

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 4 – Summer 2005

Biopsychosocial Update

HIV Prevention News

About Women

Boyer et al. (2005) studied 2,157 female Marine recruits who were randomly assigned (by platoon) to one of two conditions. In the experimental condition, recruits received four 2-hour group sessions of a **cognitive-behavioral intervention** that “used a variety of educational strategies including didactic teaching, interactive group discussion and exercises, a self-risk appraisal, and videos ...” (p. 422) to prevent sexually transmitted diseases (STDs) and unintended pregnancies. In the control condition, a time- and technique-equivalent intervention focused on preventing physical training/sports injuries and breast/cervical cancer was offered to recruits. STD and pregnancy screens were conducted at baseline and again (on average) 1 and 14 months following the interventions. On follow-up, Boyer and colleagues found that a greater proportion of women in the control condition had STDs or unintended pregnancies and that women who were not sexually experienced at baseline were “more likely to have casual and multiple sexual partners postintervention” (p. 420) if they were in the control condition. “The findings of this randomized controlled trial indicate that cognitive-behavioral, group-level interventions are effective strategies to prevent ST[D]s and [unintended pregnancies] and reduce sexual risk behaviors in large numbers of young women who are at risk but may not

access the health care system” (pp. 429-430).

About Adolescents

Rock, Ireland, Resnick, and McNeely (2005) analyzed longitudinal interview data from a nationally representative sample of 404 male adolescents who were between the ages of 15 and 17 years and sexually inexperienced when data were first collected and who reported that they had become sexually experienced when data were next collected 1 year later. At baseline, objective knowledge regarding proper condom use was measured through a five-item quiz and **perceived knowledge** was measured on a five-item scale through which the teens rated their confidence in their answers on the objective measure. Rock and colleagues found that male teens with *low objective knowledge* but *high perceived knowledge* (i.e., those who believed they knew how to use condoms correctly but, in fact, did not) were nearly 3 times less likely to report condom use at first intercourse than those with high objective knowledge or those with low objective knowledge who perceived this to be the case.

[F]indings suggest that ... providers who work with male adolescents should assess both objective and perceived knowledge ... one-on-one ..., not unlike screening assessments for depression, alcohol addiction, or other conditions. ... Once assessed, level of

objective knowledge must be interpreted in the context of perceived knowledge when predicting the likelihood of ... using a condom at first intercourse. It should not be assumed that those with high objective knowledge automatically have high confidence about their knowledge or that those with low objective knowledge ... have low perceived knowledge. The male adolescents who are most at risk seem to be those with high perceived but low objective knowledge. By considering both facets of knowledge, providers may be able to predict ... which male adolescents are at risk and thus tailor health intervention strategies to those who need it most. (p. 671)

Continuing with the subject of condom use, Bryan, Rocheleau, Robbins, and Hutchinson (2005) assessed 267 criminally involved adolescents at baseline and again 6 months later and found that intentions and attitudes toward condom use measured at baseline could predict later condom use behavior. Im-

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portantly, "alcohol use ... [did] not influence the relationships among self-esteem, positive orientation to the future, attitudes, norms, self-efficacy, and intentions to use condoms. Further, alcohol use [did] not seem to moderate the relationship of intentions to use condoms and condom use behavior" (p. 140). These results suggest that "intervention content based on the assumption that self-esteem, positive orientation toward the future, attitudes, norms, and self-efficacy are related to condom use intentions need not be altered whether the participants in the intervention are drinkers or not." [The authors] do not mean to imply that intervention content should ignore alcohol use generally or the drinking status of participants specifically ... but that the more general condom promotion content of the intervention can remain consistent" (p. 139).

Interesting intervention news comes from Jemmott, Jemmott, Braverman, and Fong (2005), who conducted a randomized controlled trial involving 682 sexually experienced, inner-city African American and Puerto Rican adolescent girls recruited from an adolescent medicine clinic. Participants were randomized to one of three single-session "250-minute interventions based on cognitive-behavioral theories and elicitation research: an information-based HIV/STD intervention [that] provided information necessary to practice safer

sex; a skill-based HIV/STD intervention [that] provided information and taught skills necessary to practice safer sex; or a health-promotion control intervention [that was] concerned with health issues unrelated to sexual behavior" (p. 440).

Although there were no statistically significant differences in outcomes among the three interventions with respect to frequency of unprotected intercourse, number of partners, or the STD rate at the 3- or 6-month follow-ups, skills-based intervention participants reported less unprotected sexual intercourse at the 12-month follow-up than did participants in the other two interventions. At that time, skills-based intervention participants also reported fewer sexual partners and were less likely to test positive for an STD in comparison with the health-promotion control intervention participants. Outcomes for the information-based and health promotion control interventions did not differ significantly at any of the follow-up intervals.

Jemmott and colleagues conclude that "[s]kill-based HIV/STD interventions can reduce sexual risk behaviors and STD rate among African American and Latino adolescent girls in clinic settings" (p. 440). They also note that their findings "were produced by **a single-session intervention of only 250 minutes**. This suggests that it is possible to effect significant long-term changes in sexual

behavior among adolescent girls – over 12 months in the present study – without great expenditure of time and effort" (p. 448). Moreover,

the present study provides some of the strongest evidence that enhancing skills should be a critical goal for interventions designed to reduce risk[y] sexual behavior. ... Methods for enhancing condom use skills include handling condoms, practicing putting condoms on anatomical models, and role-playing realistic situations that involve pressure to have unprotected intercourse. The implementation of such activities with adolescents may be controversial in certain settings, yet, the present results suggest that they hold the promise of reductions in sexual risk behavior. (p. 447)

Wu et al. (2005) recruited 817 African American youth between the ages of 13 and 16 living in and around Baltimore public housing to participate in an eight-session **HIV risk-reduction intervention that targeted multiple risk behaviors**. "An instrument designed to measure three levels of sexual risk ('abstinent,' 'protected sex' [having sex with a condom], and 'unprotected sex' [having sex without a condom]) was administered at baseline, 6 months and 12 months postintervention" (p. 56). They found that "youth who engaged in unprotected sexual behavior were significantly more likely to be involved simultaneously in multiple problem behaviors when compared with youth engaged in protected sex or with abstinent youth. The degree of sexual risk increase[d] as the number of other risks increase[d]" (p. 61). Furthermore, "[y]outh who were the highest at baseline remained the highest in risk-taking over time but demonstrated a significant decreasing trend, whereas abstinent youth remained the lowest in risk-taking over time but demonstrated a significant increas-

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ing trend” (p. 61). “These findings imply that broad-based interventions targeting multiple behaviors are effective for adolescents who exhibit multiple high-risk behaviors Additionally, interventions preventing onset of problem behaviors among abstinent adolescents may need to be structured differently from interventions for higher risk youth because there was a significant progression of risk behaviors in this group in contrast to the higher risk groups” (p. 61).

Finally, O’Sullivan, Dolezal, Brackis-Cott, Traeger, and Mellins (2005) studied 220 low-income urban **mothers and their early adolescent children** (ages 10 to 14) and found that mothers who were living with HIV were more likely to report that they talked about HIV and had discussions on related topics more frequently than did uninfected mothers. Additionally, the children of mothers who were living with HIV, compared with those whose mothers were not, reported greater comfort discussing sex- and drug-related topics. Nonetheless, the authors are quick to note that “promoting parent-child communication about HIV and risk behaviors is unlikely to directly affect adolescents’ chances of HIV infection” (p. 163). Rather, “[c]ommunication should be perceived as one mechanism by which a better parent-child relationship influences adolescents’ future choices about participation in risk activities” (pp. 163-164).

It is the promotion of stronger family relations that is likely to help in ... efforts to prevent infection among adolescents. Teaching parents how to initiate and engage their children in discussion, anticipate reactions, and tailor the content to the child’s developmental stage may be useful strategies that support efforts to reduce the risk of infection among young people. Moreover, providing information to parents

about overcoming their own inhibitions to communicate with their children, particularly those related to distressing their children, may promote more positive family communication. (p. 164)

About Women & Men

With data gathered from a weighted sample of about 3,000 23- and 24-year-olds who lived in California and Oregon as youth, Collins, Ellickson, Orlando, and Klein (2005) tested for **associations among HIV sexual risk, substance use, and victimization or partner violence**. They found that “[a]lcohol use and victimization predicted high risk sex in independent samples of single and married/cohabiting adults[, while m]arijuana use, problem drug use, and partner violence were inconsistently related to sexual risk across measures and subsamples” (p. 73). The authors conclude that during interventions with young adults in the general American population,

both those who use alcohol frequently or heavily and those whose lives involve victimization or partner violence should be targeted. And, while ... cross sectional design prohibits causal inference, the findings suggest that the best prevention efforts will be three-pronged, targeting alcohol use, violence, and sexual behavior simultaneously. Associations between alcohol use and sexual risk, and between violence and sexual risk, are independent of one another and similar in magnitude. They are also strikingly similar across [this] sample of single adults and [this] sample of those with cohabitating partners, and across males and females. Thus, both violence and alcohol use should be central to HIV prevention programs for young adults in the United States. (p. 86)

Delving further into these data,

Ellickson, Collins, Bogart, Klein, and Taylor (2005) found that, while the vast majority of young adults (nearly 80%) engaged in behavior posing some risk for HIV transmission, both high (22%) and moderate (56%) risk for HIV was associated with violence, victimization, many forms of substance use, and drug-related problems. It should be noted that

exposure to partner abuse and daily alcohol use seem[s] to have a discontinuous relationship with sexual risk, catapulting young adults into the category of high sexual risk taking. In the overall sample, participants were particularly more likely to be at high (vs. medium or low) risk for HIV if they used alcohol daily in the past month and if they had been beaten by their partner, pressured for sex, or raped in the last 3 years. These specific types of victimization and substance use problems appear to be especially important markers for high risk among young adults. (p. 406)

Turning to gender differences, Ellickson and colleagues found

first, that more women than men are at some sexual risk for HIV infection, but men’s risk is more extreme, involving both multiple partners and inconsistent condom use by the same individual. Second, the correlates of sexual risk were largely identical for young adult men and women. What differs across genders is the prevalence of these risks, with men generally reporting higher rates of substance use, substance use problems, and predatory violence, and women reporting higher rates of victimization in the form of partner abuse and sexual coercion. For example, women at high sexual risk were 2.3 times more likely to have been sexually coerced than high-risk men, while the latter were 4.8

times more likely to have committed sexual coercion. (pp. 406-407)

The authors once again observe that “[t]hese findings ... underscore the importance of addressing violence, victimization, and substance use in the context of HIV prevention interventions” (p. 408).

