. Since some HIV infected patients use marijuana for control of nausea and appetite, reduction in marijuana use may lead to increase in these symptoms. Individuals with continued chronic marijuana use should be alerted to the possibility of greater memory dysfunction, and could be encouraged to use memory books or other assistive devices to circumvent their memory problems” (p. 334).

#### Stress Management

Ironson et al. (2005) randomly assigned 56 women living with HIV to one of two conditions: a 10-week group therapy program (90 minutes of cognitive behavioral stress management, 30 minutes of relaxation training) or a low-intensity comparison condition (45 minutes of informational/educational videotapes, 75 minutes of entertainment videotapes). Through measures taken on two occasions 3 months apart, Ironson and colleagues found that

AIDS **self-efficacy** was related to both decreased viral load and increased CD4 over time. Thus people who believe they have the skills to prevent re-infection and the skills to slow down the development of symptoms actually appear to have better biological outcomes. How could this occur? Self-efficacy ... or beliefs about one’s capabilities and potential to meet situational demands is known to influence effort, perseverance, perception of control, personal choices,

thought patterns, depression and perceptions of stress ..., all of which are salient to the individual coping with AIDS. (p. 232)

These investigators also found that “increases in cognitive behavioral skills were ... related to decreases in viral load ... [and that] increases in cognitive behavioral self-efficacy were ... related to decreases in depression and anxiety” (p. 232). They conclude that “improving participants’ self-efficacy may impact on disease progression and well-being” (p. 233).

#### Adherence to Treatment

Deloria-Knoll et al. (2004) surveyed 255 predominantly white, male, and highly-educated antiretroviral recipients participating in a multi-site study and found that one-third reported **skipping at least one medication dose** in the 3-day period preceding completion of the questionnaire. Importantly,

[a]sking patients to report difficulty taking antiretroviral medications or whether they took a drug holiday identified an additional 16% of patients experiencing adherence problems and explained significantly more of the failure to achieve undetectable viral load than merely asking about skipped doses. It may be useful to further evaluate patient-expressed difficulty in taking medications as a surrogate or supplemental marker of skipping. This may promote better clinician understanding of scenarios in which medication nonadherence is likely. Likewise, such a marker may be especially useful in situations, such as face-to-face interviews, where patient concerns over “disappointing” their [provider] or being negatively stigmatized as nonadherent may interfere with the honesty

of reporting. In such situations, some patients may feel more comfortable admitting “difficulty taking their medicine” than non-adherence outright. Thus, soliciting patient responses regarding attitudes, concerns, and adverse effects consequent to HIV therapy, in addition to making direct queries regarding adherence, may help to better identify those who are suboptimally adherent and can only be of benefit in promoting enhanced patient-[provider] communication overall. (pp. 726-727)

Mannheimer et al. (2005) assessed changes in **quality of life** (QoL) over a 12-month period in a racially and ethnically diverse sample of 1,050 clinical trial participants receiving antiretrovirals.

This longitudinal study demonstrated that the QoL improved over time for HIV-infected individuals receiving [antiretrovirals]. ... Significant improvements in QoL were noted as early as 1 month after initiating ... HAART ... for the physical ... and 4 months for the mental ... component of QoL. The improved QoL was sustained over the 12-month study period. The improvements in QoL were most striking among those with the highest adherence levels. In a cross-sectional analysis at 4, 8, and 12 months after initiation of new [antiretroviral] regimens, significant differences were seen at 4 months for [the mental summary score] and at 12 months for both [mental] and [physical] summary scores and in seven of the eight QoL domains. In each case, those reporting 100% adherence had the greatest gains, those with 80-99% adherence levels had smaller benefits, and those with < 80% adherence had lower QoL scores than at baseline.

Longitudinal data showed that participants reporting 100% adherence at either 3 or 4 of the total of 4 study follow-up visits over the 12 months achieved the best QoL outcomes, highlighting the importance of consistent adherence. (p. 18)

Mannheimer and colleagues conclude that, “[w]hile previous data have suggested a requirement of at least 95% adherence for the best virological outcomes ... clinical benefits such as improved QoL may occur at lower adherence levels” (p. 19).

