

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 11, Issue 4 – Summer 2010

Biopsychosocial Update

HIV Prevention News

About Adolescents & Young Adults

In Western Australia, Edwards and Barber (2010) queried university students about “how often they wanted to use condoms in both romantic (n = 667) and casual relationship (n = 152) contexts and how often they thought their partners wanted to use condoms” (p. 59). The investigators discovered that

young adults reported wanting to use condoms more often than they thought their partners did in both casual and romantic relationship contexts. Furthermore, the **perceived condom use desire discrepancies** interacted with gender. The results suggest that gendered expectations may act as a barrier to condom negotiation, at least in romantic relationships. Young women in romantic relationships thought that their partners wanted to use condoms less often than the male participants with romantic relationship experience reported themselves. Although the same finding in casual relationships did not reach statistical significance, it was in the same direction as in the romantic relationship context. Finally, both wanting to use condoms and holding the perception that one’s partner wanted to use condoms predicted condom use behavior in both romantic and

casual relationship contexts. (pp. 63-64)

Edwards and Barber suggest that “if young women perceive that their male partners want to use condoms less often than themselves, and if such perceptions are based on inaccurate stereotypes, then correcting such misperceptions may be a sensible goal” (p. 64). More specifically,

interventions may be improved by addressing young peoples’ perceptions of their partner’s condom use desires and highlighting the notion that, generally, partners will want to use condoms more than they expect. . . . If young women learn that male partners want to use condoms more often than they expect, then it may make it easier for them to negotiate condom use. Perhaps the continuing educational focus on equipping young women with the skills to persuade their partners to use condoms led them to think that their partners did not want to use condoms. Correcting such misperceptions may provide an opportunity to increase rates of condom use. (p. 64)

Employing computer-assisted personal interviewing, Outlaw, Naar-King, Janisse, Parsons, and the Adolescent Trials Network for HIV/AIDS Interventions (2010) explored factors

that were associated with **condom use among** a multisite, clinic-based convenience sample of 186 **youth living with HIV** (YLH) who were between the ages of 16 and 24 years. The investigators found that

youth with greater motivational readiness and self-efficacy for safer sex were more likely to use condoms, indicating that interventions that promote self-efficacy and motivational readiness may be useful in understanding and conceptualizing sexual risk behavior in YLH. These data suggest that interventions that are formulated to increase motivation, perhaps by increasing social support for condom use, and increase self-efficacy, perhaps by increasing decisional balance (pros for condoms), may be beneficial. Motivational Interviewing (MI), a brief client-centered, yet goal-oriented, method of communication designed to increase motivation and boost confidence for behavior change while addressing decisional balance concerns . . . may be an effective approach. Studies have begun to suggest

In This Issue:

Biopsychosocial Update	
HIV Prevention News.....	1
HIV Assessment News.....	10
HIV Treatment News.....	12
Tool Boxes	
HIV & Hepatitis C:	
Coping with Coinfection	
(Part 2).....	6
Resources.....	14
A Note on Content.....	19

that using such an approach may be successful in reducing sexual risk behavior in YLH . . . and sexual risk and substance [use] in high-risk youth. (p. 10)

Additionally, “knowing more about the emotional problems of YLH may assist in the development of more tailored interventions for this population. Interventions that focus on social networking and the treatment of depression may help to increase social support and reduce emotional distress for youth. It may also be helpful for such interventions to involve a therapeutic component that assists youth with HIV in living with HIV” (p. 10). Outlaw and colleagues observe, however, that their model “only accounted for a modest amount of variance in condom use . . . [and that] examining additional constructs may help account for more variance in risky sexual behavior” (pp. 10-11).

The [Fall 2004](#) issue of *mental healthAIDS* highlighted a study by DiClemente et al. (2004), who randomized 522 sexually experienced, young African American women between the ages of 14 and 18 years to one of two conditions: four, 4-hour group sessions that “emphasiz[ed] ethnic and gender pride, HIV knowledge, communication, condom use skills, and healthy relationships” (p. 171) or sessions that emphasized exercise and nutrition. Following up at 6 months and 1 year post-intervention, the authors found that those

receiving the first of these interventions were more likely to use condoms consistently (i.e., during every occasion of vaginal intercourse) and less likely to have acquired a new vaginal sex partner in the preceding 30 days than those in the control condition. DiClemente and colleagues concluded that “interventions for African American adolescent girls that are gender-tailored and culturally congruent can enhance HIV-preventive behaviors, skills, and mediators and may reduce pregnancy and chlamydia infection” (p. 171).

Sales, Lang, Hardin, DiClemente, and Wingood (2010) analyzed data from a subgroup of participants in the 2004 study: those 245 participants “reporting at or above threshold **depressive symptomatology**” (p. 219). The investigators report that “similar to the main trial, among young women with at or above threshold depressive symptomatology, as indicated by [a brief, eight-item version of] the CES-D [Center for Epidemiologic Studies-Depression scale], the HIV intervention led to substantial reductions in HIV-associated sexual behaviors in comparison to the control group” (p. 222). Of note as well was the finding that

depressi[ve] . . . symptoms significantly decreased for these young women after participating in the program, regardless of whether they were assigned to

the HIV intervention or general health promotion group. Because decreasing negative affect was not targeted in the HIV intervention, it was not expected that participants with at or above threshold depressive symptomatology would significantly differ in reported depressive symptoms from the comparison group at follow-up assessment. However, the significant decrease in depressive symptoms experienced by both groups over time suggests that simply participating in a group-based intervention with peers (in this case, regardless of content yet still both focused on aspects of health) had unintended secondary benefits on mental health. Exactly how and why their depressive symptoms decreased remains a question for future research. (p. 225)

Sales and colleagues conclude that “overall, the pattern of effects found strengthen . . . confidence in the efficacy of the HIV intervention assessed for a broad range of young women, including those with high levels of depressive symptoms. Although young women with high depressive symptoms benefited from this HIV intervention, future studies employing interventions that specifically address the affective needs of this population might be even more effective in terms of sexual risk reduction and amelioration of depressive symptoms” (p. 219).

About Men Who Have Sex With Men

Findings reported by Sales et al. (2010) may be contrasted with those reported by Safren et al. (2010), who “examined whether a social-cognitive model would explain recent **sexual transmission risk behavior [(TRB)] among sexually active HIV-infected men who have sex with men (MSM) who meet or do not meet screening criteria for major depression**” (p. 215).

mental healthAIDS is produced four times a year under Contract No. 280-02-0800/280-02-0802 with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The content of this publication does not necessarily reflect the views, opinions, or policies of the CMHS, SAMHSA, or HHS.

Summaries appearing in *mental healthAIDS* are presented to promote awareness and understanding of current and continuing research in the area of HIV and mental health. They are not intended for use as the sole basis for clinical treatment nor as a substitute for reading the original research.

mental healthAIDS is compiled and edited by Abraham Feingold, Psy.D. Questions and comments may be directed to the Editor at mentalhealthAIDS@aol.com.

Reproduction of *mental healthAIDS* content is encouraged but may not be sold. The “Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services” should be cited as the information source.

Social-Cognitive Theory “is one of the most widely used models of sexual TRB. In brief, this model posits that individuals go through a cognitive process weighing the pros and cons of practicing safer sex (e.g., considering knowledge about HIV, expectancies related to using condoms, and social norms) that influences an individual’s [self-efficacy] (i.e., confidence in one’s ability to practice safer sex in difficult situations). [Self-efficacy], in turn, then becomes a key factor in determining whether one will practice safer sex” (p. 216).¹ Yet models utilizing this theory “generally do not account for the influence of clinically significant psychological problems such as major depression” (p. 215).

Among the 403 MSM participating in this study, 47 screened positive (or “in”) for major depression, while 356 screened negative for major depression. The investigators found that Social-Cognitive Theory constructs

were particularly useful for explaining pathways to HIV sexual TRB in HIV-infected MSM who did not screen in for major depression, but w[ere] . . . not useful for explaining pathways to sexual TRB in the HIV-infected MSM who did screen in for major

¹ Wulfert and Wan (1993) expand on Social-Cognitive Theory as follows: “When sexual risk reduction is analyzed from a social-cognitive perspective, knowledge and skills to exercise self-protective behaviors are necessary but not sufficient. . . . People may know how the virus is transmitted and have the skills to negotiate condom use but still engage in unprotected sexual intercourse. . . . [From a social-cognitive perspective], this happens because behavior is not directly a result of knowledge or skills. Rather, it is mediated by a process of cognitive appraisal by which people integrate knowledge, outcome expectancies, emotional states, social influences, and past experiences to form a judgment of their ability to master a difficult situation. This judgment of [self-efficacy] mediates behavior and determines whether people initiate an action, how much effort they expend, and how long they persist in the face of difficulty. Hence, people will practice safer sex only to the degree that they believe they can protect themselves when needed” (p. 346).

depression. Clinically significant symptoms of depression, including persistent sadness and/or loss of interest, worthless feelings, loss of energy, and concentration problems, can arguably interfere with the process of making social-cognitive judgments, such as [self-efficacy] perceptions, and could therefore interfere with the ability of important social-cognitive variables to predict health behaviors such as HIV TRB. (p. 219)

Safren and colleagues conclude that “the data from this analysis are consistent with the hypothesis that depression may weaken the ability of Social-Cognitive Theory to predict condom use in sexually active, HIV-infected MSM” (p. 220).

Although their findings diverge from those of Sales and colleagues (whose intervention is also based, in part, on Social-Cognitive Theory), Safren and colleagues reach a similar conclusion: “Because clinical depression is one of the most common conditions comorbid with HIV, models of health behaviors and interventions that are based on such models should address the role of depression to potentially boost their utility. Potentially, this could occur through including screening or referral for medications and/or treatment of depression into the intervention” (p. 219).

About Women & Men

Cosio et al. (2010) conducted a “pilot randomized clinical trial [that] compared 2 brief **telephone-administered interventions** designed to **reduce continued risky sexual behaviors in HIV-infected rural persons**” (p. 140). A predominantly white convenience sample of

79 HIV-infected rural persons who reported 1 or more occasions of unprotected anal, vaginal, or oral sex in the past 2 months . . .