Moreover, because risks differ by gender, interventions should be tailored differently for young men and women. Although open discussion of victimization and violence should be broadly incorporated into HIV prevention interventions for young adults, interventions for young women should stress sexual and other interpersonal victimization, whereas interventions for young men should address sexual behavior within a context of violent behavior. Interventions that promote negotiation of condom use but fail to address the interpersonal and sometimes violent context of sexual behavior are unlikely to be effective. (p. 408)

Continuing this focus on gender, Kalichman et al. (2005) randomized 612 men and women receiving STD clinic services in Milwaukee to one of four 90-minute HIV risk-reduction counseling conditions based on the **information-motivation-behavioral skills (IMB) model**.¹ Counseling focused on information only ($n = 162$); information and motivational enhancement (IM; $n = 153$); information and behavioral skills-building (IB; $n = 156$); or information, motivational

¹ “[T]he information-motivation-behavioral skills (IMB) model of health behavior change ... states that HIV prevention is a necessary precursor to risk reduction. Motivation to change, however, also directly affects whether one acts on information about risk and risk reduction. Finally, the model holds that behavioral skills are a final common pathway for information and motivation to result in preventive behavior change” (p. 199).

enhancement, and behavioral skills-building (the full IMB model; $n = 141$). Study participants were assessed in 3-month intervals over a 9-month period, and STD diagnoses were monitored over a 12-month period. Overall, 78% of study participants completed two or more follow-up assessments. Kalichman and colleagues found that

relatively brief risk-reduction counseling may have positive effects on sexual risk behaviors in people receiving ST[D] diagnostic and treatment services. Risk-reduction counseling appeared to influence enactments of new reduction behavioral skills and rates of unprotected intercourse. ...

The results ... also showed gender differences in response to intervention components derived from the IMB model. Men who received the full IMB model of risk-reduction counseling demonstrated the greatest skills-building benefits, relatively lower rates of unprotected intercourse, and relatively lower rates of chart-abstracted ST[D]s. It should be noted that the most consistent pattern of positive results occurred within the first 6 months following the intervention, with many effects dissipating by the 9-month follow-up. These findings support our hypothesis that the full IMB counseling model would be most effective for men, although for a relatively brief duration. Although men in the IMB counseling condition did not report greater use of condoms compared with the other risk-reduction counseling conditions, this finding may be explained by the observed enactments of other risk-reduction skills. ... [S]kills such as avoiding risk situations, changes in partner selection, engaging in alternative behaviors, and discussing safer sex alternatives with partners suggest ...

that men who received behavioral skills training reduced their risks by practicing behaviors other than condom use.

The intervention outcomes for women were markedly different from those observed in men and were not consistent with our study hypotheses for behavioral and ST[D] outcomes. Women who received the full IMB model for risk-reduction counseling demonstrated the highest rates of risk behaviors among women. In contrast, women who received motivational counseling delivered in the IM condition demonstrated the greatest enactment of risk-reducing behavioral skills and relatively lower rates of unprotected intercourse. This pattern of results was consistent across the three follow-up assessments. The risk behavior outcomes for women are perplexing and point to the need for additional research to identify the most and least effective elements of HIV risk-reduction counseling for women. (p. 206)

Inaccurate risk perceptions operate when one “perceive[s] that a partner is safe from HIV without any direct evidence of this safety” (p. 344), while **HIV/AIDS prevention heuristics** are “the relatively automatic decision-making rules that individuals engage in when determining whether AIDS prevention is necessary with a chosen partner” (p. 336). Thorburn, Harvey, and Ryan (2005) conducted an exploratory study to find out if these sources of HIV prevention information function as barriers to safer sexual practice among young, heterosexual African Americans at increased risk for HIV. The study involved two samples: 22 couples (both members were interviewed separately; Phase I); and an additional 40 men and 40 women interviewed individually (Phase II). “Taken together, results from Phases I and II

suggest that monogamy, knowing your partner and trusting your partner were believed by some study participants to replace, reduce or eliminate the need for HIV prevention behaviour. These findings add to a growing body of literature suggesting that people think their relationships are safe from disease, even though their relationships are potentially unsafe” (p. 343). Furthermore, while Phase I interviewees reported condom use as a major disease prevention strategy, “stronger endorsement of the ‘known partners’ heuristic was negatively associated with measures of condom use ... [among Phase II interviewees. These] findings highlight the need for interventions ... to encourage intimate partners to consistently use condoms until both members of the dyad are tested and agree to mutual monogamy” (p. 335).

Winfield and Whaley (2005) divided a sample of 223 heterosexually identified, African American college students into four groups – abstinent, consistent condom users, **inconsistent condom users**, and **noncondom users** – and found that 63% of those sampled were either inconsistent condom users or did not use condoms at all. Furthermore, “[i]nconsistent ... users differed from nonusers in terms of gender and relationship status. ... [M]ales and married students were more likely to be nonusers than inconsistent ... users. There was also a trend toward noncondom users['] perceiving more barriers to safer sex than inconsistent users” (p. 200). As Winfield and Whaley see it,

this pattern of demographic and psychological differences between inconsistent users and nonusers of condoms suggests that HIV/AIDS intervention efforts may require different approaches for the two risk categories. For example, prevention efforts directed toward noncondom users,

who are more likely to be male, should include psychological interventions that address perceived barriers to safer sex. Interventions for married couples may want to encourage an honest dialogue about how each partner’s perspective, including ... sexual mores, beliefs about fidelity, sexual behavior, and feelings about condom use, affect ... risk for HIV/AIDS infection. (p. 200)

El-Bassel et al. (2003) conducted a randomized clinical trial to study the efficacy of *Project Connect*, a **relationship-based HIV/STD prevention intervention designed for at-risk heterosexual couples**. English- and/or Spanish-speaking low-income women receiving outpatient medical care were recruited into the study, and these women, in turn, recruited their regular male sexual partners. The 217 couples were randomized to one of three conditions: a six-session couples intervention ($n = 81$); the same intervention offered to the woman alone ($n = 73$); or a single educational session offered to the woman alone ($n = 63$). “The intervention emphasized the importance of relationship communication, negotiation, and problem-solving skills and highlighted how relationship dynamics may be affected by gender roles and expectations. The session content emphasized each couple’s contribution to enhancing the future health of ethnic communities hardest hit by HIV/AIDS” (El-Bassel et al., 2003, p. 965). After 3 months, in the first two conditions, *regardless of whether the male partner was present or not*, the intervention was associated with a reduction in the number of unprotected sex acts and an increase in the proportion of protected sex acts.

At 12 months postintervention, El-Bassel et al. (2005) reported findings consistent with those reported at 3 months. The authors observed that

these latest findings “provide evidence of sustained efficacy of a relationship-based intervention for reducing HIV risk behavior in two alternative modalities over a 12-month post-intervention time period” (pp. 11-12). The results “lend support to the desirability of delivering relationship-based HIV/ST[D] prevention interventions in primary care settings for women and their intimate partners who are at elevated risk for transmission of HIV and other ST[D]s” (p. 11).

About Men Who Have Sex With Men

Examining data gathered separately from each partner in 59 gay male couples (yet maintaining the couple as the unit of analysis), Fergus, Lewis, Darbes, and Butterfield (2005) explored associations between **social involvement with and assimilation into the gay community and sexual risk behavior**. Controlling for alcohol problems, the authors found that “[t]he pattern of effects suggests that gay couples’ social involvement in the gay community [that is] centered on going to bars and clubs is associated with more HIV risk behaviors. Other types of social involvement appeared to have no relationship with HIV risk behaviors independent of any bar and club effects. In addition, one partner’s assimilation in the gay community was associated with his own HIV risk behaviors independent of any effects of his partner’s assimilation” (p. 162).

The results ... suggest that interventions targeted specifically for gay men in couples are warranted. The sexual behavior of a gay man in a couple relationship may be influenced not only by his own level and type of integration into a gay community but also by those of his partner. HIV prevention efforts among gay men in couple relationships may therefore benefit from practitioners encouraging participants to practice the tenets of negotiated

safety ... whereby couples establish their HIV serostatus and then develop explicit agreements regarding sexual behavior within and outside of the relationship.²

... Practitioners may ... [also] find it beneficial to encourage gay men in couples to be aware of how their assimilation influences their HIV risk behaviors. One way to do this is to implement empowerment education interventions ... specifically targeted toward gay couples. ...

Finally, this study suggests that HIV prevention interventions among gay partners should examine a variety of social interactions they have with each other while paying particular attention to social interactions that involve bars and clubs. Practitioners should aim to encourage those gay men in couple relationships to learn skills they can use to reduce their HIV risk behaviors when their interactions with others are in environments such as bars and clubs. (p. 167)

Dutch investigators (van der Snoek, de Wit, Mulder, & van der Meijden, 2005) conducted a longitudinal study involving a cohort of 151 highly educated, HIV-negative men who have sex with men (MSM) residing in Rotterdam to explore the relationship

² Regarding the practice of negotiated safety (NS), Guzman et al. (2005) observe 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).

between beliefs regarding highly active antiretroviral therapy (HAART) and post-exposure prophylaxis (PEP) and the occurrence of new STDs and new HIV infections. Although the vast majority of men were realistic about the effectiveness of HAART and PEP and did not indicate that safer sexual practices were needed less because of the availability of these interventions, "[p]erceiving less HIV/AIDS threat since HAART availability and younger age were significantly associated with a higher incidence of STDs. Perceiving less need for safe[r] sex since HAART availability was significantly associated with an increased likelihood of HIV seroconversion" (p. 170). Notably, seven cohort members contracted HIV during the 30-month study period. These findings "are consistent with the hypothesis that a decreased perception of HIV/AIDS threat because of HAART availability might lead to increasing incidence of STD and HIV infections. Therefore, ongoing prevention emphasis on reducing risky sexual behavior by using condoms during anal sex is essential" (p. 175).

Similarly, Belcher et al. (2005) studied **HIV transmission risk perceptions** and associated behaviors in a convenience sample of 174 HIV-positive MSM residing in New York and San Francisco. The authors found that

although a general risk consensus has developed among MSM about some behaviors, such as unprotected insertive anal intercourse (with ejaculation), the collective perception of the risk from other behaviors is much more variable. ... [N]ot all MSM agree on the level of transmission risk associated with insertive oral sex, the protective value of withdrawal before ejaculation, or the extent to which HIV treatment reduces the likelihood of HIV transmis-

sion. For these lower risk behaviors, for which there is less definitive epidemiological evidence and less direct public health guidance concerning HIV risk, as the perception of transmission risk associated with a particular behavior increases, so too does the likelihood of condom use during the practice of that behavior. (p. 87)

Although Belcher and colleagues attribute behavioral differences to personal evaluations of risk, as well as variability in risk tolerance across study participants, they suggest that "risk perception may be an important primary point of intervention for prevention messages designed to reduce gray-area behaviors, for which there is no consensus about risk. Such messages might include more specific information about the risk from insertive anal intercourse even when a condom is used, the risks associated with oral sex (oral lesions, [STDs]) or the limited protective value of withdrawal before ejaculation" (p. 87).