#### Coping, Social Support, & Quality of Life

Orlando, Tucker, Sherbourne, and Burnam (2005) assessed **the association between psychiatric symptoms** of depressive and anxiety disorders **and physical components of health-related quality of life** (HRQOL) over time. They studied 2,431 individuals within a nationally representative sample of 2,864 adults receiving HIV medical care in 1996. Controlling for a number of variables (including HIV disease stage and symptoms), Orlando and colleagues found that “[p]atients who initially had a greater number of symptoms of depressive disorder showed increased pain and declines in general health perceptions over an 8-month follow-up, and patients who initially had higher perceptions of general health, lack of pain, and physical functioning exhibited significant decreases in the number of symptoms of either depressive or anxiety disorders or both” (p. 24). They go on to observe that

[t]he reciprocal nature of the association between psychiatric symptoms and certain physical components of HRQOL emphasizes the importance of addressing poor HRQOL among HIV-infected individuals, as well

as detecting and treating psychiatric problems in this population. Given that improvement in HRQOL can lead to improved mental health, identifying and treating HIV-positive people experiencing high levels of pain, for example, may prevent development and escalation of mental health symptomatology. On the other hand, adequately addressing psychiatric problems in this population should result in improved functioning and well-being. (p. 25).

Vosvick et al. (2004) surveyed 146 adults living with HIV and found that “[g]reater pain and stress were associated with greater **sleep disturbance**. Greater assistance from friends was associated with greater sleep disturbance, whereas greater understanding from friends regarding participants’ HIV-related stress was associated with less sleep disturbance” (p. 459). Vosvick and colleagues therefore suggest that “assessing the available sources of social support as well as what type of support each source can provide may allow ... providers to effectively intervene and improve sleep quality for persons living with HIV or AIDS” (pp. 461-462).

In Canada, Burgoyne (2005) evaluated **the relationship between perceived social support and viral load** over a 4-year period among 34 adults receiving outpatient medical care for HIV. “Social support in this study emphasized perceptions of accessibility to others with whom to express mutual loving and caring, share activities and openly discuss issues of concern” (p. 122). Measures were taken at baseline, in Year 2, and again in Year 4. Burgoyne reports that

[a]dults living with HIV infection and who consistently took HAART over a relatively long-

term period of time appeared to experience better clinical benefit in terms of virological suppression if they perceived having positive interpersonal, informational and emotional support available to them. Attempts to illuminate the direction of causation between social support perceptions and viral load outcome met with some success. Study results suggested a trend in which social support did portend viral load outcomes. However, not all of the criteria for supporting causality were satisfactorily met. (p. 122)

Burgoyne nonetheless suggests that “[t]hese findings underscore the importance of service delivery provision in which patients’ social support and goals directed to maximizing that support receive focused attention” (p. 121).

Of course, not all relationships are supportive. To estimate the proportion of adults engaged in HIV care whose close relationships can be characterized as abusive, Galvan et al. (2004) employed a self-administered, computer-assisted instrument with a stratified random subsample of 1,421 persons included in a nationally representative sample of 2,864 adults receiving HIV medical care in 1996. Of the 51% of subsample respondents reporting that they had a spouse or primary relationship partner during a 6-month period, *26.8% reported abuse in that close relationship*. Forty-eight percent of the reported abuse was mutual and, interestingly, abuse was received and perpetrated with equal frequency. Abuse in a close relationship was associated with younger age, drug dependence, binge drinking, the presence of a psychiatric disorder, and HIV seroconcordance between partners. When controlling for these factors, however, these investigators found that “[m]ales and

females, those with male partners and those with female partners, were all about equally likely to be in an abusive relationship” (p. 449). Also, abuse was more common among African Americans and Latinos in this sample. Even when controlling for the factors noted above, these investigators found that “African Americans were more likely than Whites to be involved in an abusive relationship” (p. 441).

Galvan and colleagues expand on these findings as follows:

**Abuse in the close relationships of HIV-positive people**

is a problem of substantial magnitude with implications for the physical and psychological health of this already vulnerable group. [As with] many other public health problems, African Americans and Latinos appear to be more vulnerable to relationship abuse. HIV medical and social service providers should routinely inquire about issues of abuse, particularly in these subpopulations, and regardless of the gender or sexual orientation of the individuals. Appropriate referrals to abuse prevention programs, as well as to substance abuse and mental health programs, should be provided as needed. Curbing substance abuse among people with HIV may be a particularly potent [method] of reducing relationship abuse. Although problems with both relationship abuse and substance use have been previously recognized in the at-risk population, the present study indicates that the scope of these problems among people already infected with HIV is substantial. (p. 450)