[was] recruited through AIDS service organizations in rural areas of 27 states and assigned randomly to either a 2-session, [MI] plus skills-building intervention (i.e., integrated intervention; n = 48) or a 2-session, skills-building only comparison intervention (n = 31).² Participants com-

² The Skills-Building Only Intervention “was a psycho-educational intervention in which participants discussed 1 or more of 15 topics (e.g., sexual assertiveness communication, condom negotiation, HIV-serostatus disclosure) listed in a ‘Skills Building Topic Form’ (STF) they received via regular mail several days before Session 1. After reviewing the STF, the participant chose topics that he or she wished to discuss and the interventionist provided information and practical strategies needed to master the skills. . . .

[The MI] + Skills-Building Intervention (Integrated Intervention) . . . served as the main experimental intervention. In session 1, participants and interventionists discussed the ‘Personal Feedback Form’ (PFF) that was mailed to the participant before the session. Based on self-report data provided in the participant’s preintervention assessment, the interventionist summarized the participant’s risky sexual behaviors and provided feedback along 12 different areas related to risky sex (e.g., use of alcohol or drugs before sex). During session 1, the interventionist elicited self-motivational statements from the participant by asking open-ended questions, such as ‘What worries you about your sexual behavior?’ and ‘How do you think you might reduce your sexual risk behavior if you wished to do so?’ During these questions, interventionists utilized standard MI strategies to increase intrinsic motivation to change. . . . One practical adaptation made to the intervention to administer it over the telephone was to increase the use of ‘verbal check-ins’ during intervention sessions. For example, if a participant was silent for several seconds, the interventionist might ask ‘How do you feel about what I just said?’ or ‘Is there something you are thinking about right now?’ Verbal check-ins were used to better engage participants in the session and ensure they were not distracted by persons or events in their environment.

After attempting to enhance participants’ motivation to change in session 1, interventionists began the skills-building component of the intervention (i.e., providing risk-reduction education and skills using the same manual used with skills-building only participants). By doing this, the integrated intervention did not simply motivate participants to reduce their risky sexual behaviors but also provided skills and information participants would need to act upon their heightened levels of risk reduction motivation. A greater amount of time was devoted to topics that had been identified during session 1, as

pleted self-report measures of sexual behaviors and factors related to risky sex at preintervention and 2-month follow-up. (p. 140)

Cosio and colleagues report that “before enrolling into the intervention, 37% of participants had 2 or more sexual partners in the past 2 months, 29% had sex with 1 or more partners without knowing their partners’ HIV serostatus, and almost one-third of participants located sex partners in high-risk environments (e.g., public parks, roadside rest areas)” (p. 140). The investigators found, however, that the

brief telephone-administered [MI] plus skills-building intervention increased participants’ motivation to reduce risky sex and the proportion of participants who reported using condoms “all the time” with their vaginal and oral sex partners compared to an attention equivalent skills-building only intervention.

Findings from this study are consistent with those from previous research showing that telephone-delivered interventions can reduce risky sexual behavior in persons living with, or at risk for, HIV infection. . . . Several differences, however, differentiate the current study from previous research. Participants in the current study were all HIV-seropositive men and women from rural areas; past research in this area has typically used samples consisting primarily of HIV-seronegative men (usually MSM) from large urban centers. As such, findings from the current study provide a unique contribution to the HIV risk-reduction literature by showing that telephone-administered, MI-based interventions have poten-

areas in which the participant appeared to evince knowledge or skills deficits” (Cosio et al., 2010, p. 142).

tial to reduce risky sexual behaviors in HIV-infected men and women living in geographically-remote areas. (p. 145)

Of course, Cosio and colleagues caution that

before an intervention of this genre can be widely disseminated via AIDS-service and rural-based health care organizations, more large-scale and scientifically-rigorous evaluations of this intervention approach are needed. Future investigations of this intervention approach should include larger and more geographically-diverse samples, additional assessment periods, and more objective outcome measures (e.g., [sexually transmitted disease] testing and/or chart review data). (p. 146)

About Women

Cavanaugh, Hansen, and Sullivan (2010) examined **posttraumatic stress disorder resulting from intimate partner violence** (IPV-related PTSD), alcohol problems, and drug problems as potential correlates of sexual risk behavior among 136 low-income women who had experienced physical violence inflicted by a male partner during the preceding 6-month period. “Sexual risk behavior was assessed by whether women had unprotected sex with a risky primary partner (i.e., HIV-positive, injection drug user, and/or nonmonogamous), unprotected sex with a risky nonprimary partner (i.e., HIV-positive or unknown status), or traded sex during the past 6 months” (p. 318). The investigators found that “nearly one in five women engaged in these recent sexual risk behaviors[, and] . . . IPV-related PTSD, but not drug or alcohol problems, was significantly associated with sexual risk behavior while controlling for childhood abuse and demographic covariates. Women with IPV-related PTSD had four times greater odds of

recent sexual risk behavior compared to women without IPV-related PTSD” (p. 318). Interestingly,

an exploratory post hoc finding suggests that two of the three IPV-related PTSD symptom clusters were associated with women’s sexual risk behavior, albeit in different directions. Avoidance and numbing symptom severity was associated with a greater likelihood of women having engaged in recent sexual risk behavior. Detachment from others is one component of avoidance and numbing symptom cluster that may particularly heighten women’s sexual risk behavior as women may be detached from the entire sexual act including the riskiness of their partner and having their partner use a condom. Another component of the avoidance and numbing symptom cluster is a sense of foreshortened future; women may not use safe[r] sex practices because they do not believe their efforts to do so would improve their health and functioning in the short term. Arousal symptom severity, however, was associated with a lower likelihood of women having engaged in recent sexual risk behavior. It is possible that heightened arousal and vigilance leads to increased attention to and avoidance of sexual risk behavior. To better understand the relationship between PTSD and women’s sexual risk behavior[,] additional studies are needed to examine whether the severity of PTSD symptom clusters are differentially related to women’s sexual risk behavior. (p. 325)

With regard to HIV prevention, Cavanaugh and colleagues reinforce a repeated observation that

behavioral interventions focused on HIV-risk alone are inappropri-

ate for women experiencing IPV. . . . In fact, women may be nonresponsive to risk-reduction messages given their preoccupation with personal safety. Further, women in violent relationships may lack the means to implement risk reduction given the nature and consequences of IPV in their intimate relationships. . . . Low-income women experiencing IPV may have particular difficulty implementing risk reduction given their greater likelihood of experiencing IPV, dependency upon male partners for basic needs (food/shelter), and being subject to more male dominated sexual decision making. . . . Attempting to implement safe[r] sex practices may act as a trigger for physical IPV or affect women's access to meeting their basic needs. Therefore, multimodal HIV prevention interventions are needed that address the context of women's sexual practices, including whether women may be able to safely negotiate such practices, in order to improve effectiveness. . . . For example, recent studies suggest trauma-focused mental health treatment may reduce women's sexual risk behavior . . . including risk for sexual revictimization . . . and IPV (including sexual coercion . . .), while empowerment-focused HIV prevention interventions for women experiencing IPV have also demonstrated promise in reducing sexual risk behavior. . . . Thus, it is imperative that women-focused HIV prevention interventions address contextual factors such as violence and abuse that increase women's sexual risk behavior to effectively promote women's health and well-being. (pp. 325-326)

On the topic of trauma-focused mental health treatment, Hien et al. (2010) conducted "the first random-

ized controlled trial to examine the effect of **integrated trauma and substance abuse therapy**, with a focus on building self[-]efficacy and safe coping behavior, on HIV sexual risk behavior among a diverse sample of women with comorbid substance use disorders [(SUDs)] and PTSD" (p. 422). The study examined "the impact of two group therapy interventions on reduction of unprotected sexual occasions (USO) among women with SUDs and PTSD. Participants were 346 women recruited from and receiving treatment at six community-based drug treatment programs. . . . Participants were randomized to receive 12 sessions of either **seeking safety** (SS), a cognitive behavioral intervention for women with PTSD and SUD,³ or women's health education (WHE), an attention control psychoeducational group"

³ Seeking Safety Treatment (SS; Najavits, 2002), "a short-term manualized therapy, applies cognitive-behavioral strategies to the goals of reducing substance use and the negative impact of trauma exposure and was developed for both individual and group modalities. Sessions are structured and include basic education on [SUDs] and PTSD, action skills to prevent drug use and control PTSD symptoms, cognitive restructuring with particular attention to maladaptive thoughts associated with substance use and trauma symptoms, and a focus on relationship issues and developing effective communication skills to build a healthy support network. Session topics are meaningfully connected to participant reports of unsafe behavior and coping skills.

The basic format of each session includes: (1) a check in for the therapist to find out how the participant is doing and identify safe and unsafe coping used since the last session; (2) a session quotation to provide a brief point of inspiration; (3) connecting the session topic and materials to the patient's experience, offering intensive skill rehearsal; and (4) a check out to provide an opportunity for the therapist to reinforce progress and to provide feedback. While SS does not focus on specific HIV risk behaviors or provide any HIV prevention education, discussion about safety and coping may include sexual or drug risk behaviors. For example, in the context of learning to be assertive in relationships, setting boundaries with partners around safer sex may be discussed. The group format allows for women to discuss the application of coping skills in their lives and participants provide support and reinforcement to each other" (Hien et al., 2010, pp. 423-424).

(p. 421).⁴ "Treatment consisted of two 90-min sessions per week for 6 weeks. Groups ranged in size from two to eight women and operated with an open, rolling admission so that participants entered the group at any point in the session cycle (i.e., a participant could enter at session three and complete treatment with session two)" (p. 423). Hien and colleagues found that "participants receiving SS who were at higher sexual risk (i.e., at least 12 USO per month) significantly reduced the number of USO over 12-month follow up compared to WHE" (p. 421). These findings demonstrate that "SS, a trauma-focused cognitive group therapy targeting skills building and self-efficacy in the context of integrated trauma and substance abuse treatment, was significantly more effective in reducing HIV sexual risk for women with higher levels of unprotected sex when compared with a [WHE] curriculum which provided specific psychoeducation on HIV risk reduction" (p. 427).