Moving from risk perceptions to actual risk, Buchbinder et al. (2005) drew data from a cohort of 3,257 MSM in 6 U.S. cities and found that "**independent risk factors for HIV seroconversion** were increased number of reported HIV-negative male sex partners ..., nitrite inhalant use ..., unprotected receptive anal sex with an HIV unknown serostatus partner ... or HIV-positive partner ..., protected receptive anal sex with an HIV-positive partner ..., lack of circumcision ..., and receptive oral sex to ejaculation with an HIV-positive partner ..." (p. 82).

The risk factors appearing to contribute to the greatest number of infections in this cohort included a larger number of HIV-negative sex partners, inhaled nitrite use, and younger age. Although many counseling messages aimed at

HIV-negative persons focus on unsafe sexual activity with HIV-positive sex partners or those of unknown HIV serostatus, [this] study suggested that more than one quarter of new infections arose from men having HIV-“negative” partners. This probably reflects error in presumed partner serostatus, particularly among men with multiple partners, as well as residual confounding by factors such as partner infectiousness and level of sexual trauma. ... Prevention messages should emphasize the impor-

... tance of reducing the number of sexual partners, even those presumed to be HIV-negative. (p. 86)

In addition to reductions in the number of sex partners, Buchbinder and colleagues point to “a number of opportunities for building effective prevention strategies: reductions in the number of ... episodes of receptive anal sex; regular HIV antibody testing and disclosure of test results to all sex partners; and strategies focused on reducing sexual risk associated with substances, including inhaled nitrites” (p. 87).

Carballo-Diéguez et al. (2005) conducted a randomized controlled trial involving 180 Latino gay and bisexual men in New York City, who were assigned to either an empowerment intervention tailored to the target population and designed to **reduce unprotected anal intercourse (UAI)**, or a wait-list control group.

The final version [of the intervention] consisted of eight sessions, each one including basic exercises and focusing on a specific theme. The exercises included word association, story analysis, problem solving, analysis of Spanish ‘dichos’ or proverbs, and the discussion of the aggregate tallies of weekly sexual diaries kept by the participants. The themes of the eight sessions were presented in the form of stories which covered oppression, transgression of rules, excuses (or rationalizations), substance use, goal setting, the role of pleasure, self-efficacy and plans for the future. (p. 316)

Participants were assessed at baseline and again at 2, 8, and 14 months after completing the intervention. “In the course of this longitudinal study, about a third of a group of Latino MSM who had twice acknowledged having had recent UAI reported no longer engaging in this risky practice at two different assessment occasions. Furthermore, a larger group – about half of the participants – reported going through at least two-month periods in which they had no UAI. However, *the changes cannot be attributed to the intervention, since both intervention and control groups modified their behavior to a similar extent*” (p. 325).

The authors speculate on possible reasons for these findings. They include a selection bias favoring participants highly motivated to change behavior; use of a comprehensive baseline assessment that might have

From the Block

Positive Impact

Positive Impact (PI), an urban, community-based mental health services agency, has served metropolitan Atlanta since 1992. Both historically and presently, PI’s HIV-related mental health services have been provided by scores of clinicians practicing in greater Atlanta who volunteer their services, as well as through an in-house training program for students in the mental health disciplines.

Funding from CMHS/SAMHSA has permitted PI to develop partnership arrangements with a number of other programs and, in doing so, to extend care to clients living with HIV/AIDS for whom private practice services are often unavailable. Current program partners include:

- o Our Common Welfare, an urban mental health/substance abuse treatment program specifically for HIV-positive persons;
- o AID Gwinnett, a suburban multidisciplinary AIDS service organization (ASO) located northeast of downtown Atlanta;
- o St Joseph’s Mercy Mobile Care Program and Edgewood residential facility, serving Atlanta’s homeless population;
- o The Cobb County Board of Health’s Marietta Clinic, northwest of downtown Atlanta;
- o The Grady Infectious Disease Program, serving Atlanta residents with CD4 cell counts below 200 cells/mm³; and
- o The Medical College of Georgia (MCG) and its outreach component, CSRA AIDS Resources and Education (C.A.R.E.), an ASO in Augusta, Georgia, with services directed to a more rural population.

PI places its CMHS/SAMHSA-funded clinicians at all these sites with the exception of MCG, which has a subcontract with PI to provide mental health services through its doctoral-level Medical Psychology HIV/AIDS Track. C.A.R.E., MCG’s outreach component, also has a subcontract with PI.

The Principal Investigator is Paul Plate, MA, LPC; the Project Director is Sandra Muckle, BSW; and the Clinical Director is Gwen Davies, PhD. For more information, please call 404/589-9040 or go to <http://www.positiveimpact-atl.org/>.

– Compiled by the MHHS Program Coordinating Center

elicited a desire to change behavior; and selection of participants who felt socially oppressed, but not disempowered and who elected risky behavior as an expression of adventurism and/or spontaneity. Carballo-Diéguez and colleagues caution clinicians to question assertions regarding “the effectiveness of a prevention strategy based on post-intervention versus baseline comparison, without control arms, or with control arms to which participants were not randomly assigned” (p. 326).

About Substance Users

Shoptaw et al. (2005) randomized 162 urban **methamphetamine** (meth)-dependent, treatment-seeking gay and bisexual men in Los Angeles County to one of four 16-week behavioral substance abuse treatment conditions: standard cognitive behavioral therapy (CBT, $n = 40$), contingency management (CM, $n = 42$), combined cognitive behavioral therapy and contingency management (CBT+CM, $n = 40$), or a culturally tailored, gay-specific cognitive behavioral therapy (GCBT, $n = 40$).³ Urine drug screens to assess stimulant use were administered three times weekly, and sexual risk behaviors were monitored monthly during treatment. Follow-up assessment occurred at 6 and 12 months postintervention.

As expected, maximal suppres-

³ “Cognitive behavioral therapy [CBT] is a broad set of psychological and educational techniques that provide substance-dependent individuals with critical knowledge about stimulant dependence and trains them with skills to initiate abstinence and to return to abstinence should relapse occur Contingency management [CM] contrasts with CBT in that it is a behavioral therapy that manipulates available reinforcers in the environment to shape the behaviors of substance-dependent individuals to avoid drug use. ... [Tailored gay-specific cognitive behavioral therapy (GCBT)] integrates the standard [CBT] with referents to cultural norms and values of urban [gay and bisexual men] and [emphasizes the] reduction of HIV-related sexual behaviors” (p. 126).

sion of [meth] use was produced during treatment by conditions containing CM. During treatment, the CM condition produced the greatest number of ... [clean] urine samples followed by the combined CBT+CM condition and then the GCBT condition, compared to CBT. Maximal reductions in unprotected receptive anal intercourse resulted from the specially tailored GCBT condition. The GCBT condition produced the fastest rate of reductions in reported unprotected receptive anal intercourse during the treatment period as compared to the CBT condition. Incorporating CM with CBT significantly reduced [meth] use and increased attendance at therapy sessions over standard CBT during treatment as measured using urine drug screening results. Similarly, severity of self-reported drug use and psychiatric problems ... lessened during the treatment period across conditions, with maintenance of improvements to 1 year after randomization. ... Reductions in both [meth] use and sexual risk behaviors demonstrated only modest regression of treatment effects to 1-year follow-up evaluations. Together, sustained reductions both in [meth] use and sexual risk behaviors observed over the longer term suggest that the specific treatments delivered to [gay and bisexual men] seeking treatment for [meth] dependence are less important than that the men received a significant exposure to some treatment. Structural effects of being in treatment, such as regular clinic attendance, monitoring drug use through collection of urine samples, and reporting sexual risk behaviors may contribute to maintenance of long-term behavior changes. (p. 132)

Given the significant reductions in meth use and sexual risk behaviors

noted among these meth-dependent gay and bisexual men, “[d]rug abuse treatments merit consideration as a primary HIV prevention strategy for this population” (p. 125).

Additional insights on treatment for meth dependence emerge from Kurtz (2005), who conducted focus groups with 15 gay men in Miami to explore the motivations and consequences of crystal meth use, which has become increasingly prevalent in that setting in recent years. “Loneliness, fears about physical attractiveness due to aging and illness, and desires to lose sexual inhibitions were common motivations for using the drug. Continued use of crystal was often described as the cause of lost friendships, employment and long-term relationships, as well as sexual behaviors that put men at risk for HIV and other [STDs]” (p. 63). Kurtz indicates that “[t]he extent of the **isolation and loss of social relationships** attributed by [focus group participants] to crystal use have not been previously described in the literature ... [and suggest] that interventions to reduce drug use and sexual risks among this population may be more successful to the extent they address men’s needs for – and skills at attaining – social connectedness to other individuals and to the broader community” (pp. 70-71).

Moore et al. (2005) assessed substance use, sexual risk behaviors, and **underlying temperamental characteristics** among 230 participants in a long-term cohort study, 186 of whom were also living with HIV. “[F]indings suggest that individuals who are current heavy substance users have differing temperamental profiles from those that are not heavy substance users. Examination of specific substance abusing groups revealed that an irritable-explosive temperament is most related to potentially risky use of cocaine, stimulants other than cocaine, and alco-

hol. In the case of heavy users of opioids, individuals generally endorsed longstanding problems with irritability and self-doubt (i.e. depressive), as well as consistently elevated-activated mood (i.e. hyper-thymic)" (p. 197).

The authors reason that "[i]f individuals with risky temperamental profiles could be identified prior to HIV-infection, it may be possible to target these individuals for intervention both pharmacologically and through psycho-education. ... [For example], individuals who display irritable-explosive temperaments may be candidates for interventions that focus on anger management and impulse control. An early intervention may decrease substance use and help to curb the spread of HIV" (p. 198).

HIV Assessment News

HIV Counseling & Testing

Ransom, Siler, Peters, and Maurer (2005) interviewed 26 nonpregnant women who were **seeking HIV testing for the first time**. A pattern of **worry** was evident across three phases of the experience: 1) deciding to get tested; 2) the testing process itself; and 3) contemplating what happens next. "Findings ... indicate the need for sensitive, realistic discussions with women about risks for HIV infection and to encourage testing. ... Deciding to get tested might require a long time. Regardless of how positive the process, the testing experience is stressful. However, the testing experience offers an opportunity to reflect about ways to reduce the risk of HIV by choosing safer sex behaviors" (pp. 391-392).