Continuing on this theme, Newcomb and Carmona (2004) conducted baseline and follow-up interviews with a community sam-

ple of 113 **Latinas** (79 HIV-positive, 34 HIV-negative) “to estimate the influence of acculturation, HIV status, and **adult trauma**, including ... [IPV] and sexual assault, on subsequent changes in psychological adjustment (depression) and substance use 1 year later” (p. 417). They found that education protected study participants from HIV, depression, and IPV, but increased the likelihood of substance use. Additionally, IPV and sexual assault were found to be the “primary predictors” of changes in depression and substance use, and these effects were exacerbated when the woman was HIV-positive. “HIV status [has] an immediate impact on psychological adjustment in the form of depression and higher incidents of adult trauma” (p. 424), according to the authors. They stress that “intervention programs that work specifically with HIV-positive Latinas need to ... assess for adult trauma and victimization, as well as provide intervention to minimize depression ...” (p. 424). Furthermore, “Latinas who experience violence may look to substances to cope with such trauma, highlighting the need ... to address both psychological adjustment and substance use prevention for battered and traumatized women” (p. 425). Finally, Newcomb and Carmona contend that “support groups for HIV-positive women that address trauma histories and target the enhancement of coping skills may help to ameliorate depression and self-medication through drugs” (p. 426).

Over a 24-month period, Pereira et al. (2004) studied 28 black, non-Hispanic (i.e., African American, Haitian, Bahamian, and Jamaican) women living with HIV and **human papillomavirus (HPV) infection**. HPV infection is a risk factor for cervical dysplasia, a gynecologic condition common among HIV-positive women and the precancerous

phase of cervical cancer. The authors found that women with an **inhibited interpersonal coping style**<sup>3</sup> kept fewer clinic appointments for special immunology primary care and obstetrics/gynecology care during the first 12-month

<sup>3</sup> “Individuals who are interpersonally inhibited have the desire to reach out to others in times of need but actively restrain themselves from doing so, of ten because of the fear of negative interpersonal consequences. By this definition, it is likely that interpersonal inhibition is associated with health behaviors that occur within a social context, such as health care utilization” (p. 197).

**Tool Box**  
**Books & Articles**

Baskin, M.L., Braithwaite, R.L., Eldred, L., & Glassman, M. (Eds.) (2005). Prevention with persons living with HIV. *AIDS Education & Prevention, 17*(Suppl. A), 1-115. “Why are efforts to prevent persons with HIV from transmitting the virus to others receiving increased attention? Are interventions for persons living with HIV effective? Does the effectiveness of prevention programs vary by program setting or target population? What are the prevention community’s challenges in planning, implementing, monitoring, and evaluating these interventions? [This supplement addresses] these questions with the presentation of both quantitative and qualitative findings from individual- and group-level interventions for HIV-infected persons. Interventions for men and women, ranging from black non-gay-identified men who have sex with men to female injection drug users, are presented and real-world implementation and evaluation challenges in community-based settings are discussed. Suggestions for addressing these challenges are also presented” (p. 1).

Frederick, R.J. (2004). The multidimensional challenge of psychotherapy with HIV positive gay men. *Journal of Gay & Lesbian Social Services, 17*(2), 63-79. Frederick identifies and discusses current concerns for gay men living with HIV, as well as clinical chal-

period under study, an association that strengthened during the second 12-month study period. This association continued even when the authors controlled for the possible influence of recent depressed mood on attendance at clinic visits.

[T]hese findings suggest that psychosocial assessment, including interpersonal coping style assessment, should be implemented at the point of a woman's entry into the health care system for the medical management of HIV. For many

women, entry occurs during pregnancy, suggesting that psychosocial assessment should be performed at a woman's first prepartum visit. Based on the results of these assessments, brief coping skills interventions could be delivered to women with vulnerable coping styles throughout the prepartum period ... . Given the amount of stress many women experience after childbirth, HIV+ HPV+ women may benefit from more intensive psychosocial interventions postpartum. (p. 201)

Lastly, to identify factors associated with attempts at **workforce reentry**, Martin, Arns, Chernoff, and Steckart (2004) compared 235 people living with HIV/AIDS who were enrolled in a workforce-reentry assistance project to 51 people living with HIV/AIDS who were not. They observed "a consistent pattern of improved health among those who enrolled in the program compared to those who did not. No other pattern of group differences was observed, but both groups evidenced indices of poorer mental health and higher rates of sub-

lenges confronting therapists working with this population.

Gatrad, A.R., & Sheikh, A. (2004). Risk factors for HIV/AIDS in Muslim communities. *Diversity in Health & Social Care, 1*(1), 65-69.

"In this paper, we seek to describe Muslim customs and practices that may represent risk factors for developing HIV/AIDS. ... We consider issues such as polygamy, attitudes towards extra-marital relationships, homosexuality and the custom of male circumcision, all of which may have a bearing on the risk of acquiring HIV/AIDS. An appreciation of such factors is ... crucial in order to develop and implement culturally competent and sensitive population-based risk reduction strategies" (p. 65).