Of note is the fact that

the SS curriculum did not directly address HIV risk reduction, but rather focused on developing safe coping skills, communication and boundary setting, and generally identifying and reducing unsafe

(Biopsychosocial Update is continued on Page 8)

⁴ Women's Health Education (WHE; Miller, Pagan, & Tross, 1998) "is a psychoeducational intervention that focuses on topics such as female anatomy, human sexual behavior, pregnancy and childbirth, nutrition, and diabetes. It also includes a session on risk behaviors associated with sexually transmitted infections and a session on HIV risk exposure and transmission. WHE provides equivalent facilitator attention, expectancy of benefit, and issue oriented focus, but does not provide theory driven techniques such as cognitive behavioral therapy and psychoeducation specific to substance abuse and PTSD. All sessions followed a common format: (1) introduction of topic; (2) review of group rules; (3) review of between[-]session assignments; (4) topic presentation using mini-lecture, video, story-telling and/or text readings; (5) exercises to facilitate group discussion and application of materials; and (6) goal-setting" (Hien et al., 2010, p. 424).

Tool Box

HIV & Hepatitis C: Coping with Coinfection (Part 2)

Part 1 of this series (presented in the [Spring 2010](#) issue of *mental health AIDS*) provided a medical, psychiatric, psychosocial, and neuropsychological overview of HIV/hepatitis C virus (HCV) coinfection, the process of determining eligibility for HCV treatment, and the important role mental health clinicians play in assessing eligibility and intervening with clients who elect to receive treatment for HCV.

This concluding segment expands on how providers make the decision to offer HCV treatment to individuals living with HIV and chronic HCV infection, how coinfecting individuals make decisions to accept or defer treatment for HCV, and the latest thinking on HCV treatment interventions.

What Providers Say

Wagner et al. (2009) documented “findings from semistructured, qualitative interviews conducted with 11 HCV primary care providers and 11 support staff at 3 HIV clinics in Los Angeles, California. The goals of the study were to explore the factors and processes by which providers make HCV treatment decisions, and the barriers to HCV treatment uptake, among HCV treatment-naïve HIV patients with chronic HCV infection” (p. 716). Among these three clinics,

rates of HCV treatment uptake varied from 10% to 38%. Providers agreed that stable HIV disease, favorable genotype, and significant signs of liver disease progression are all signs of need for treatment. However, two divergent treatment approaches emerged for genotype[-]1 and [-]4 patients with minimal disease, and in definitions of patient readiness. Providers with lower treatment rates preferred to delay treatment in hopes of better future treatment options, and were more conservative in requiring complete mental health screens and treatment and abstinence from substance use. Conversely, providers with higher treatment rates viewed all patients as needing treatment as soon as

possible, and defined readiness more leniently, with some willing to treat even in the context of untreated depression and drug use, so long as ability to adhere well was demonstrated. (p. 715)

Wagner and colleagues’ findings thus highlight

two approaches to managing HCV treatment decisions. One views treatment initiation as more urgent and is willing to accept the risk of a more lenient definition of patient readiness for treatment. The other takes a more cautious approach with a preference for holding off treatment until it is clear that a patient’s liver disease is in need of treatment and the patient has all the signs of being ready to adhere well. There is no clear evidence indicating whether one approach is more appropriate than the other. An urgent approach to treatment results in more patients being treated and thus more patients being “cured,” but also more patients who endure significant side effects that compromise mental health and quality of life without virologic benefit.

Conversely, delaying [HCV] treatment can reduce unnecessary burden on a patient’s quality of life, and better, less toxic treatment may become available before the patient’s disease progresses to the point of definitively needing treatment; however, ultimately treatment is needed to avoid liver failure and the longer a patient waits, the lower the odds of treatment being successful with the currently available treatment. Regardless of which approach may be more appropriate, development of effective programs for promoting patient readiness for treatment are critical to ensuring that more patients receive treatment, either earlier in the disease or later, given the high mortality associated with liver disease among HIV/HCV coinfecting patients. (p. 723)

Of course, “provider decisions to recommend or offer treatment [are] critical to providing treatment access, but whether or not a patient starts treatment is ultimately in the hands of the patient” (Wagner et al., 2009, p. 723), “and 15%-30% of coinfecting patients decline treatment. . . . Clearly, many patients perceive the risks of treatment to outweigh its benefits, though few studies have examined specifically how coinfecting patients make HCV treatment decisions” (Osilla et al., 2009, p. 993). On this point, two recent studies examined how coinfecting individuals make decisions regarding treatment for HCV.

What Their Patients Say

This same Los Angeles-based research team (Osilla et al., 2009) conducted semistructured interviews with 35 HIV/HCV coinfecting patients at the same three HIV clinics and also drew data from their interviews with the 11 primary care providers included in the study by Wagner et al. (2009), for the purpose of exploring factors that influence the decision to initiate HCV treatment. The investigators interviewed “patients who had been offered treatment ($n = 26$) as well as those who had not ($n = 9$), and among patients who had been offered treatment, those who had started treatment ($n = 17$) as well as those who declined treatment ($n = 9$). The site coordinator at each clinic (a clinic staff member) identified a convenience sample of coinfecting patients who represented these various treatment decision points and informed the patient[s] of the study to assess their interest in participating” (p. 994). Among these 35 patients,

31 (89%) were male, mean age was 49.8 years (standard deviation [SD] = 8.1), and 22 (63%) were non-Caucasian (12 Hispanic, 9 African American, 1 Asian). Patients reported being diagnosed with HIV between 1986 and 2005. All but two were currently on HIV antiretroviral therapy, and the mean self-reported CD4 count was 470 (SD = 250; range: 93-1000). Timing of HCV diagnosis ranged from 2 to 18 years prior to the interview. The majority (27/35;

77%) had a history of alcohol or drug problems, with the latter including use of marijuana, cocaine, methamphetamine, and heroin. Over half (56%) reported past injection drug use. In terms of current substance use, 27% reported some alcohol use and 19% reported drug use (mostly marijuana). (p. 995)

Additionally, the investigators conducted semistructured interviews with 11 primary care providers who were “the primary decision makers with regard to whether or not HCV treatment was recommended to patients. As part of these interviews, providers were asked about how their relationships with patients influenced the patient’s decision to accept or refuse HCV treatment” (p. 994).

Among the 26 patients who were offered treatment, “fear of treatment side effects and being uncertain of one’s emotional stability and drug use were all concerns to patients who chose to refuse treatment” (p. 997). On the other hand,

factors related to wanting to start treatment ranged from not wanting to waste time and the hope of being cured and being healthy, to feeling like there was nothing to lose by going on treatment, and a sense of trust and faith that their doctor would help them be successful with treatment. The most common factors across both groups of patients were perceived need to preserve physical health and survival, trust in the quality of relationship with one’s provider, level of support for treatment within one’s social network, and self-perception of treatment readiness. (p. 995)

Osilla and colleagues expand on these factors as follows:

Need for treatment to preserve physical health and survival. The most common reason patients reported for deciding to start treatment was concern over the effects of HCV disease on their physical health and related motivation to live

and remain healthy, which was reported by 8 of the 17 patients (47%) who started treatment. . . . (p. 995)

Treatment readiness. One factor that strongly influenced decisions to start treatment as well as to defer treatment was a sense of personal readiness for treatment. How patients viewed or defined their readiness for treatment varied considerably. For some patients, feeling that their HIV disease was under control and stable implied a readiness to then take on HCV disease. . . . Others spoke of treatment readiness with regard to feeling ready to tolerate side effects, and being medically and psychologically stable. . . . Seven of the 17 (41%) patients who decided to start treatment expressed a confidence in being able to handle treatment side effects compared to only one of nine (11%) patients who refused treatment. . . . For many patients, treatment readiness was viewed in reference to a sense of stability in one’s life – from feeling stable mentally and emotionally, to having substance use under control, and having a roof over one’s head and being able to support oneself. Patients understood that treatment was going to be stressful and therefore they felt the need for more stability in their lives before starting treatment. . . . (pp. 995-996)

Social support. While most patients expressed intrinsic reasons for wanting to start or defer treatment, several patients also referred to the influence of people in their social network.

Six of 17 patients (35%) who decided to start treatment stated that the HCV support group they attended was influential in their decision; HCV support groups were not mentioned at all by those who refused treatment, although it is not known whether these patients were members of such groups. Patients reported consulting with fellow patients about their experiences with treatment, including how they dealt with side effects and whether they viewed treatment as

“worth it.” Being able to address their fear of side effects with a patient actually in treatment or who had recently completed treatment helped dispel misunderstandings about the treatment. . . . (p. 996)

Doctor-patient relationship. When asked about the influence of the relationship with their doctor, 11 of the 17 (65%) patients who decided to start treatment reported that having a supportive doctor contributed to their decision compared to 2 of the 9 (22%) patients who refused treatment. While all patients in the study spoke favorably of their providers, it was the patients who decided to start treatment who often made especially strong statements about the quality of relationship they had with their doctor. . . . When discussing how their doctors were supportive, patients referred to how their providers were responsive, dependable, and provided hope and encouragement regarding benefits that could be derived from treatment. (p. 996)

Given the strong influence that HIV primary care providers appear to have with regard to HCV treatment decisions made by their patients, Osilla and colleagues surmise that the way in which providers

present treatment recommendations may play a key role in the patient’s response. . . . [Approaches] can vary from one that reflects strong advocacy and encouragement of treatment, to one that is more neutral and [a] mere presentation of options, to a presentation that may subtly dissuade a patient from considering treatment. In many cases, the provider’s general philosophy and sense of urgency toward treatment was reflected in [his or her] approach to presenting treatment as an option for the patient.