Ransom and colleagues urge clinicians to be

sensitive to the worry associated with testing by exploring the meaning of testing for each woman. Communication might be enhanced by asking how much women perceive themselves as

worriers, how much and how long they have been worried about HIV infection, and their perception of their risk of infection. ... To identify continuing concerns and worry even after receiving negative results, ... providers could ask clients how much they anticipate worrying about HIV infection in the future. The continued worrying apparent in what seems initially as a circumscribed experience might reflect the lingering fear of the threat of AIDS and its possible outcomes, as well as the social and political stigma attached to this disease. Conversely, the continued worry might reflect clients at risk for generalized anxiety disorder. Women who use worry for problem solving might benefit from suggestions about what to do next, how to reduce risks, how to access emotional support, and how to locate relevant resources. Clients who anticipate high levels of continuing worry might benefit from suggestions for improved coping ... (p. 391)

With a diverse sample of 560 heterosexually active men and women presenting for HIV counseling and testing at publicly funded sites, Amaro, Morrill, Dai, Cabral, and Raj (2005) administered questionnaires both before and 3 months after counseling and testing. They found that learning of one's positive serostatus was the strongest predictor of safer sexual behavior following counseling and testing. In addition, while many with negative serostatus discontinued sexual involvement with *non-main* partners, sexual practices with main partners were more resistant to change and varied by "stage of change" for safer sex as identified at the pre-test assessment. "Taken together, these findings indicate that risk behaviors and behavior change are dependent on [a] complex interaction of factors that include personal characteristics, HIV status,

HIV risk history and stage of change, as well as [counseling and testing] services. The study findings ... [point] to **the complex nature of changing heterosexual risk behaviors**, which are embedded in a host of social, psychological and personal-history factors that need to be targeted in individualized prevention efforts" (p. 296). The authors conclude that

HIV [counseling and testing]'s most important role may be to facilitate entry of individuals who are infected into medical care for the management of HIV disease. For individuals who are not infected, [counseling and testing] in its current form has limited sustainable prevention value. ... [A]n important question remains whether HIV [counseling and testing] can be utilized as an effective entry point for the identification and triage of clients to prevention programs that can more appropriately meet the multifaceted behavioral risk reduction needs of diverse groups. This would require effective screening and a corresponding mechanism for effective triage of high-risk clients into tailored interventions as well as a variety of referral resources available for individual, couples and group interventions. (p. 297)

Psychiatric Assessment

Reid and Dwyer (2005) reviewed 29 prevalence studies on **insomnia** in people living with HIV and AIDS. While these studies

have many methodologic flaws, available evidence indicates that insomnia is a common complaint in people with HIV and AIDS. ... Reports of insomnia are reported at all stages of HIV infection, but the presence of cognitive impairment or an AIDS-defining illness is a significant risk factor. ... Insomnia is an adverse effect fre-

Tool Box

Casting a Mindful “I” on HIV-Related Stigma

Erving Goffman, whose seminal work “provide[s] the theoretical underpinnings for much of the literature on stigma and stereotyping” (Health Resources and Services Administration, HIV/AIDS Bureau [HRSA/HAB], 2003), defines stigma as “an attribute that is deeply discrediting” and reduces the stigmatized individual “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3).

Within this framework, highly stigmatized diseases share a number of common attributes:

- o The person with the disease is seen as responsible for having the illness
- o The disease is progressive and incurable
- o The disease is not well understood among the public
- o The symptoms cannot be concealed.

HIV infection fits the profile of a condition that carries a high level of stigmatization ... First, people infected with HIV are often blamed for their condition and many people believe HIV could be avoided if individuals made better moral decisions. Second, although HIV is treatable, it is nevertheless a progressive, incurable disease ... Third, HIV transmission is poorly understood by some

people in the general population, causing them to feel threatened by the mere presence of the disease. Finally, although asymptomatic HIV infection can often be concealed, the symptoms of HIV-related illness cannot. HIV-related symptoms may be considered repulsive, ugly, and disruptive to social interaction ... (HRSA/HAB, 2003)

The result is the widely documented phenomenon of HIV-related stigma. “HIV-related stigma refers to all unfavorable attitudes, beliefs, and policies directed toward people perceived to have HIV/AIDS as well as toward their significant others and loved ones, close associates, social groups, and communities. Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities – especially those of gender, sexuality, and race – that are at the root of HIV-related stigma” (HRSA/HAB, 2003).

Research has demonstrated that HIV-related stigma and discriminatory practices can negatively affect condom use, HIV test-seeking behavior, willingness to disclose HIV-positive serostatus, the pursuit of HIV-related health care, the quality of that care, and the solicitation of social support. Stigma and discriminatory practices can also affect the treatment of people living with HIV/AIDS by partners, families, community members, and health care providers (Brown, Macintyre, & Trujillo, 2003).

Not unlike their impacts on the general public, “fear of contagion and fear

of death have clear negative effects on health care workers’ attitudes toward and treatment of [people living with HIV/AIDS] These attitudes range from mild disdain to refusal to treat to outright abuse ...” (Brown, Macintyre, & Trujillo, 2003, p. 51). Additionally, HIV-related stigma *by association* can affect informal caregivers (i.e., friends and family) and formal caregivers (i.e., health care workers) alike (Brown, Macintyre, & Trujillo, 2003).

As suggested earlier, “[t]he stigma of [HIV] infection is layered with other stigmas, such as those associated with the routes of transmission (e.g., sex work and injecting drug use) and personal characteristics (e.g., race, religion, ethnicity and gender)” (Reidpath & Chan, 2005, p. 425). By extension, then, the stigma associated with mental illness bears concurrent examination by health care workers, including those who provide mental health services to people living with HIV/AIDS (see [sidebar](#)).

The Limitations of Current Research

Brown, Macintyre, and Trujillo (2003) assessed 22 published studies carried out in developed and developing countries in which an assortment of interventions designed to reduce HIV-related stigma were tested.

The target group, setting, type of intervention, measures, and scale of these studies varied tremendously. The majority ... aimed to increase tolerance of [people living with HIV/AIDS] ... among the general population. The remaining studies tested interventions to

quently reported in association with antiretroviral therapy, but studies evaluating ... antiretroviral drugs as a class have not demonstrated a significant effect. The exception was efavirenz, which has been carefully evaluated and found to be an independent predictor of insomnia. ... The most notable finding to emerge from this review was the consistent and strong association between psychological morbidity, in particu-

lar depression, and insomnia in asymptomatic seropositive patients. (p. 266)

Reid and Dwyer are quick to note that while “[i]nsomnia is one of the criteria for the diagnosis of depression, which creates an association by definition ... [, a]n association remains ... when the criteria for depression are restricted to mood symptoms and exclude sleep-related questions ...” (p. 267). They further

observe that a relationship between insomnia and anxiety disorders was also noted and sleep disturbance is not a diagnostic criterion for anxiety disorders.

Turning to intervention, the authors found “limited evidence for the effect of specific treatments for insomnia in HIV infection” (p. 260). “However, given that psychiatric disorders are often missed in general medical settings, from a clinical perspective an

increase willingness to treat [people living with HIV/AIDS] among health care providers or improve coping strategies for dealing with AIDS stigma among [people living with HIV/AIDS] or at-risk groups. Results suggest some stigma reduction interventions appear to work, at least on a small scale and in the short term, but many gaps remain especially in relation to scale and duration of impact and in terms of gendered impact of stigma reduction interventions. (p. 49)

Triple A Model Suits Clinicians to a T

For practicing clinicians, the first steps in identifying and addressing HIV-related stigma in others are identifying

and addressing stigmatizing attitudes and behaviors in themselves. “Understanding one’s own HIV/AIDS biases ... [is] crucial to effective and culturally competent social service and health care delivery. ... Despite the best professional intentions across disciplines, ... stigma remains a persistent obstacle to effective prevention and treatment” (Rutledge & Abell, 2005, pp. 195-196).

In a recent paper, Rutledge and Abell (2005) lay out a conceptual model designed “to address the experience and expression of stigma by providers of health care and social services” (p. 187).

We propose a three-step model for

responding to HIV/AIDS-related stigma. Based on principles of mindfulness ..., these steps suggest a strategy for better understanding self and situation as a precursor to responding, rather than reacting, to life experiences. ...

Mindfulness principles are derived from Buddhism ... and have, as their overriding concern, the relief of suffering and the dispelling of illusions. ... [T]he practices are essentially techniques for looking deeply into oneself to cultivate compassion and understanding

... As applied to the dynamics of HIV/AIDS provider stigma, our proposed Awareness/Acceptance/Action Model (AAAM) suggests a framework for intentional response in health care and social service settings. Following mindfulness principles, one would take full account of initial experiences when confronted with a challenge, concentrating first on cultivating awareness. In mindfulness training, this implies two related steps: looking deeply and listening well. (pp. 190-191)

Cultivating Awareness: Looking Deeply and Listening Well

According to Rutledge and Abell, the first step in cultivating awareness is “looking deeply.” “Looking deeply involves paying attention to the full range of one’s initial experience so as not to respond prematurely. How am I feeling? What thoughts and associations

(Tool Box is continued on Page 12)

A Separate Piece (of Work)

Sriram and Jabbarpour (2005) conducted a brief anonymous survey of 50 clinical staff members (including psychiatrists, psychologists, social workers, and nursing staff) at a state psychiatric facility. The investigators used a written questionnaire to pose two simple yes-or-no questions: “If you were to be diagnosed with schizophrenia, would you be uncomfortable talking about it to a nonprofessional (such as friends or acquaintances)?” If respondents answered “Yes,” they were then asked whether “it [was] because of stigma?” (p. 610). Thirty respondents (60%) indicated that they would be uncomfortable talking about their diagnosis to friends and acquaintances. Seventeen respondents (34%) indicated that it was because of stigma.

As the authors see it, these findings suggest that “[w]e may be practicing a double standard – expecting consumers and the public to cast off their stigmatizing beliefs but harboring those beliefs ourselves” (p. 610). Building on recommendations made by the President’s New Freedom Commission on Mental Health (2003; summarized in a **Building Block** in the [Fall 2004 issue](#) of *mental health AIDS*), Sriram and Jabbarpour astutely observe that efforts to eradicate stigmatizing beliefs associated with mental illness should not be confined to the general public and mental health service consumers, but should extend to mental health professionals as well.

References

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Executive summary*. Rockville, MD: DHHS Pub. No. SMA-03-3831.