Halkitis, P.N., Gómez, C.A., & Wolitski, R.J. (Eds.). (2005). *HIV+ sex: The psychological and interpersonal dynamics of HIV-seropositive gay and bisexual men's relationships*. Washington, DC: American Psychological Association.

"Giving voice to the stories of hundreds of seropositive individuals, the editors and contributors explore how gay and bisexual men live with HIV and make decisions about sex, express their sexuality, choose their sexual partners, and balance their physical and emotional health while attempting to maintain viable and responsible sex lives. The personal narratives, in addition to featured findings of extensive behavioral research studies, provide orientation and valuable insight for studying and working

with this population."

Kalichman, S.C. (Ed.). (2005). *Positive prevention: Reducing HIV transmission among people living with HIV/AIDS*. New York: Springer.

"... [A] timely volume containing the latest contributions from ... top scholars ... on preventing the spread of HIV/AIDS. Issues covered include unprotected sex with HIV-positive gay and bisexual men; issues around whether disclosure leads to safer sex; mental health and HIV with young adults; the impact of HIV diagnosis on sexual risk behaviors; interventions in community settings; and more."

Kalichman, S.C., Cain, D., Fuhrel, A., Eaton, L., Di Fonzo, K., & Ertl, T. (2005). Assessing medication adherence self-efficacy among low-literacy patients: Development of a pictographic visual analogue scale. *Health Education Research, 20*(1), 24-35.

"Based on a review of the research literature and qualitative research with key informants, a pictographic medication adherence self-efficacy scale was developed. ... This newly developed pictographic scale may be useful in assessing medication adherence self-efficacy in lower-literacy populations" (p. 24).

Pargament, K.I., McCarthy, S., Shah, P., Ano, G., Tarakeshwar, N., Wachholtz, A., Sirmine, N., Vasconcelles, E., Murray-Swank, N., Locher, A., & Duggan, J. (2004). Religion and HIV: A review of the literature and clinical implications. *Southern Medical Journal, 97*(12), 1201-1209.

"In this paper, we review the literature on religious coping among individuals with HIV and outline a clinical intervention that incorporates religious issues relevant to this population" (p. 1201).

Weinhardt, L.S. (Ed.). (2005). Changing HIV/AIDS-related behavior. *Behavior Modification, 29*(2), 219-463.

"In this special issue, six groups of clinician-researchers focusing on HIV and AIDS-related behavior present their most recent intervention strategies. The articles included represent interventions for a range of target behaviors, including sexual activity, injection drug use, and HIV medication adherence. The interventions described were designed for a variety of groups and communities increasingly being affected by HIV and AIDS, including low-income, urban, ethnic-minority women, adolescents, injection drug users, and ... people who have HIV" (p. 221).

Wynn, G.H., Cozza, K.L., Zapor, M.J., Wortmann, G.W., & Armstrong, S.C. (2005). Antiretrovirals, Part III: Antiretrovirals and drugs of abuse. *Psychosomatics, 46*(1), 79-87.

"In an overview format ..., the metabolism and drug interactions in the context of antiretroviral therapy are presented for the following drugs of abuse: alcohol, benzodiazepines, cocaine, GHB (liquid X), ketamine (special K), LSD (acid), MDMA (Ecstasy), opiates, PCP (angel dust), and THC (marijuana)" (p. 79).

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stance abuse than suggested by national norms” (p. 28). Martin and colleagues are quick to point out that

people with HIV/AIDS who choose not to attempt workforce entry may have legitimate concerns over their health and health stability. ... [T]hese concerns may be related to ... objective health indices and thus may reflect a rational and deliberate decision-making process in determining whether to attempt workforce reentry. ... People with HIV/AIDS are well advised to carefully consider the potential health-related effects that their workforce-reentry efforts may have, and [clinicians] working with people with HIV/AIDS-related disabilities should be sensitive to the impact these health indices may have on workforce-reentry attempts. Many HIV-related physical symptoms (e.g., disabling neuropathy: pain in limbs and extremities) may be invisible to interviewers ... [Also, because substance abuse has been found to be an obstacle to successful workforce reentry among people with disabilities, substance abuse treatment may need to be closely coordinated or integrated into workforce-reentry programs targeted at people with HIV/AIDS. (p. 35)

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## Tool Box

### A Note on Content

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

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Toro-Alfonso, J., & Rodríguez-Madera, S. (2004). Sexual coercion in a sample of Puerto Rican gay males. *Journal of Gay & Lesbian Social Services*, 17(1), 47-58.

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Vosvick, M., Gore-Felton, C., Ashton, E., Koopman, C., Fluery, T., Israelski, D., & Spiegel, D. (2004). Sleep disturbances among HIV-positive adults: The role of

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

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

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

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