. . . [Among the] strategies some providers use to encourage and motivate patients to accept the [recommendation for HCV] treat-

(Tool Box is continued on Page 8)

(Tool Box -- continued from Page 7)

ment . . . [are] emphasizing the importance of treatment for the patient's health, the chance for treatment resulting in a cure, and confidence that the provider can effectively address any side effects that the patient may experience. . . . Other providers described a more neutral stance in presenting treatment as an option to the patient. These providers described an approach in which they lay out the potential benefits and costs of treatment, so that the patient can make an informed decision. Providers may be more likely to use this approach when they themselves feel ambivalent or unsure of the importance of treatment for the patient. . . . There are also providers who took a more cautious view of treatment. These providers viewed treatment as urgent for some patients with advanced disease, but for many patients with less progressed disease they believed it was best to defer treatment and wait for better treatment to become available, and this preference can be detected in how they offer treatment to the patient. (pp. 996-997)

Osilla and colleagues conclude that

the patients in this study confirmed what had been reported by their providers, that stability of HIV disease, perceived need for HCV treatment, and treatment readiness with regard to motivation, preparedness to deal with side effects, absence of substance abuse, and stability of mental health and overall life circumstances are key factors influencing treatment decision-making. Providers play a critical role in the treatment decisions of their patients, not only by providing information and being trustworthy experts, but also through their partnership with the patient and the

sequential interactions whereby both the patient and provider may influence the other's evaluation of the patient's readiness for treatment. Providers serve as key catalysts for evaluating treatment readiness, but also helping patients to address issues that impede readiness, whether through referrals, counseling, or simply ongoing support that fosters the patient's trust. (p. 998)

What Other Patients Say

Similar to Osilla and colleagues, Bova, Ogawa, and Sullivan-Bolyai (2010) set out "to describe the experiences of HIV-infected patients as they made decisions to begin or defer HCV treatment and to develop a model to guide the development of future interventions to support HCV treatment efforts in coinfectd patients" (p. 65). "The study sample included 39 HIV/HCVcoinfectd adults, 54% male, 51% minority, 36% without a high school diploma or GED (high school graduation equivalent), 87% with a history of mental illness, 95% with a history of substance abuse, and 59% with HCV subtype 1. The mean age of the study sample was 45.1 years (range, 34-56), and 36% had AIDS" (p. 66). Among these study participants, there were "16 in the HCV-treated cohort (who were interviewed a maximum of 3 times) and 23 in the HCV-nontreatment cohort" (p. 63).

"Analysis of qualitative data from the entire sample resulted in six major themes. These themes were further categorized into treatment barriers or treatment-facilitating factors. The two treatment barriers were (a) treatment fears (associated with side effects, liver biopsy, substance abuse relapse, and needle use) and (b) vicarious experiences. The four facilitating factors were (a) experience with illness management, (b) patient-provider relationships, (c) gaining sober time, and (d) facing treatment head-on" (pp. 66, 68). Bova and colleagues

elaborate on these themes, all of which are "amenable to behavioral intervention" (p. 72), as follows:

Fears. The major concern discussed by most participants ($n = 32$, 82%) was fear of side effects of HCV treatment. . . . Fear of the liver biopsy was specifically mentioned by 14 (36%) participants. . . . It is also important to note that 7 participants (18%) had no major problems with the liver biopsy. . . . Many participants were aware of the potential risk of HCV treatment to their sobriety. . . . A total of 7 participants expressed concerns about the need to use needles to administer the interferon component of the HCV treatment regimen. Some were concerned about the "feeling of self-injecting," whereas others were more worried about having needles around the house. . . . (pp. 68-69)

Vicarious experiences. Many participants ($n = 11$) discussed seeing others going through HCV treatment or hearing the stories of others who had been treated. They said they formed their opinions about beginning treatment based on these vicarious experiences. . . . (p. 69)

Experience with illness management. Study participants ($n = 7$) discussed their experiences managing HIV and many other illnesses (including cancer, heart disease, diabetes, and asthma). They discussed using strategies developed over time to manage these chronic conditions as a way to manage HCV and subsequent treatment. . . . (pp. 69-70)

Patient-provider relationships. Participants also spoke about the importance of patient-provider relationships as a means to help them get through HCV treatment.

(Biopsychosocial Update -- continued from Page 5)

behavior. . . . [These] findings provide support for interventions that alter scripted behavior (through safe coping and cognitive therapy) in the context of sys-

temic factors (such as trauma, substance use and social interaction) to more effectively impact sexual risk behavior compared to a health education curriculum with HIV[-]specific content for women

with comorbidity engaging in high risk sexual behavior. It is not known from this study whether SS combined with HIV[-]prevention[-]specific content would be associated with additional sexual

They discussed the positive aspects of their relationships with various health care providers and how these relationships were integral to evaluation and treatment acceptance. . . . (p. 70)

Gaining sober time. An important concern mentioned by 6 study participants was gaining sober time. In addition, many participants discussed the role of substance use in making their treatment decisions. Participants agreed that a certain amount of sober time was needed before starting HCV treatment; the sober time mentioned ranged from 6 months to 2 years. . . . (p. 70)

Facing treatment head-on. The last theme involved facing treatment head-on. Participants described how they reframed all the negative issues associated with HCV treatment and established a mind-set that helped them move forward. (p. 70)

In discussing these findings, Bova and colleagues observe the irony that

HIV-infected patients are dying from liver-related complications while having an undetectable HIV viral load. This knowledge creates a tremendous need to reduce the risk imposed by liver disease in HIV-infected patients. . . . Results of this study highlight three important issues. First, patients who accept HCV treatment differ in some way from those who refuse or defer treatment. Patients who begin treatment do reasonably well when significant supports are put in place. They tend to use strategies that help them prepare and begin treatment on the basis of earlier illness experiences. The authors' data are consistent with other reports that state that preexisting psychiatric illness was not a major barrier to HCV treatment.

risk reduction. (p. 427)

Hien and colleagues observe that this randomized controlled trial "highlights ways in which cognitive behavioral groups that enhance coping

. . . Effective preevaluation and support strategies were in place that helped facilitate HCV treatment.

In contrast, those who do not begin treatment tend to be fearful and use other patients' negative experiences as a reason to hold off on HCV treatment. (p. 71)

From Theory to Practice

Bova and colleagues (2010) believe that these findings

shed light on possible theoretical orientations that might be useful for developing HCV-treatment interventions. For example, the result that participants used vicarious experiences to make decisions about moving forward with HCV treatment implies that Bandura's social learning theory (Bandura, 1986) might be useful for intervention development. Bandura . . . indicated that different types of information could influence a person's self-efficacy to perform certain behaviors (e.g., deciding to be treated for HCV infection). Vicarious experience is a form of learning that occurs when patients watch those similar to themselves take part in a certain behavior or activity. If HIV-infected patients have the opportunity to watch others master HCV treatment, they may be more likely to decide to move forward with HCV treatment. Likewise, an appraisal-centered theoretical orientation may be useful for intervention development. The cognitive appraisal model, for example . . . (Lazarus & Folkman, 1984)[,] focuses on the appraisal or meaning of an event (i.e., HCV infection) to one's personal well-being. An intervention that helps patients reframe the negative meaning associated with HCV treatment may be useful for helping them make HCV treatment decisions. Other models that focus on the evaluation of perceived risks and benefits (e.g.,

skills, safety, and self-efficacy may indirectly impact risky sexual behavior among women with comorbid trauma and [SUDs]. . . . In all, findings from the present investigation are encouraging and support new

health belief model, self-regulation) may also be useful for guiding HCV intervention development. (pp. 71-72)

To conclude their discussion, Bova and colleagues reference an ethical consideration about treatment for patients living with HCV in a letter written by Rifai (2006), who "suggested that for patients to make a truly informed treatment decision, primary care providers, specialty care providers (e.g., hepatology, psychiatry), patients, and their families need to engage in a dynamic dialogue. . . . The authors concur and believe that interventions with the best chance of success in helping coinfecting patients make this complicated treatment decision will be theoretically based, intense enough, and will include interprofessional involvement" (p. 72).

References

- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Bova, C., Ogawa, L.F., & Sullivan-Bolyai, S. (2010). Hepatitis C treatment experiences and decision making among patients living with HIV infection. *Journal of the Association of Nurses in AIDS Care, 21*(1), 63-74.
- Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Osilla, K.C., Ryan, G., Bhatti, L., Goetz, M., Witt, M., & Wagner, G. (2009). Factors that influence an HIV coinfecting patient's decision to start hepatitis C treatment. *AIDS Patient Care & STDs, 23*(12), 993-999.
- Rifai, M.A. (2006). Ethical impasses in the care of patients with hepatitis C [Letter]. *Psychosomatics, 47*(6), 540-541.
- Wagner, G., Ryan, G., Osilla, K.C., Bhatti, L., Goetz, M., & Witt, M. (2009). Treat early or wait and monitor? A qualitative analysis of provider hepatitis C virus treatment decision-making in the context of HIV coinfection. *AIDS Patient Care & STDs, 23*(9), 715-725.

— Compiled by
Abraham Feingold, Psy.D.

directions for HIV prevention research to explore ways in which behavior therapies can improve symptom management and coping skills for populations with co-occurring PTSD and [SUDs]" (p. 428).

HIV Assessment News

HIV Counseling & Testing

Kowalczyk Mullins, Braverman, Dorn, Kollar, and Kahn (2010) "conducted a study to determine (a) **adolescent preferences for different HIV testing methods** (rapid oral fluid vs. rapid fingerstick vs. traditional venipuncture), (b) factors associated with choice of a rapid vs. traditional test, and (c) whether those who chose a rapid method were more likely to receive test results" (p. 162) among 99 adolescents and young adults between the ages of 13 and 22 years attending an urban hospital-based general adolescent primary care clinic. The investigators found that 70% of this adolescent and young adult sample, primarily African American and female, "preferred rapid to traditional HIV testing, and rapid testers were more likely to receive their results within the follow-up period" (p. 162). Interestingly, the

desire to avoid venipuncture or needles was the most common reason for choosing a rapid test; smaller numbers of participants cited same[-]day results as the reason they selected a rapid test. These results . . . support . . . survey findings that availability of same visit results is not the predominant reason for selecting a rapid testing method in this sample of adolescents. Participants who chose the traditional test method cited concerns about the accuracy of rapid tests; clinician-provided education about the comparative accuracy of different HIV test methods may address these patient concerns. Because participants reported multiple reasons for choosing a particular test, offering a variety of tests may appeal to a larger number of potential HIV testers. (p. 166)

Kowalczyk Mullins and colleagues further speculate that "by offering less[-]invasive rapid testing to at-risk

youth, clinicians may increase the proportion of teens who agree to undergo HIV testing and receive their test result" (p. 167).