Sriram, T.G., & Jabbarpour, Y.M. (2005). Are mental health professionals immune to stigmatizing beliefs? [Letter]. *Psychiatric Services*, 56(5), 610.

important first step would be to improve the assessment and management of anxiety and depression in people with HIV infection” (p. 267).

Gielen, McDonnell, O’Campo, and Burke (2005) interviewed 611 women residing in an urban setting and receiving health or social services, half of whom were living with HIV, regarding their experiences with **intimate partner violence** (IPV), suicidal ideation and attempts, depression, and

anxiety. The findings are noteworthy:

Having thought about suicide was reported by 31% of the sample and 16% reported having attempted suicide. Among HIV-positive women, thoughts of suicide occurred more frequently among those who were recently diagnosed. One-half of the sample reported problems with depression, and 26% reported problems with anxiety; of women

reporting these problems, 56% received mental health treatment. Rates varied significantly by HIV and IPV status, with women who were both HIV-positive and abused consistently faring worse. Relative to HIV-negative non-abused women, HIV-positive abused women were 7.0 times as likely to report problems with depression, 4.9 times as likely to report problems with anxiety,

(Biopsychosocial Update is continued on Page 13)

do I have? How are these impacting my choices about how to deal with this person or situation? ... In the framework of mindfulness, ignoring the full expression of one's initial reactions can set the stage for ill-considered and unintentional reactions that perpetuate discrimination ..., and inhibit the ... provider from effectively performing his or her role" (p. 191).

A related second step in cultivating awareness is "listening well." "Whereas the process of looking deeply centers initially on understanding self in the encounter with others, listening entails paying undistracted attention to a set of cues communicated by another. When attempting to understand the [client's] needs and wishes, the ... provider must track speech content and tone, emotional expression, and body language. In mindfulness terms, ... listening ... emphasizes a readiness to suspend prior considerations and biases, and to learn from another through careful observation" (p. 191).

Additionally, "[e]ducating oneself about the nature of HIV, the routes and means of transmission, the implications for testing, treatment, and caregiving, and the psychosocial complications faced by family, friends, professionals, and community members can enhance the provider's ability to respond based on fact rather than misinformation" (p. 192).

Achieving Acceptance

The next component of this approach centers on "acceptance." In this context, acceptance has several meanings. These include acknowledging:

- o The reality of our own biases and fears;
- o Contradictions between what we know intellectually and what we feel or enact interpersonally;
- o That underestimating our potential to stigmatize people living with HIV/AIDS necessarily detracts from our effort to offer the best possible response; and

o That use of the concepts "us" and "them" to distance ourselves from people living with HIV/AIDS delays acceptance of the pervasiveness of HIV across a range of people and circumstances.

"Coming to grips with the full extent to which 'they' are 'we' calls for a literal transformation of one's identity, and challenges providers to a deeper understanding of self-care. Whereas one might formerly have considered service to be a one-way transaction, it now becomes part-and-parcel of creating health-enhancing community environments" (p. 192).

Taking Action

The final component of this approach involves "action," or the use of awareness and acceptance in developing *intentional* responses to people living with HIV/AIDS. Rather than falling back on habitually patterned reactions, action signifies the development of responses that are both compassionate and constructive.

o "On the most personal level, individual action can include deepening awareness of one's own prejudices as a prelude for more clear thinking about HIV/AIDS services. How is it that my attitudes are clouding my ability to see this situation as it actually is, rather than how I first imagine[d] it to be? In this sense, self care includes a commitment to preventing one's misconceptions from blocking understanding or clouding emotional responses to the needs of [people living with HIV/AIDS]" (p. 193).

o "On an interpersonal level, action represents the commitment to cultivate a compassionate approach to service provision. This includes respecting others as they are, and striving to listen deeply to their true circumstances before determining a plan of action. Admittedly, this is extremely challenging in the context of limited resources, openly fearful or hostile families and communities, and demanding or needy clients. In this context, the notion of self-care rests on the awareness that the suffering of one inevitably contributes to suffering of all others, and that communities cannot thrive

as long as the needs of some are systematically disregarded" (p. 193).

In this way, action "pushes the notion of self-care to its highest level. In the end, AAAM principles recognize that the stigma surrounding HIV/AIDS is deeply rooted both within and across cultures ... and responses failing to take this into account are incomplete. The notion of an activist is inseparable from comprehensive HIV/AIDS responses. In the context of the proposed model, such actions include attending to social policies and institutions that, intentionally or otherwise, pose barriers to necessary and constructive responses" (p. 193).

Not So Fast ...

Rutledge and Abell close by reminding clinicians that, while they "may feel competent in delivering services, they may remain solely unaware of how their unintended stigmatizing behaviors may be interpreted by vulnerable populations. Although we may consider ourselves 'ready for action,' we may remain unaware of how we evoke stigmatizing responses. It is critical to continually 'look deeper'; the AAAM is not intended to be a short-term experience" (pp. 197-198).

References

- Brown, L., Macintyre, K., & Trujillo, L. (2003). Interventions to reduce HIV/AIDS stigma: What have we learned? *AIDS Education & Prevention, 15*(1), 49-69.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster.
- Health Resources and Services Administration, HIV/AIDS Bureau. (2003, May). *Stigma and HIV/AIDS: A review of the literature*. Rockville, MD: Author. Retrieved April 21, 2005, from the World Wide Web: <http://hab.hrsa.gov/publications/stigma/introduction.htm>
- Reidpath, D.D., & Chan, K.Y. (2005). A method for the quantitative analysis of the layering of HIV-related stigma. *AIDS Care, 17*(4), 425-432.
- Rutledge, S.E., & Abell, N. (2005). Awareness, acceptance, and action: An emerging framework for understanding AIDS stigmatizing attitudes among community leaders in Barbados. *AIDS Patient Care & STDs, 19*(3), 186-199.

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3.6 times as likely to have thought about suicide, and 12.5 times as likely to have ever attempted suicide. ... [F]indings that abused HIV-negative women were also at significantly elevated risk for all of these outcomes lend ... support to the conclusion that it is the experience of abuse that is associated with the negative outcomes. (p. 89)

Gielen and colleagues strongly urge clinicians serving low-income urban “women who may be HIV-positive and/or in abusive relationships [to] routinely assess for mental health status, especially suicide risk, which may need crisis intervention” (p. 89).

On a similar theme, Cooperman and Simoni (2005) conducted structured interviews with a sample of 207 largely Hispanic and black women living with HIV in New York City and found that 78% of these women experienced suicidal ideation and 26% attempted suicide since learning of their HIV seropositive status. Among attempters, 42% acted within the first month and 27% within the first week of receiving this news; there was also a spike in attempts around the 1-year anniversary of the seropositive diagnosis. **Suicidal ideation and attempts** were positively associated with an AIDS diagnosis, psychiatric symptoms, and a history of physical or sexual abuse. Unexpectedly, suicidal ideation and attempts were also positively associated with having children and employment outside the home. Spirituality, by contrast, was negatively associated with suicidal ideation, but was not associated with attempts. Cooperman and Simoni conclude that “suicide prevention measures should be implemented for HIV-positive women immediately after diagnosis. Specifically, interventions should target those with an AIDS diagnosis, psychiatric symptoms, an abuse history,

children, or employment. The encouragement of spiritual connection seems to be a deterrent to suicidal thoughts and is a possible avenue for intervention” (p. 149).

Tsao, Dobalian, and Naliboff (2004) looked at **panic disorder, posttraumatic stress disorder (PTSD), major depression, and pain** among 1,489 individuals within a nationally representative sample of 2,864 adults receiving HIV medical care in 1996 and found that “panic disorder showed a strong association with pain ... , which was significantly greater than PTSD ... but only marginally greater than major depression Longitudinal analyses of the three psychological disorders revealed that increasing pain from baseline to follow-up (an approximately 6-month period) was associated with panic disorder only ... , after controlling for baseline pain scores, baseline HIV disease status and change in disease stage across time” (p. 172). These findings “suggest that increased attention should be paid to co-existing anxiety disorders in HIV patients with pain” (p. 178).

Continuing this focus on anxiety disorders, Katz and Nevid (2005) explored risk factors associated with symptoms of PTSD in a low-income sample of 102 largely single African American women living with HIV. “Overall, ... **HIV-related PTSD** symptomatology was associated with a greater number of HIV physical symptoms, greater number of past traumatic events, lower satisfaction with perceived availability of social support, a greater degree of current negative life change, and a greater degree of perceived stigma” (p. 115). Katz and Nevid also identified three individual predictors of such symptoms: “negative life change, stigma, and number of HIV physical symptoms. The strongest predictor was stigma, showing that the higher the level of perceived stigma, the greater

the number of HIV-related PTSD symptoms tended to be” (pp. 115-116).

With regard to treatment,

[f]irst, a psychoeducational component that focuses on shame, guilt, and humiliation and how they arise is an important tool before starting an effective therapy program. In the case of HIV-related PTSD, this may involve the therapist discussing the stigma often attached to HIV infection and how this stigma may result in an infected person feeling shamed or guilty. The most common aspects of stigma as they relate to HIV should be discussed. Second, when working with humiliation, the therapist should be aware of any desires for revenge or feelings of rage. Techniques directed at dealing with these feelings may be necessary before exposure therapy is used to extinguish feelings of humiliation. ... Third, the therapist should distinguish between feelings of internal shame, external shame, and humiliation when working with shame-based PTSD.

In working with women with HIV, it may be useful for the therapist to understand the woman’s cognitive appraisals of her infection, such as whether she feels shamed because she views herself as bad or disgusting (internal shame), or if she feels shamed because she believes that others will now perceive her as disgusting or inadequate in some way. Fourth, the therapist should take care not to reshape the person during the assessment period in order to ensure continued treatment participation. The therapist should also be aware of any indications of shame, such as behavioral indi-

caters (loss of eye contact, reddening of the face), or previous shame experiences and maladaptive core beliefs being applied to the meaning of the trauma of being infected with HIV. Last, the therapist may need to work with underlying maladaptive schemas, challenging them and rebuilding more adaptive schemas. Thus, the work with HIV-infected women may involve focusing on their maladaptive schemas, such as beliefs that they were infected with HIV because they are bad or disgusting, and challenging these beliefs so that new, more adaptive meanings may be applied toward their illness. (p. 117)

Lightfoot et al. (2005) surveyed 3,806 adults living with HIV in four major U.S. metropolitan areas – a sample “demographically reflective of the current HIV epidemic in the United States” (p. 136) – and categorized recent **substance use** among those surveyed as frequent (40%), occasional (32%), or abstinent (28%). “Participants using drugs at a frequent level identified as heterosexual, had public insurance, and had higher levels of depression. Participants who reduced from a lifetime high seriousness in substance use were female, older, and knew their HIV status for a longer period of time” (p. 129). Given the high level of substance use uncovered through this survey, Lightfoot and colleagues recommend that “screening and identification of substance misuse and abuse, as well as referral for additional services, should be included in all interventions aimed at improving the physical functioning, mental health, and quality of life of those living with HIV” (p. 137).