Psychiatric Assessment & Intervention

In another study comparing "**rates of psychopathology in youths perinatally infected with HIV** (N = 319) with a comparison sample of peers (N = 256) either HIV-exposed or living in households with HIV-infected family members" (p. 116; see [Winter 2010](#) issue of *mental healthAIDS* for other recent studies), Gadow et al. (2010) randomly recruited study participants "from 29 sites in the United States and Puerto Rico and completed an extensive battery of measures including standardized DSM-IV-referenced ratings scales" (p. 116). The investigators report that

the HIV+ group was relatively healthy . . . and 92% were actively receiving antiretroviral therapy. Youths with HIV (17%) met symptom and impairment criteria for the following disorders: attention-deficit/hyperactivity disorder (12%), oppositional defiant disorder (5%), conduct disorder (1%), generalized anxiety disorder (2%), separation anxiety disorder (1%), depressive disorder (2%), or manic episode (1%). Many youths with HIV (27%) and peers (26%) were rated (either self- or caregiver report) as having psychiatric problems that interfered with academic or social functioning. With the exception of somatization disorder, the HIV+ group did not evidence higher rates or severity of psychopathology than peers, although rates for both groups were higher than the general population. Nevertheless, self-awareness of HIV infection in younger children was associated with more severe symptomatology, and youths with HIV had higher

lifetime rates of special education (44 vs. 32%), psychopharmacological (23 vs. 12%), or behavioral (27 vs. 17%) interventions. Youth-caregiver agreement was modest, and youths reported more impairment. (p. 116)

In short,

contrary to pre[-]highly active antiretroviral . . . [therapy] (HAART)[-]era research suggesting a possible link between HIV infection and mental health issues, [these] findings generally indicated youths with HIV were not at differentially greater risk for current psychiatric problems (i.e., point prevalence) than peers living in similar environmental settings. This was true whether the comparison group was comprised of uninfected youths who were perinatally exposed to HIV or who were living in a household with an HIV-infected person. Moreover, both caregiver and youth self-reports (which evidenced only modest convergence) suggested that if anything the peer comparisons were generally at greater risk of psychiatric symptoms, particularly aggressive and antisocial behavior and self-perceptions of impairment. (p. 124)

Gadow and colleagues reason that "it is . . . likely that youths with HIV benefitted from access to medical specialists with demonstrated excellence in HIV management, including referral to relevant mental health care professionals. In its own curious way this disease and its clinical management may have interacted with family environment variables to protect these particular youths with HIV from even greater psychological adversity" (p. 125). At the same time, the psychopharmacological and behavioral "treatment findings suggest that lifetime rates of mental health problems may actually be higher in youths with

HIV versus peer comparisons. Moreover, compared with normative data samples, both HIV+ and peer comparison samples manifested greater frequency and severity of co-occurring symptoms” (p. 125). Although the investigators conclude that “youths perinatally infected with HIV do not appear to be at differentially greater risk of mental health problems than peers from similar community and home environments” (p. 126), they hasten to add that “this is but one in a series of reports that will address various aspects of mental health issues in youths with HIV[. The series will] . . . include a longitudinal analysis of the role of specific biologic and environmental variables in pathogenesis of mental distress in this at-risk clinical population of largely poor, minority youth” (p. 126).

Keiser et al. (2010) “examined time trends and predictors of suicide in the pre-HAART (1988-1995) and HAART (1996-2008) eras in HIV-infected patients and the general population in Switzerland” (p. 143) to determine “to what **extent the introduction of . . . HAART . . . has affected suicide rates**” (p. 143). The investigators found that, among those participating in the Swiss HIV Cohort Study, which “includes an estimated 40% of all HIV-positive patients in Switzerland and 70% of all patients with an AIDS diagnosis” (p. 144),

suicide rates declined substantially after the introduction of HAART, in both men and women, with a somewhat steeper decline in men. The association of increasing suicide rates with declining CD4 cell counts supports the hypothesis that HAART-related improvements in disease status may be responsible for the reduction in suicide rates over time. Comparisons with the general population showed that despite this decline, suicide

rates remained well above those observed in the general population; the standardized mortality ratio in recent years was 3.5 in HIV-infected men and 5.7 in HIV-infected women. The risk factors observed in the general population – older age, male sex, and Swiss nationality – were also evident in the HIV-infected patients, in whom advanced clinical disease and a history of injection drug use or psychiatric treatment were additional risk factors. (p. 147)

Importantly, Keiser and colleagues point out that

a diagnosis of mental illness in those who died by suicide was more common in the HAART era than in the pre-HAART era, and patients were more likely to be treated for mental illness in the HAART era. . . . [These findings suggest] that in the pre-HAART era, high suicide rates were driven by disease progression, which at that time could not be prevented, whereas in the HAART era, mental illness has become relatively more important. However, although the number of patients receiving psychiatric care increased, even in the HAART era a substantial proportion of patients remained untreated. These results provide a compelling rationale to improve psychiatric care, including mental health screening and greater access to pharmacological and psychological treatment. Finally, [Keiser and colleagues] stress that the survey of mental illness in patients who died by suicide also had limitations: questionnaires were completed by infectious disease specialists, rather than by the treating psychiatrists, and depended on a review of charts. Also, there was no comparison group of patients who did not die by suicide. (p. 148)

Nevertheless, the investigators conclude that “suicide rates decreased significantly with the introduction of HAART, but they remain above the rate observed in the general population, and risk factors for suicide remain similar. HIV-infected patients remain an important target group for suicide prevention” (p. 143).

On this point, Lawrence et al. (2010) “sought to implement **routine screening of suicidal ideation** and associated conditions **using computerized patient-reported outcome (PRO) assessments**” in “two geographically distinct academic HIV primary care clinics,” where “touch-screen, computer-based PRO assessments were implemented into routine clinical care. Substance abuse, alcohol consumption, depression, and anxiety were assessed. The 9-item Patient Health Questionnaire assesses the frequency of suicidal ideation in the preceding 2 weeks. A response of ‘nearly every day’ triggered an automated page to predetermined clinic personnel, who completed more detailed self-harm assessments” (p. 1165). Among a convenience sample of 1,216 patients who were predominantly white and male,

170 patients (14%) endorsed some level of suicidal ideation, whereas 33 (3%) admitted suicidal ideation nearly every day. The odds of reporting suicidality were increased with more severe depression and current substance abuse, whereas advancing age was associated with lower risk. [This] experience supports the use of novel technologies and user-friendly interfaces (i.e., touch screens or tablet computers) to facilitate the collection of self-reported information in high-volume clinical settings. . . . Such interventions augment the detection of suicidal ideation and other important psychosocial comorbidities, allowing for timely

diagnosis and intervention for these potentially life-threatening conditions. (p. 1170)

HIV Treatment News

Medical Care

No studies were selected for summarization this quarter.

Psychiatric/Psychological/ Psychosocial/Spiritual Care Adherence to Treatment

"Although several cross-sectional studies and a few longitudinal studies . . . have found associations between depression and suboptimal adherence, . . . few have examined whether *onset* of depression is associated with poorer adherence to HAART" (p. 267), according to Kacanek et al. (2010), who set out "to determine the **relationship between incident depression symptoms and suboptimal adherence** to . . . HAART" (p. 266) "in a socio-demographically diverse cohort of [225] persons with HIV in Eastern Massachusetts and Rhode Island" (p. 267) who had been receiving HAART for at least 2 years. "Incident depression was defined as having 2 [semiannual study] visits with a negative depression screening test followed by 2 visits with a positive test. Comparison group participants had 4 consecutive visits with a negative depression screening test. Suboptimal adherence was defined as missing >5% of HAART doses in the past 7 days" (p. 266). "Controlling for sociodemographic, behavioral, and clinical variables" (p. 266), the investigators found that 22% of study participants "developed depression symptoms. Those developing depression symptoms had higher rates of suboptimal adherence at follow-up (45.1% vs. 25.9% . . .). Among those with optimal baseline adherence, those with incident depression were nearly 2 times more likely to develop suboptimal adherence . . . at follow-up" (p. 266). Similar to Keiser and colleagues (2010), Kacanek and colleagues conclude

that these findings "underscore the importance of ongoing aggressive screening for depression to intervene to improve mental health and HAART adherence in patients with HIV infection. For screening to be cost effective and have an impact, it is critical to strengthen referral systems to ensure appropriate treatment of and follow-up for depression for patients with HIV and depression not only because it may improve adherence and HAART outcomes but also because of its potential impact on quality of life overall" (p. 270).

Lopez, Jones, Villar-Loubet, Arheart, and Weiss (2010) investigated "**the extent to which . . . IPV . . . influences antiretroviral medication adherence**" (p. 61) among

a sample of HIV seroconcordant and serodiscordant heterosexual couples . . . recruited from the Miami area and assessed on rates of medication adherence, conflict resolution tactics, and coping strategies. Of these, 190 individual participants were prescribed antiretroviral medication. Baseline rates of adherence were 90.29% for men and 87.77% for women. Acts of violence were found to have negative effects on adherence for women but not for men. However, negative coping strategies were predictive of poor adherence for men but not women. Violence was found to be related to poor coping styles for both men and women. (p. 61)

Lopez and colleagues expand on these findings by observing that

although these data are provocative, the study sample (low socioeconomic status, minority current or former drug users) limits the generalizability of the findings. A more diverse sample would provide a broader understanding of the effects of IPV on medication adherence.

This study provides support for research conducted with couples rather than individuals. As noted above, men appear to play a strong role in medication adherence, both their own adherence, through substance use, and their partners' adherence, through acts of violence. By assessing both partners in a relationship, addressing communication styles as well as conflict resolution tactics, interventions may increase the potential for behavioral change. Furthermore, results highlight the role of religion for men as a means of coping when faced with violent relationships. It may be useful to incorporate spirituality or religion when developing behavioral interventions for HIV seropositive men. Additionally, it may be helpful to further explore the role of denial in violent relationships, examining the perceived reinforcement associated with this coping strategy and the perpetuation of its use. Finally, these results suggest the importance of encouraging the use of more adaptive coping strategies; strategies associated with decreased IPV among women. By improving women's skills in coping, providing additional focus on enhancing positive strategies of conflict resolution, the occurrence of IPV may decrease within the couple.

When interpersonal conflict leads to violence, . . . [i]t *may* be beneficial for men to be included in interventions with women, as the active involvement of both partners may be more likely to yield successful outcomes. Clinicians should include assessment of IPV in their counseling regarding health behaviors such as medication adherence. (italics added; p. 67)

On the other hand, "given the importance of family members as sources

of support and empowerment, interventions designed to improve family interactions may serve as a means of promoting and maintaining HIV medication adherence,” according to Feaster et al. (2010), who examined “the efficacy of **Structural Ecosystems Therapy** (SET; Mitrani, Szapocznik, & Robinson-Batista, 2000; Szapocznik et al., 2004) in increasing medication adherence in African American women infected with HIV” (p. 52).⁵ In this secondary analysis of data from an earlier randomized controlled trial, Feaster and colleagues measured “the **effect of SET on HIV medication adherence** relative to a person-centered condition [(PCA)] and a community control condition” (p. 51) among “156 urban, low-income[,] . . . African American mothers who . . . [we]re HIV seropositive [and] enrolled in the . . . trial” (p. 55).⁶ Feaster and colleagues found that

⁵ Additional studies on caregivers/family members and their involvement in antiretroviral adherence interventions are highlighted in the [Spring 2010](#) issue of *mental health AIDS*. Earlier papers on the systemic family therapy intervention known as SET are highlighted in the [Spring 2003](#) and [Summer 2004](#) issues of *mental health AIDS*.

⁶ “SET targets maladaptive interpersonal interactions within the family, as well as interactions between the family and other important systems (e.g., health care providers). SET therapists work in the present to restructure these interactions and to promote healthy relationships within and outside the family. . . . SET consists of three primary techniques: joining (gaining entry into the family and building trust with family members), diagnosing (identifying the patterns of interactions, both within the family and between the family and outside systems, that prevent the family from being more supportive to the woman who is HIV seropositive), and restructuring (implementing therapeutic techniques to correct these maladaptive patterns of interactions). Eight therapy sessions were considered a minimum dosage of therapy . . . ; though as a psychotherapeutic intervention, therapy and/or booster sessions could continue up to 9 months with agreement of participant and therapist that it was necessary. More details on the SET model can be found in Mitrani et al. (2000)” (Feaster et al., 2010, p. 53).

“PCA was incorporated to control for common factors in therapy such as attention,

SET significantly improved HIV medication adherence in African American women who are HIV+ compared to those women assigned to a person-centered counseling condition. . . . [O]ver time, women in the SET condition demonstrated increased probability of being at least 95% adherent whereas women in the PCA condition demonstrated decreased probability of being 95% adherent. The third condition, a community control group, also showed declines in the likelihood of being 95% adherent over time, though these declines were not significantly different than the other two conditions. These results point to the possibility that an ecosystemic approach to medication adherence may benefit low-income urban minority women. (p. 56)

It bears mentioning that the SET intervention

is process focused and does not emphasize any particular content. Instead, it is theorized that improving family functioning, regardless of content area, and improving the efficacy of the

supportiveness, and empathy. The aim of this condition was to implement an intervention that was distinct from the central techniques and active ingredients of SET. PCA is nondirective whereas SET is directive; PCA targets the individual whereas SET targets the family and ecosystem; PCA targets the self whereas SET targets family interactions; and PCA sets no goals for the client, whereas SET is strategic/goal directed. The focus in PCA is the quality of the relationship between the therapist and the client, in which the therapist demonstrates empathy, unconditional positive regard, and congruence. . . . By definition, the PCA does not incorporate any specific therapeutic techniques; rather, it is the therapeutic relationship that is the active ingredient. Dosing opportunity for PCA was the same as for SET” (Feaster et al., 2010, p. 53).

“The community control condition was intended to reflect (and control for) the baseline services that African American women who are HIV infected receive in the local community. Women in this condition received no services from the study” (Feaster et al., 2010, p. 53).

woman and the family in interacting with resources, will lead to improved psychosocial functioning, which in turn, can result in improved adherence. As such, the intervention does not focus on medication adherence. Instead, the therapist uses any issues that are relevant to the family as a vehicle to change interaction patterns. The changes brought about by the intervention include reductions in family-related hassles – evidence that SET operates through improving family interaction patterns. (p. 57)

The investigators report, however, that even though “family hassles were . . . significantly reduced by SET, . . . the effect of SET on medication adherence did not appear related to this change in family hassles” (p. 51).

Continuing a line of research highlighted in the [Spring 2005](#) issue of *mental health AIDS*, Bogart, Wagner, Galvan, and Banks (2010) “examined whether a specific form of medical mistrust – **HIV conspiracy beliefs** (e.g., HIV is genocide against African Americans) – was associated with **antiretroviral treatment nonadherence among African American men with HIV**” (p. 648). A convenience sample of 214 African American men living with HIV, “many of whom were . . . MSM” (p. 652), “reported their agreement with 9 conspiracy beliefs, sociodemographic characteristics, depression symptoms, substance use, disease characteristics, medical mistrust, and health care barriers. Antiretroviral medication adherence was monitored electronically for one month postbaseline among 177 men in [this] sample” (p. 648). The investigators

found high levels of mistrust about HIV treatment and the government’s role in the HIV epidemic. Adherence rates were

generally low, with less than a quarter of participants adhering to their regimens at high enough levels to be effective against virological failure and the development of drug-resistant strains of the virus. . . .

In an extension of prior research, [Bogart and colleagues] examined 2 distinct types of conspiracy beliefs: genocidal [e.g., “HIV is manmade” (p. 648)] and

treatment-related [e.g., “people who take antiretroviral treatments are human guinea pigs for the government” (p. 648)]. Both types of beliefs were associated with nonadherence in bivariate models. In multivariate models, only belief in treatment-related HIV conspiracies was associated with nonadherence. The association between treatment-related conspiracy beliefs and nonadherence was significant controlling

for age and structural and tangible health care barriers such as lack of insurance or transportation to the clinic. . . . The present research demonstrates that suspicion of treatments may contribute to nonadherence. (p. 652)⁷

⁷ These findings differ from those reported in a study (Clark, Mayben, Hartman, Kallen, & Giordano, 2008) summarized in the [Winter 2009](#) issue of *mental health AIDS*. Bogart and colleagues address Clark and colleagues' "cross-sectional study of 113 African Americans, Latinos, and Whites with HIV attending

Tool Box

Resources

Batkis, M.F., Treisman, G.J., & Angelino, A.F. (2010). Integrated opioid use disorder and HIV treatment: Rationale, clinical guidelines for addiction treatment and review of interactions of antiretroviral agents and opioid agonist therapies. *AIDS Patient Care & STDs*, 24(1), 15-22.

“We present a programmatic approach to the evaluation and treatment of opioid use disorders for HIV care providers, as well as a summary of the available knowledge of interactions of methadone and buprenorphine with ART [antiretroviral therapy], along with the level of evidence for each actual or potential interaction. Based on the available information of practice and the level of clinical significance of drug-drug interactions, we conclude that buprenorphine-based maintenance treatment for opioid dependent patients is the preferred maintenance therapy for integrated treatment systems” (p. 15).

Benton, T.D. (2010). Treatment of psychiatric disorders in children and adolescents with HIV/AIDS. *Current Psychiatry Reports*, 12(2), 104-110.

“We review what is known about psychiatric syndromes among HIV-positive youth, and their treatments” (p. 104).

Burton, J., Darbes, L.A., & Operario, D. (2010). Couples-focused behavioral interventions for prevention of HIV: Systematic review of the state of evidence. *AIDS & Behavior*, 14(1), 1-10.

“Although couples-focused HIV prevention interventions have been pro-

moted as a potentially promising strategy, there exists no known synthesis of the research on the effectiveness of these programs. Based on a comprehensive literature search of all high-quality evaluations of couples-focused HIV prevention programs” (p. 2), Burton and colleagues report that “results across studies consistently indicated that couples-focused programs reduced unprotected sexual intercourse and increased condom use compared with control groups. However, studies were heterogeneous in population, type of intervention, comparison groups, and outcomes measures, and so meta-analysis to calculate pooled effects was inappropriate. Although couples-focused approaches to HIV prevention appear initially promising, additional research is necessary to build a stronger theoretical and methodological basis for couples-focused HIV prevention, and future interventions must pay closer attention to same-sex couples, adolescents, and young people in relationships” (p. 1).

Holstad, M.M., Foster, V., Dilorio, C., McCarty, F., & Teplinskiy, I. (2010). An examination of the psychometric properties of the Antiretroviral General Adherence Scale (AGAS) in two samples of HIV-infected individuals. *Journal of the Association of Nurses in AIDS Care*, 21(2), 162-172.

“The purpose of this study was to describe and examine the psychometric properties of the Antiretroviral General Adherence Scale (AGAS), a practical and easy to administer five-item self-report measure of [antiretroviral] medication adherence over a 30-day period. A comprehensive examination of scale reliability and validity is presented” (p. 163). “The results of these analy-

ses provided evidence for both reliability and validity of the AGAS when used for research purposes. The AGAS is easy to read and easy to administer, taking less than 5 minutes to complete, which makes it potentially beneficial for clinical purposes as well” (p. 170).

Kelly, A. (2010). Lost the feel for the game: Meanings of onset and diagnosis of AIDS dementia for significant others. *Qualitative Health Research*, 20(4), 531-540.

“In this article [Kelly] examine[s] how significant others made sense of the changes in their loved one with HIV prior to the diagnosis of dementia, and their response to such a diagnosis” (p. 532). For significant others, “the onset and subsequent diagnosis of AIDS dementia comes to signify . . . a moment in which life is permanently altered, whereby [significant others] no longer have the feel for the game [of life]. . . . This change . . . further marginalizes significant others . . . because dementia is not the socially acceptable way of being ill with HIV” (p. 531).

Letourneau, E.J., Ellis, D.A., Naar-King, S., Cunningham, P.B., & Fowler, S.L. (2010). Case study: Multisystemic therapy for adolescents who engage in HIV transmission risk behaviors. *Journal of Pediatric Psychology*, 35(2), 120-127.