HIV Treatment News

Medical Care

On February 25, 2005, the U.S. Food and Drug Administration (FDA) approved a combination treatment for

adults **co-infected with hepatitis C** (HCV) and clinically stable HIV disease. The two drugs, peginterferon alfa-2a (Pegasys®) and ribavirin (Copegus®), had already received FDA approval for the treatment of chronic HCV infections in adults without HIV. This drug combination is now the first to receive approval for use in adults living with HIV (FDA, 2005a).

On April 29, 2005, the FDA approved a once-daily liquid and softgel capsule formulation of Kaletra® for the treatment of antiretroviral-naïve adults living with HIV. Kaletra® is a protease inhibitor (PI) composed of two HIV medications, lopinavir (LPV or Aluviran®) and ritonavir (RTV or Norvir®). It is taken with food and in combination with other antiretrovirals and was initially administered twice daily. When given in combination with once-daily tenofovir (TDF or Viread®) and emtricitabine (FTC or Emtriva®), **once-daily Kaletra®** compared favorably in safety and efficacy to twice-daily Kaletra®, although diarrhea occurred with greater frequency when the once-daily Kaletra® formulation was administered (FDA, 2005b).

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Adherence to Treatment

Spanish investigators (Fumaz et al., 2005) assessed the long-term effects of **efavirenz** (EFV or Sustiva®) by comparing 60 individuals taking an EFV-based antiretroviral regimen for at least 1 year with 60 taking a PI-containing regimen for a comparable period of time.

Mild dizziness, sadness, mood changes, irritability, lightheadedness, nervousness, impaired concentration, abnormal dreams, and somnolence were reported more frequently in the EFV group than in the PI group Forty-nine of 60 patients presented with therapeutic [EFV]

plasma levels ... [and EFV] plasma levels were similar in subjects with and without neuropsychiatric disorders. No significant differences were found between the EFV group and the PI group regarding quality of life and psychologic status. Sixty percent of patients in the EFV group and 55% in the PI group reported adherence $\geq 95\%$. (p. 560)

Drawing on these findings, Fumaz and colleagues conclude that “neuropsychiatric disorders may persist in the long term in a significant proportion of patients on [EFV] treatment. These disturbances were mild and clinically tolerable and did not impair patients’ quality of life and psychologic status. Because adherence decreased with time, interventions to enhance long-term compliance should be applied in clinical practice” (p. 564).

To examine the relationship between perceived stress and nonadherence to HAART, French et al. (2005) reduced the validated, 14-item **Perceived Stress Scale** (PSS) to 4 items:

In the past month, how often have you felt

(a) That you were unable to control the important things in your life?

(b) Confident in your ability to handle your personal problems?

(c) That things were going your way?

(d) Difficulties were piling up so high that you could not handle them? (p. 591)

This revised measure “takes ~1-2 minutes to complete ... is straightforward and requires no specialized training for its use” (p. 595). The authors assessed the utility of this

screening instrument with 590 clients attending adherence support programs in New York State and found that “clients who scored in the highest quartile of perceived stress were more than twice as likely to be nonadherent at baseline and follow-up 1 and more than 5 times as likely to be nonadherent at follow-up 2 than clients in the lowest quartile of perceived stress scores” (p. 590). French and colleagues contend that, along with the routine measurement of adherence by clinicians, “this revised, 4-item version of the PSS may serve as an effective, additional tool to assist in identifying those at higher risk of nonadherence to target these individuals for enhanced adherence support and referral to mental health, substance use, and other necessary services” (p. 595).

Exploring factors associated with **discontinuing HAART** among 936 women living with HIV and participating in a multisite, prospective study, Ahdieh-Grant et al. (2005) found discontinuation to be associated with high **depressive symptoms** scores. These findings “emphasize that access to treatment of depression may have important implications for the management of HIV-infected individuals on [antiretroviral therapy]” (p. 502).

Does the use of **antidepressant medication** improve adherence to HAART regimens? Yun, Maravi, Kobayashi, Barton, and Davidson (2005) looked at adherence both before and after the initiation of antidepressant treatment in 507 people seen for HIV medical care in an urban setting who were depressed and receiving HAART. They found that “antiretroviral adherence was higher for depressed patients prescribed and adherent to [antidepressant treatment] compared with those neither prescribed nor adherent to [antidepressant treatment]. Attention to diagnosis and treatment of depressive disorders in this population may im-

prove antiretroviral adherence and ultimate survival” (p. 432). For these reasons, the authors conclude that “[m]ental health evaluation should be an integral health care component of all HIV-infected patients receiving medical care” (p. 437).

Can interventions with couples be of help when adherence is flagging? To find out, Remien et al. (2005) conducted a randomized controlled trial involving 215 gay and heterosexual HIV-serodiscordant, predominantly lower income and racial/ethnic minority couples in New York City in which the partner living with HIV was assessed to have < 80% antiretroviral adherence at baseline. Couples were assigned to either a **couple-based adherence intervention** or “usual” care. The intervention

aimed to improve patients’ adherence to HIV/AIDS medical care regimens by fostering the support of their partners; in addition the intervention sought to help couples to address issues of sex and intimacy. The intervention was individually administered to each couple by a nurse practitioner through four 45-60 min sessions held over 5 weeks. The session content included structured discussions and instruction, as well as specific problem-solving and couple-communication exercises. Key components included education about the importance of adherence to avoid viral resistance and maintain health, identifying patterns of non-adherence, developing communication and problem-solving strategies to overcome adherence barriers, optimizing partner support, and building confidence in the couple for achieving and maintaining improved adherence. (p. 809)

At week 8, those participating in the intervention “showed higher mean medication adherence ... when com-

pared with controls whether adherence was defined as proportion of prescribed doses taken (76% versus 60%) or doses taken within specified time parameters (58% versus 35%). Also, participants in the intervention arm were significantly more likely to achieve high levels of adherence (> 80%, > 90%, or > 95%) when compared with controls. However, in most cases, effects diminished with time, as seen at follow-up at 3 and 6 months” (p. 807).

Notwithstanding observations that even the improved levels of adherence achieved in this study remained suboptimal for many participants and that the effect of the intervention was attenuated over time, Remien and colleagues point to “the paucity of tested interventions with positive adherence outcomes in any population” (p. 812) in concluding that “[t]his brief, theoretically based, dyad-focused behavioral intervention was effective in improving medication adherence among ethnically diverse and relatively poor patients in an urban clinic setting. Outcomes of this trial suggest that ... clinicians should try to include patients’ partners in discussions of treatment decisions and adherence” (p. 813).

Stress Management

Laperriere et al. (2005) measured self-reported depression in 154 women in New York, New Jersey, and Miami 1 year after completing “a 10-week group cognitive-behavioral stress management/expressive supportive therapy (CBSM+) intervention [for] **disadvantaged minority women** living with AIDS” (p. 223). The intervention, modified to promote engagement of the target population,⁴

⁴ “The modifications included techniques to complement the more didactic components of the cognitive behavioral therapies of the CBSM intervention, thereby resulting in a more engaging intervention for disadvantaged ethnically diverse women. For instance, a number of the examples used within the modules reflect a cultural emphasis on family relationships rather than on

focused on stress management, cognitive-behavioral skills training, relaxation techniques, and expressive-supportive therapeutic strategies. The investigators report that “[t]he CBSM+ Group intervention significantly decreased depression scores ... for women following the intervention and maintained the decreased level at one-year follow-up” (p. 223).

Coping, Social Support, & Quality of Life

Over a 6-year period, Rotheram-Borus, Weiss, Alber, and Lester (2005) examined the adjustment patterns of 414 adolescents who had a parent living with HIV. During that time, about half of the parents died, allowing for a comparison of **bereaved adolescents** with those who were coping with similar HIV-related stressors, but whose parents had not died. They found that

[b]ereaved adolescents had significantly more emotional distress, negative life events, and contact with the criminal justice system than nonbereaved youths[, although this pattern declined linearly] ... after parental death. Depressive symptoms and passive problem solving increased soon after parental

work situations or relationships with friends. In addition, there are specific instances where spirituality is addressed. For example, the coping module incorporates ‘The Serenity Prayer’ to demonstrate the importance of applying the appropriate coping response (emotion-focused vs problem-focused) to stressors. The expressive/supportive component is designed to help women who are feeling depressed, helpless and hopeless, allowing the women to express their feelings and to learn successful styles of adaptive coping used by other women in the group The expanded CBSM+ Group intervention is tailored to address issues of disclosure, loss of personal control, domestic violence, financial difficulties, housing, social isolation and depression; all salient issues for women living with AIDS. Finally, child care and refreshments were provided, and transportation costs were reimbursed” (p. 227).

death, as compared with nonbereaved adolescents. One year subsequent to parental death, depression and passive problem solving were similar to the levels of nonbereaved peers. Only sexual risk behaviors increased following parental death. (p. 221)

Reflecting on these findings, Rotheram-Borus and colleagues emphasize that, while

it is not surprising that adolescents reported acute depressive symptoms for a year following parental death, ... high distress more than a year prior to parental death indicates the importance of early identification and preventive interventions for families affected by HIV. When a parent is diagnosed with HIV, the entire family needs support and information about the impact of HIV illness. Developmentally sensitive interventions must be designed to promote parenting skills, family communication, and positive coping for both parents and children. ... Interventions that improve coping skills and address HIV-related challenges may help decrease the increases in problem behaviors, particularly contact with the criminal justice system, in the period prior to parental death. (p. 227)

Continuing this focus on bereavement, Tarakeshwar, Hansen, Kochman, and Sikkema (2005) examined the influence of ethnicity and gender on the use of **spiritual coping** by a diverse sample of 252 men and women living with HIV who had also lost a loved one to AIDS. While a wide range of coping strategies were endorsed by study participants, female and ethnic minority participants reported greater use of spiritual coping than white male participants did. This remained true even after the investigators controlled for

perceived social support, “suggesting that spiritual coping ... is distinct from perceived social support potentially accessible within religious institutions ...” (p. 119). Interestingly,

spiritual coping was more strongly tied to grief among Whites than ethnic minorities. Perhaps, in general, ethnic minorities use spiritual coping irrespective of their level of grief whereas spiritual practices may be more compelling for Whites when faced with a relatively uncontrollable stressor such as bereavement. Furthermore, among Whites, the association

Tool Box
Books & Articles

Artz, L., Macaluso, M., Kelaghan, J., Austin, H., Fleenor, M., Robey, L., Hook, E.W., III, & Brill, I. (2005). An intervention to promote the female condom to sexually transmitted disease clinic patients. *Behavior Modification*, 29(2), 318-369.