Letourneau and colleagues “present a case study using multisystemic therapy (MST), an intensive family focused psychotherapy. For the clinical trial from which this case was drawn, MST was adapted to address multiple . . . HIV . . . transmission risk behaviors in HIV-infected youth. Targeted be-

Bogart and colleagues believe that

adherence interventions designed to address culturally specific

public treatment facilities [in which the investigators] did not find significant relationships between conspiracies and treatment nonadherence or engagement in care, . . . although the majority (63%) of the sample endorsed at least 1 conspiracy belief. [Clark and colleagues] suggested that conspiracies are common among patients with HIV but do not influence treatment behaviors. An alternate explanation may be that conflating responses across 3 racial/ethnic groups may

haviors included medication nonadherence, risky sexual behaviors, and substance use. . . . Findings from this case study suggest that MST has the potential to reduce transmission risk behaviors among teens with HIV” (p. 120).

Neilands, T.B., Chakravarty, D., Darbes, L.A., Beougher, S.C., & Hoff, C.C. (2010). Development and validation of the Sexual Agreement Investment Scale. *Journal of Sex Research*, 47(1), 24-37.

“The Sexual Agreement Investment Scale (SAIS) is a psychometrically sound [13-item] measure of the level of investment in sexual agreements among gay men in relationships. Men with higher agreement investment were less likely to break agreements and less likely to engage in unprotected anal intercourse with outside partners” (p. 24). “Sex therapists and psychotherapists could administer this scale to gay male couples, and individual gay men who are in committed relationships, to identify troubled areas in their sexual agreements and other risk factors that could, with intervention, be improved” (p. 35).

Operario, D., Smith, C.D., Arnold, E., & Kegeles, S. (2010). The Bruthas Project: Evaluation of a community-based HIV prevention intervention for African American men who have sex with men and women. *AIDS Education & Prevention*, 22(1), 37-48.

“This is the first known HIV prevention intervention developed for African American MSMW [men who have sex with men and women] who engage in secretive sex with men to show promising results. This pilot study of the

roots of nonadherence may help to overcome medical mistrust.

. . . [Additionally, p]roviders who are open to dialogue about patients’ treatment-related concerns have an opportunity to ad-

have diluted any adherence effects; research suggests that beliefs indicative of medical mistrust may be more highly related to health behaviors among African Americans than Whites. . . . Further work is needed to determine the relationship between belief in conspiracies and treatment adherence among African Americans in particular” (Bogart et al., 2010, p. 649).

Bruthas Project showed significant reductions in unsafe sexual behaviors with male partners, fewer numbers of unsafe female and male partners overall, and less sex while under the influence of drugs following completion of the intervention. Improvements in psychological well-being – including increased feelings of social support and self-esteem and reduced loneliness – were also observed” (p. 46). These “preliminary findings . . . suggest this is a promising approach to recruiting and counseling African American MSMW in HIV prevention and sexual risk reduction services” (p. 47).

Palmer, N.B., Basinski, J.R., & Uldall, K.K. (2010). Psychiatric illness, access and adherence to HAART: A brief review of recent findings and implications for care [Review]. *HIV Therapy*, 4(2), 215-230.

“This review outlines research since 2006 addressing psychiatric illness and/or co-occurring psychiatric illness and substance abuse as it relates to HAART [highly active ART] access and adherence. Highlighted here are effective or promising interventions, or models of care, designed to enhance adherence among HIV-infected individuals with mental illness. Overall, we found that recent studies reinforce earlier findings that co-occurring substance abuse and psychiatric illness are associated with HAART nonadherence. Studies of depression/anxiety disorders among HIV patients reviewed here show that while depression is related to poorer medication adherence, treatment for depression can lead to increased HAART adherence. New studies also suggest that HIV patients with psychiatric diagnoses can effectively maintain HAART

dress and overcome mistrust-related barriers to adherence, improve patient relationships, and counteract inaccurate information patients hear in the community.

. . . [Finally, a]dherence-promoting interventions that openly address and acknowledge HIV misconceptions, and identify and then target sources of misconceptions in communities, may contribute to overcoming such mistrust. (p. 653)

adherence with close monitoring by providers. While there are still very few adherence interventions among HIV patients with co-occurring mental illness and substance abuse, promising interventions include cognitive behavioral therapy and integration of mental health services with HIV primary care” (p. 215).

Poindexter, C.C. (Ed.). (2010). *Handbook of HIV and social work: Principles, practice, and populations*. Hoboken, NJ: Wiley.

From the publisher: This “book draws on a distinguished roster of HIV advocates, educators, case managers, counselors, and administrators, assembling the most current knowledge into this volume. *Handbook of HIV and Social Work* reflects the latest research and its impact on policy and practice realities.”

Sikkema, K.J., Watt, M.H., Drabkin, A.S., Meade, C.S., Hansen, N.B., & Pence, B.W. (2010). Mental health treatment to reduce HIV transmission risk behavior: A positive prevention model. *AIDS & Behavior*, 14(2), 252-262.

“Secondary HIV prevention, or ‘positive prevention,’ is concerned with reducing HIV transmission risk behavior and optimizing the health and quality of life of people living with HIV/AIDS (PLWHA). . . . We propose that mental health treatment, including behavioral and pharmacologic interventions, can lead to reductions in HIV transmission risk behavior and should be a core component of secondary HIV prevention. We present a conceptual model and recommendations to guide future research on the effect of mental health

(Tool Box is continued on Page 16)

(Tool Box -- continued from Page 15)

treatment on HIV transmission risk behavior among PLWHA" (p. 252).

Silverman, B.C., Kim, A.Y., & Freudenreich, O. (2010). Interferon-induced psychosis as a "psychiatric contraindication" to hepatitis C treatment: A review and case-based discussion [Review]. *Psychosomatics*, 51(1), 1-7. "In this article, we present a case of psychosis induced by interferon treatment for chronic hepatitis C in a patient with a very complex psychiatric history that included past intravenous drug use, depression, posttraumatic stress disorder (PTSD), and borderline personality disorder. Her psychosis resolved with discontinuation of interferon and initiation of an antipsychotic, but re-occurred when interferon was restarted, in spite of ongoing antipsychotic treatment. In our discussion, we will ask this question: For whom should we decide to withhold interferon-based treatment in the face of psychiatric contraindications, given interferon's potential to change the natural history of HCV infection?" (p. 2).

Simoni, J.M., Amico, K.R., Smith, L., & Nelson, K. (2010). Antiretroviral adherence interventions: Translating research findings to the real world clinic. *Current HIV/AIDS Reports*, 7(1), 44-51.

"In this article, we update current reviews, focusing specifically on the 13

studies evaluating behavioral interventions to promote ART adherence published since September 2007. We describe the range of intervention strategies employed and qualitatively summarize findings of their efficacy. In conclusion, we consider implications and offer strategies for enhancing adherence in clinic-based HIV care prior to ART initiation, at initiation, and over the course of treatment" (p. 44).

Talley, A.E., & Bettencourt, B.A. (2010). A relationship-oriented model of HIV-related stigma derived from a review of the HIV-affected couples literature. *AIDS & Behavior*, 14(1), 72-86.

"The current review will integrate previous research findings to substantiate a relationship-oriented theoretical model of HIV-related stigma that delineates interpersonal variables important for understanding the influence of types of HIV-related stigma on couple-level as well as relevant individual-level outcomes. In doing so, supportive evidence is presented from the extant quantitative and qualitative literature that has assessed or examined HIV-affected couple members' experiences with HIV-related stigma. Implications from this review are presented for researchers who examine issues related to HIV-related stigma" (p. 72).

— Compiled by
Abraham Feingold, Psy.D.

Service Engagement, Retention, & Utilization

Halkitis, Kupprat, and Mukherjee (2010) retrospectively analyzed "participant case management, supportive service, and medical charts . . . to examine both descriptive and relational data on **use of case management and supportive services** over a 2-year period from 2002 to 2005" (p. 99) among 46 women living with HIV in New York City who were predominantly African American and Latina. The analyzed charting

revealed that participants interacted with their case manager four times and received 3.6 supportive services per month.

Transportation, primary health-care/medical specialists, and support groups were the services most used, with rates ranging from 70% to 80%. . . . [C]ase management and supportive service use patterns remained constant over the 24-month period . . . [and] a significant positive relationship between case management and supportive services [is suggested by this analysis]. No moderation was indicated in the association between case management and supportive service use by person-level (e.g., mental illness, substance use) and institution-level (i.e., service delivery model) factors. (p. 99)

Halkitis and colleagues point out that the synergistic relationship between supportive and case management services "suggests that increases in either may result in retaining women in care" (p. 99), and these "findings appear to bolster what both the literature cites and many participants stated verbally: that the relationship with their case manager is important [to clients]" (p. 105).

With regard to service delivery, the investigators emphasize "the need for skills[-]building training for case managers, outreach workers, or system navigators to assist with short-term goals of establishing rapport and maintaining the client relationship, as this may lead to HIV-positive women accessing services" (p. 99). In fact,

HIV system navigators in [another study] were trained in the strengths-based perspective from social work practice, [MI] techniques, stages of change model, and a strengths-based approach to working with clients. Perhaps similar training for all case managers, outreach workers, and system navigators would aid in establishing rapport and maintaining a relationship with clients, which [Halkitis and colleagues] hypothesize would ultimately improve the health, increase quality of life, and slow the disease progression in HIV-positive women. (p. 105)

Finally, "outreach and engagement strategies need to be developed for those who typically underuse [supportive and case management] services" (p. 99), according to Halkitis and colleagues.