“This article describes a 1-hour behavioral intervention designed to promote female condoms and safer sex to women at a high risk for sexually transmitted diseases (STDs). The intervention includes a promotional videotape; a skills-oriented counseling session with a nurse clinician; assorted take-home items, including a videotape for men; and free supplies of female and male condoms. Designed for women ages 18 to 34 attending public STD clinics, ... [m]ost elements of the intervention could be replicated in settings other than STD clinics and delivered by persons other than nurse clinicians” (p. 318).

Martinez, S.M., Kemper, C.A., Diamond, C., Wagner, G., & the California Collaborative Treatment Group. (2005). Body image in patients with HIV/AIDS: Assessment of a new psychometric measure and its medical correlates. *AIDS Patient Care & STDs*, 19(3), 150-156.

The 12-item Body Image Scale (BIS) was “designed to assess body image perception along five dimensions (comfort, competence, appearance, predictability, and existential

between spiritual coping and grief was stronger for men than women, suggesting that spiritual coping is greater among White men who are experiencing higher levels of grief. ... In contrast, for ethnic minorities spiritual coping was related to grief more strongly for women than men. (p. 120)

Tarakeshwar and colleagues conclude by highlighting how this study

emphasized the significance of the spiritual dimension in the lives of individuals with HIV who were also coping with AIDS-related bereavement. ... [F]indings dem-

self" (p. 151) in people living with HIV/AIDS. Drawing on their assessment of the scale's psychometric properties and its relationship to HIV disease symptoms and progression, as well as demographic factors, the authors conclude that "the BIS has good construct validity and is a highly reproducible measure of self-perce[ived] ... body image in HIV-infected patients" (p. 150) and "may be a useful clinical ... tool, especially given the increased awareness of psychosocial factors and quality of life issues related to bodily changes cause[d] by lipodystrophy and other complications of HIV and antiretroviral therapy" (p. 155).

Miller, R.L., Jr. (2005). An appointment with God: AIDS, place, and spirituality. *Journal of Sex Research*, 42(1), 35-45.

"This article describes how an African American gay man living with AIDS used his spiritual, religious, and cultural strengths to resist internalized dislocation because of heterosexism and homophobia. He was able to experience a relocation of God from places that rejected him to places that were conducive to his healing. By using these strengths, he was able to reject his physician's prediction of death and to call on God in response to an end-stage AIDS crisis" (p. 35).

Scheft, H., & Fontenette, D.C. (2005). Psychiatric barriers to readiness for treatment for hepatitis C virus (HCV) infection among injection drug users: Clinical experience of an addiction

onstrate the distinctness of the support that individuals derive from their religion/spirituality. It follows that psychosocial interventions that integrate spirituality along with other coping resources, particularly among women and ethnic minorities, should prove beneficial for those coping with the social, emotional, and health-related complications associated with HIV-infection. (p. 121)

Drawing 235 individuals from this same sample of bereaved, HIV-positive men and women, Sikkema, Hansen, Meade, Kochman, and Lee

psychiatrist in the HIV-HCV coinfection clinic of a public health hospital. *Clinical Infectious Diseases*, 40 (Suppl. 5), S292-S296.

"Among injection drug users, psychological and psychiatric barriers to readiness for treatment for hepatitis C virus (HCV) infection include mood and anxiety disorders, cognitive deficits, temperament disorders, and personality vulnerabilities, as well as ongoing drug use. ... To establish effective treatment for HCV infection in this population of patients, it is ... important that the patient make an effort to adhere to the treatment requirements and that the patient receive the appropriate evaluation and management of treatable barriers" (p. S292).

Scott, K., Gilliam, A., & Braxton, K. (2005). Culturally competent HIV prevention strategies for women of color in the United States. *Health Care for Women International*, 26(1), 17-45.

"This article reviews the literature for culturally competent HIV prevention efforts for women of color – Latina, African American, Asian Pacific Islander, and Native American – and synthesizes components that need to be addressed in programs and interventions. Findings suggest that for programs to be culturally competent, both race/ethnicity and gender, along with population-specific, culturally based attitudes, beliefs, and behaviors, must be considered in interpersonal and organizational strategies" (p. 17).

Silberbogen, A.K., Mori, D.L., & Sogg,

(2005) randomly assigned study participants to one of two conditions: a 12-week, cognitive-behavioral **bereavement coping group intervention** conducted in 90-minute sessions and tailored to gender, ethnicity, and sexual orientation (*Living Beyond Loss*)⁵ or to a comparison condition that consisted of individual psychotherapy and psychiat-

⁵ "The group ... format combined semi-structured cognitive-behavioral and support group approaches. ... Specific strategies for dealing with problems of grief included: (1) establishing a sense of control and predictability; (2) anger expression and management; (3) resolution of guilt; (4) promoting self-mastery through empowerment; (5) development of new relationships" (p. 997).

S. (2005). The Structured Interview for the Treatment of the Hepatitis C Virus (SIT-HCV). *Journal of Clinical Psychology in Medical Settings*, 12(1), 57-69. Silberbogen, Mori, and Sogg provide a detailed description of the SIT-HCV. "This comprehensive interview expands upon a standard psychiatric interview by including those medical, psychological, and behavioral factors that are essential to determining a patient's psychological appropriateness for interferon therapy" (p. 57).

Whetten, K., Reif, S., Swartz, M., Stevens, R., Ostermann, J., Hanisch, L., & Eron, J.J., Jr. (2005). A brief mental health and substance abuse screener for persons with HIV. *AIDS Patient Care & STDs*, 19(2), 89-99.

"This article reports on the creation and preliminary testing of a [13-item] screening tool, the Substance Abuse and Mental Illness Symptoms Screener (SAMISS). ... The finding that the screener is highly predictive of having a general mental disorder and substance use disorder among those screening positive for mental illness symptoms and substance use problems, as well as its brevity and ease of administration, make[s] it a useful tool to detect symptoms of co-occurring disorders so that patients can be referred to mental health and substance abuse specialists. The screener is not a diagnostic instrument and has limited value in predicting specific psychiatric diagnoses" (p. 89).

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ric services on demand (the community standard-of-care). Health-related quality of life (HRQOL) measures were taken at baseline and again 2 weeks following the intervention. "The bereavement coping group intervention significantly improved general [HRQOL] and health issues specific to HIV/AIDS in comparison to community standard-of-care" (pp. 1000-1001). Of note is the finding that "women in the group intervention exhibited more improvement than men, and women in the comparison condition exhibited a deterioration of [HRQOL]" (p. 1001). Sikkema and colleagues conclude that "[t]his bereavement group aimed at improving coping with grief also had a positive impact on [HRQOL] among HIV+ men and women, and suggests that cognitive-behavioral interventions may have a broad impact on both emotional and physical health" (p. 991).

In Canada, Trépanier et al. (2005) evaluated neuropsychological functioning, the presence and severity of depressive symptomatology, and HRQOL in a sample of 155 people living with HIV. "Results suggest that neuropsychological impairment and depression can differentially affect dimensions of [HRQOL]. Specifically, depression has a significant impact on mental health dimensions of [HRQOL]. Additionally, some evidence exists for an impact of neuropsychological impairment, or a combined impact of **depression and neuropsychological impairment**, on the [p]hysical [h]ealth dimensions of [HRQOL]" (p. 1). Trépanier and colleagues stress that "[r]outine medical, psychiatric and neuropsychological assessments can aid in the early detection of cognitive and emotional difficulties and the implementation of timely, effective treatments. ... Given the disproportionately negative impact of depression on the [m]ental [h]ealth dimension of HRQOL, treatment of emotional distress is likely to lead to clinically

meaningful improvements in perceived HRQOL in individuals with HIV-infection" (pp. 11-12).

Finally, analyzing data from a survey involving a nationally representative sample of 2,864 adults receiving HIV medical care in 1996, Cunningham, Crystal, Bozzette, and Hays (2005) found that "the physical health dimension of [HRQOL] was a strong predictor of subsequent **survival**. ... Importantly, physical HRQOL added prognostic information over and above ... CD4 count and stage of HIV infection based on CDC criteria. The magnitude of the effect of being in the highest quartile of physical HRQOL was comparable to that of using HAART versus no antiretrovirals in the population of American adults under care for HIV infection at the start of the HAART era" (p. 26). Further, "the specific domains of HRQOL most associated with survival were physical functioning and bodily pain" (p. 26), factors that may be addressed through treatment. For these reasons, Cunningham and colleagues suggest that "[m]easuring HRQOL in clinical settings may be useful for practicing health care providers trying to assess prognosis, and could lead to a search for prognostically important problems that might benefit from additional interventions" (p. 26).

References

Ahdieh-Grant, L., Tarwater, P.M., Schneider, M.F., Anastos, K., Cohen, M., Khalsa, A., Minkoff, H., Young, M., & Greenblatt, R.M. (2005). Factors and temporal trends associated with highly active antiretroviral therapy discontinuation in the Women's Interagency HIV Study. *Journal of Acquired Immune Deficiency Syndromes*, 38(4), 500-503.

Amaro, H., Morrill, A.C., Dai, J., Cabral, H., & Raj, A. (2005). Heterosexual behavioral maintenance and change following HIV counseling and testing. *Journal of Health Psychology*, 10(2), 287-300.

Belcher, L., Sternberg, M.R., Wolitski, R.J., Halkitis, P., Hoff, C., & the Se-

ropositive Urban Men's Study Team. (2005). Condom use and perceived risk of HIV transmission among sexually active HIV-positive men who have sex with men. *AIDS Education & Prevention*, 17(1), 79-89.

Boyer, C.B., Shafer, M.-A., Shaffer, R.A., Brodine, S.K., Pollack, L.M., Bettinger, K., Chang, Y.J., Kraft, H.S., & Schachter, J. (2005). Evaluation of a cognitive-behavioral, group, randomized controlled intervention trial to prevent sexually transmitted infections and unintended pregnancies in young women. *Preventive Medicine*, 40(4), 420-431.

Bryan, A., Rocheleau, C.A., Robbins, R.N., & Hutchinson, K.E. (2005). Condom use among high-risk adolescents: Testing the influence of alcohol use on the relationship of cognitive correlates of behavior. *Health Psychology*, 24(2), 133-142.

Buchbinder, S.P., Vittinghoff, E., Heagerty, P.J., Celum, C.L., Seage, G.R., III, Judson, F.N., McKirnan, D., Mayer, K.H., & Koblin, B.A. (2005). Sexual risk, nitrite inhalant use, and lack of circumcision associated with HIV seroconversion in men who have sex with men in the United States. *Journal of Acquired Immune Deficiency Syndromes*, 39(1), 82-89.

Carballo-Diéguez, A., Dolezal, C., Leu, C.-S., Nieves, L., Díaz, F., Decena, C., & Balan, I. (2005). A randomized controlled trial to test an HIV-prevention intervention for Latino gay and bisexual men: Lessons learned. *AIDS Care*, 17(3), 314-328.

Collins, R.L., Ellickson, P.L., Orlando, M., & Klein, D.J. (2005). Isolating the nexus of substance use, violence and sexual risk for HIV infection among young adults in the United States. *AIDS & Behavior*, 9(1), 73-87.

Cooperman, N.A., & Simoni, J.M. (2005). Suicidal ideation and attempted suicide among women living with HIV/AIDS. *Journal of Behavioral Medicine*, 28(2), 149-156.

Cunningham, W.E., Crystal, S., Bozzette, S., & Hays, R.D. (2005). The association of health-related quality of life with survival among persons with HIV infection in the United States. *Journal of General Internal Medicine*, 20(1), 21-27.

El-Bassel, N., Witte, S.S., Gilbert, L., Wu, E., Chang, M., Hill, J., & Steinglass, P. (2003). The efficacy of a relationship-based HIV/STD pre-

- vention program for heterosexual couples. *American Journal of Public Health*, 93(6), 963-969.
- El-Bassel, N., Witte, S.S., Gilbert, L., Wu, E., Chang, M., Hill, J., & Steinglass, P. (2005). Long-term effects of an HIV/STI sexual risk reduction intervention for heterosexual couples. *AIDS & Behavior*, 9(1), 1-13.
- Ellickson, P.L., Collins, R.L., Bogart, L.M., Klein, D.J., & Taylor, S.L. (2005). Scope of HIV risk and co-occurring psychosocial health problems among young adults: Violence, victimization, and substance use. *Journal of Adolescent Health*, 36(5), 401-409.
- Fergus, S., Lewis, M.A., Darbes, L.A., & Butterfield, R.M. (2005). HIV risk and protection among gay male couples: The role of gay community integration. *Health Education & Behavior*, 32(2), 151-171.
- French, T., Weiss, L., Waters, M., Tesoriero, J., Finkelstein, R., & Agins, B. (2005). Correlation of a brief perceived stress measure with nonadherence to antiretroviral therapy over time. *Journal of Acquired Immune Deficiency Syndromes*, 38(5), 590-597.
- Fumaz, C.R., Muñoz-Moreno, J.A., Moltó, J., Negrodo, E., Ferrer, M.J., Sirera, G., Pérez-Alvarez, N., Gómez, G., Burger, D., & Clotet, B. (2005). Long-term neuropsychiatric disorders on efavirenz-based approaches: Quality of life, psychological issues, and adherence. *Journal of Acquired Immune Deficiency Syndromes*, 38(5), 560-565.
- Gielen, A.C., McDonnell, K.A., O'Campo, P.J., & Burke, J.G. (2005). Suicide risk and mental health indicators: Do they differ by abuse and HIV status? *Women's Health Issues*, 15(2), 89-95.
- Guzman, R., Colfax, G.N., Wheeler, S., Mansergh, G., Marks, G., Rader, M., & Buchbinder, S. (2005). Negotiated safety relationships and sexual behavior among a diverse sample of HIV-negative men who have sex with men. *Journal of Acquired Immune Deficiency Syndromes*, 38(1), 82-86.
- Jemmott, J.B., III, Jemmott, L.S., Braverman, P.K., & Fong, G.T. (2005). HIV/STD risk reduction interventions for African American and Latino adolescent girls at an adolescent medicine clinic: A randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*, 159(5), 440-449.
- Kalichman, S.C., Cain, D., Weinhardt, L., Benotsch, E., Presser, K., Zweben, A., Bjodstrup, B., & Swain, G.R. (2005). Experimental components analysis of brief theory-based HIV/AIDS risk-reduction counseling for sexually transmitted infection patients. *Health Psychology*, 24(2), 198-208.
- Katz, S., & Nevid, J.S. (2005). Risk factors associated with posttraumatic stress disorder symptomatology in HIV-infected women. *AIDS Patient Care & STDs*, 19(2), 110-120.
- Kurtz, S.P. (2005). Post-circuit blues: Motivations and consequences of crystal meth use among gay men in Miami. *AIDS & Behavior*, 9(1), 63-72.
- Laperriere, A., Ironson, G.H., Antoni, M.H., Pomm, H., Jones, D., Ishii, M., Lydston, D., Lawrence, P., Grossman, A., Brondolo, E., Cassells, A., Tobin, J.N., Schneiderman, N., & Weiss, S.M. (2005). Decreased depression up to one year following CB5M+ intervention in depressed women with AIDS: The Smart/EST Women's Project. *Journal of Health Psychology*, 10(2), 223-231.
- Lightfoot, M., Rogers, T., Goldstein, R., Rotheram-Borus, M.J., May, S., Kirshenbaum, S., Weinhardt, L., Zadoretzky, C., Kittel, L., Johnson, M., Gore-Felton, C., & Morin, S.F. (2005). Predictors of substance use frequency and reductions in seriousness of use among persons living with HIV. *Drug & Alcohol Dependence*, 77(2), 129-138.
- Moore, D.J., Atkinson, J.H., Akiskal, H., Gonzalez, R., Wolfson, T., Grant, I., & the HNRC Group. (2005). Temperament and risky behaviors: A pathway to HIV? *Journal of Affective Disorders*, 85(1-2), 191-200.
- O'Sullivan, L.F., Dolezal, C., Brackis-Cott, E., Traeger, L., & Mellins, C.A. (2005). Communication about HIV and risk behaviors among mothers living with HIV and their early adolescent children. *Journal of Early Adolescence*, 25(2), 148-167.
- Ransom, J.E., Siler, B., Peters, R.M., & Maurer, M.J. (2005). Worry: Women's experience of HIV testing. *Qualitative Health Research*, 15(3), 382-393.
- Reid, S., & Dwyer, J. (2005). Insomnia in HIV infection: A systematic review of prevalence, correlates, and management. *Psychosomatic Medicine*, 67(2), 260-269.
- Remien, R.H., Stirratt, M.J., Dolezal, C., Dognin, J.S., Wagner, G.J., Carballo-Diequez, A., El-Bassel, N., & Jung, T.M. (2005). Couple-focused support to improve HIV medication adherence: A randomized controlled trial. *AIDS*, 19(8), 807-814.
- Rock, E.M., Ireland, M., Resnick, M.D., & McNeely, C.A. (2005). A rose by any other name? Objective knowledge, perceived knowledge, and adolescent male condom use. *Pediatrics*, 115(3), 667-672.
- Rotheram-Borus, M.J., Weiss, R., Alber, S., & Lester, P. (2005). Adolescent adjustment before and after HIV-related parental death. *Journal of Consulting & Clinical Psychology*, 73(2), 221-228.
- Shoptaw, S., Reback, C.J., Peck, J.A., Yang, X., Rotheram-Fuller, E., Larkins, S., Veniegas, R.C., Freese, T.E., & Hucks-Ortiz, C. (2005). Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviors among urban gay and bisexual men. *Drug & Alcohol Dependence*, 78(2), 125-134.
- Sikkema, K.J., Hansen, N.B., Meade, C.S., Kochman, A., & Lee, R.S. (2005). Improvements in health-related quality of life following a group intervention for coping with AIDS-bereavement among HIV-infected men and women. *Quality of Life Research*, 14(4), 991-1005.
- Tarakeshwar, N., Hansen, N., Kochman, A., & Sikkema, K.J. (2005). Gender, ethnicity and spiritual coping among bereaved HIV-positive individuals. *Mental Health, Religion & Culture*, 8(2), 109-125.
- Thorburn, S., Harvey, S.M., & Ryan, E.A. (2005). HIV prevention heuristics and condom use among African-Americans at risk for HIV. *AIDS Care*, 17(3), 335-344.
- Trépanier, L.L., Rourke, S.B., Bayoumi, A.M., Halman, M.H., Krzyzanowski, S., & Power, C. (2005). The impact of neuropsychological impairment and depression on health-related quality of life in HIV-infection. *Journal of Clinical & Experimental Neuropsychology*, 27(1), 1-15.
- Tsao, J.C.I., Dobalian, A., & Naliboff, B.D. (2004). Panic disorder and pain in a national sample of persons living with HIV. *Pain*, 109(1-2), 172-180.
- U.S. Food & Drug Administration.

(2005a, March 2). *Pegasys and Copegus indications expanded to include treatment of hepatitis C and HIV coinfection* [News release]. Bethesda, MD: Author. Retrieved March 18, 2005, from the World Wide Web: <http://www.fda.gov/oashi/aids/listserve/listserve2005.html#copeg>

U.S. Food & Drug Administration. (2005b, April 29). *Approval of KALETRA 800/200mg once-daily administration for the treatment of HIV-infection in therapy-naïve adult patients* [News release]. Bethesda, MD: Author. Retrieved May 11, 2005, from the World Wide Web: <http://www.fda.gov/oashi/aids/listserve/listserve2005.html#april29>

van der Snoek, E.M., de Wit, J.B.F., Mulder, P.G.H., & van der Meijden, W.I. (2005). Incidence of sexually transmitted diseases and HIV infection related to perceived HIV/AIDS threat since highly active antiretroviral therapy availability in men who have sex with men. *Sexually Transmitted Diseases*, 32(3), 170-175.

Winfield, E.B., & Whaley, A.L. (2005). Relationship status, psychological orientation, and sexual risk taking in a heterosexual African American col-

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.

lege sample. *Journal of Black Psychology*, 31(2), 189-204.

Wu, Y., Burns, J.J., Stanton, B.F., Li, X., Harris, C.V., Galbraith, J., & Wei, L. (2005). Influence of prior sexual risk experience on response to intervention targeting multiple risk behaviors among adolescents. *Journal of Adolescent Health*, 36(1), 56-63.

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

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

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

Yun, L.W.H., Maravi, M., Kobayashi, J.S., Barton, P.L., & Davidson, A.J. (2005). Antidepressant treatment improves adherence to antiretroviral therapy among depressed HIV-infected patients. *Journal of Acquired Immune Deficiency Syndromes*, 38(4), 432-438.

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