In a novel investigation, Mkanta, Mejia, and Duncan (2010) "examined the **relationship between the length of survival after an AIDS diagnosis and outpatient mental health service use**" (p. 34) among 1,913 black/non-Hispanic and 1,684

white/non-Hispanic men who were living with AIDS and receiving HAART in 2003 through the Veterans Affairs health care system. The investigators found that “36% of the patients in [this] sample used outpatient mental health services” (p. 34) and that

patients with longer survival after AIDS had higher rates of outpatient visits for stress and adjustment disorders as well as for mood, anxiety, and sexual disorders. Blacks had more visits for stress and adjustment disorders[, and] . . . prolonged survival after [an] AIDS [diagnosis] . . . , having [a] CD4 cell count less than 200 cells/mm³ . . . , and . . . [death of the patient during the study period] were associated with greater number of visits for mood, anxiety, and sexual disorders. Injection drug users . . . , [MSM] . . . , and patients with AIDS-defining illness . . . had greater rates of visits for stress and adjustment disorders. (p. 31)

Mkanta and colleagues conclude that “survival after [an] AIDS [diagnosis] is associated with mental health service use” (p. 31) and that “as increased numbers of HIV patients attain long-term survival, both health care providers and networks of support groups should become aware of the potential mental health challenges facing these patients. Timely intervention and continual assessment of mental health conditions of the patients could result in reductions of suboptimal use of services and . . . [reduce] cost of care, degree of disparities and AIDS-related mortality” (p. 36).

Coping, Social Support, & Quality of Life

Trevino et al. (2010) “investigated the relationships between **positive religious coping** (e.g., seeking spiritual support) and **spiritual struggle** (e.g., anger at God) versus viral load, CD4 count, quality of life, HIV symp-

toms, depression, self-esteem, social support, and spiritual well-being in 429 patients with HIV/AIDS” (p. 379) who were either white or African American, predominantly Christian, and receiving care at one of four clinical sites. “Data were collected through patient interview and chart review at baseline and 12-18 months later” (p. 379). At baseline,

positive religious coping was associated with positive outcomes, including greater self-esteem and spirituality. Spiritual struggle was associated with negative outcomes, such as poorer quality of life, higher levels of HIV symptoms, and higher levels of depressive symptoms. In addition, the longitudinal analyses indicated that participants scoring relatively high on positive religious coping reported improvements in well-being over time whereas participants scoring high on spiritual struggle reported declines over time, even when controlling for demographic variables. Though the magnitudes of these effects were modest, the findings were consistent across various outcomes, including depressive symptoms, quality of life, spiritual well-being, and clinical indicators of disease severity. (pp. 385-386)

Since these results “suggest that positive religious coping is associated with small but significant improvements in well-being in individuals with HIV/AIDS over time, whereas spiritual struggle is associated with small but significant declines in well-being over time,” Trevino and colleagues suggest that “assessing positive religious coping and spiritual struggle in patients with HIV/AIDS may help health professionals identify and support patients using positive religious coping methods while targeting those individuals whose spiritual struggle may adversely affect their well-being” (p. 387).

According to the investigators,

early identification of individuals experiencing spiritual struggle could allow professionals to intervene and perhaps avert the detrimental effects of spiritual struggle. Appropriate interventions may include discussing religious or spiritual beliefs, referring to a pastoral counselor or religious clergy, or . . . [engaging in] psychotherapy to address spiritual struggle. . . . [Additionally,] these results suggest that psycho-spiritual interventions that promote positive religious coping and target spiritual struggle may improve psychological, physiological, and spiritual well-being in individuals with HIV/AIDS. Research on psycho-spiritual interventions is in its infancy[, but] . . . manualized psycho-spiritual interventions for HIV/AIDS patients have been developed. . . . The preliminary success of these interventions suggests that psycho-spiritual treatments can be relevant and beneficial to individuals with HIV/AIDS. However, additional research on their effectiveness is needed. (p. 387)

Continuing this focus on intervention, Breitbart et al. (2010) “assessed the **impact of treatment for depression on desire for hastened death**” among 372 patients with advanced AIDS in palliative-care facilities, who “were interviewed shortly after admission . . . and were reinterviewed monthly for the next 2 months. Patients diagnosed with a major depressive syndrome were provided with antidepressant treatment and reinterviewed weekly. Desire for hastened death was assessed with two questionnaire measures” (p. 98). The investigators found that

virtually all depressed patients with advanced AIDS who experienced significant improvement in

depressive symptoms also showed a significant reduction in desire for hastened death. Conversely, those individuals who remained depressed rarely showed significant improvement in desire for hastened death. Moreover, desire for hastened death emerged in some patients as they became more depressed over time. Thus, these data suggest that successful treatment for depression, whether success is due to antidepressant medications, other palliative care, psychosocial interventions, or the natural course of mood disorders, is likely to reduce desire for hastened death, even in patients with an advanced and/or life-threatening illness. (pp. 103-104)

Breitbart and colleagues acknowledge that these findings “do not suggest that desire for hastened death is always due to depression”; rather, the findings “demonstrate the importance of careful assessment for depression and, when present, aggressive treatment, particularly when patients articulate a desire for hastened death” (p. 104). Moreover, the “finding that desire for hastened death may persist, in a small proportion of individuals, even in the absence of depression, highlights the importance of investigating other sources of despair that may also benefit from mental health intervention” (pp. 104-105).

References

Bogart, L.M., Wagner, G., Galvan, F.H., & Banks, D. (2010). Conspiracy beliefs about HIV are related to antiretroviral treatment nonadherence among African American men with HIV. *Journal of Acquired Immune Deficiency Syndromes*, 53(5), 648-655.

Breitbart, W., Rosenfeld, B., Gibson, C., Kramer, M., Li, Y., Tomarken, A., Nelson, C., Pessin, H., Esch, J., Galiotta, M., Garcia, N., Brechtel, J., & Schuster, M. (2010). Impact of treatment for depression on desire for hastened death in patients with ad-

vanced AIDS. *Psychosomatics*, 51(2), 98-105.

Cavanaugh, C.E., Hansen, N.B., & Sullivan, T.P. (2010). HIV sexual risk behavior among low-income women experiencing intimate partner violence: The role of posttraumatic stress disorder. *AIDS & Behavior*, 14(2), 318-327.

Clark, A., Mayben, J.K., Hartman, C., Kallen, M.A., & Giordano, T.P. (2008). Conspiracy beliefs about HIV infection are common but not associated with delayed diagnosis or adherence to care. *AIDS Patient Care & STDs*, 22(9), 753-759.

Cosio, D., Heckman, T.G., Anderson, T., Heckman, B.D., Garske, J., & McCarthy, J. (2010). Telephone-administered motivational interviewing to reduce risky sexual behavior in HIV-infected rural persons: A pilot randomized clinical trial. *Sexually Transmitted Diseases*, 37(3), 140-146.

DiClemente, R.J., Wingood, G.M., Harrington, K.F., Lang, D.L., Davies, S.L., Hook, E.W., III, Oh, M.K., Crosby, R.A., Hertzberg, V.S., Gordon, A.B., Hardin, J.W., Parker, S., & Robillard, A. (2004). Efficacy of an HIV prevention intervention for African American adolescent girls: A randomized controlled trial. *Journal of the American Medical Association*, 292(2), 171-179.

Edwards, G.L., & Barber, B.L. (2010). Women may underestimate their partners' desires to use condoms: Possible implications for behaviour. *Journal of Sex Research*, 47(1), 59-65.

Feaster, D.J., Brincks, A.M., Mitrani, V.B., Prado, G., Schwartz, S.J., & Szapocznik, J. (2010). The efficacy of structural ecosystems therapy for HIV medication adherence with African American women. *Journal of Family Psychology*, 24(1), 51-59.

Gadow, K.D., Chernoff, M., Williams, P.L., Brouwers, P., Morse, E., Heston, J., Hodge, J., Di Poalo, V., Deygoo, N.S., & Nachman, S. (2010). Co-occurring psychiatric symptoms in children perinatally infected with HIV and peer comparison sample. *Journal of Developmental & Behavioral Pediatrics*, 31(2), 116-128.

Halkitis, P.N., Kupprat, S.A., & Mukherjee, P.P. (2010). Longitudinal associations between case management and supportive services use among black and Latina HIV-positive

women in New York City. *Journal of Women's Health*, 19(1), 99-108.

Hien, D.A., Campbell, A.N.C., Killeen, T., Hu, M.-C., Hansen, C., Jiang, H., Hatch-Maillette, M., Miele, G.M., Cohen, L.R., Gan, W., Resko, S.M., DiBono, M., Wells, E.A., & Nunes, E.V. (2010). The impact of trauma-focused group therapy upon HIV sexual risk behaviors in the NIDA Clinical Trials Network “Women and Trauma” multi-site study. *AIDS & Behavior*, 14(2), 421-430.

Kacanek, D., Jacobson, D.L., Spiegelman, D., Wanke, C., Isaac, R., & Wilson, I.B. (2010). Incident depression symptoms are associated with poorer HAART adherence: A longitudinal analysis from the Nutrition for Healthy Living Study. *Journal of Acquired Immune Deficiency Syndromes*, 53(2), 266-272.

Keiser, O., Spoerri, A., Brinkhof, M.W.G., Hasse, B., Gayet-Ageron, A., Tissot, F., Christen, A., Battegay, M., Schmid, P., Bernasconi, E., & Egger, M. (2010). Suicide in HIV-infected individuals and the general population in Switzerland, 1988-2008. *American Journal of Psychiatry*, 167(2), 143-150.

Kowalczyk Mullins, T.L., Braverman, P.K., Dorn, L.D., Kollar, L.M., & Kahn, J.A. (2010). Adolescent preferences for human immunodeficiency virus testing methods and impact of rapid tests on receipt of results. *Journal of Adolescent Health*, 46(2), 162-168.

Lawrence, S.T., Willig, J.H., Crane, H.M., Ye, J., Aban, I., Lober, W., Nevin, C.R., Batey, D.S., Mugavero, M.J., McCullumsmith, C., Wright, C., Kitahata, M., Raper, J.L., Saag, M.S., & Schumacher, J.E. (2010). Routine, self-administered, touch-screen, computer-based suicidal ideation assessment linked to automated response team notification in an HIV primary care setting. *Clinical Infectious Diseases*, 50(8), 1165-1173.

Lopez, E.J., Jones, D.L., Villar-Loubet, O.M., Arheart, K.L., & Weiss, S.M. (2010). Violence, coping, and consistent medication adherence in HIV-positive couples. *AIDS Education & Prevention*, 22(1), 61-68.

Miller, S., Pagan, D., & Tross, S. (1998). Women's health education. In *Peer activism for female partners of injection drug users*. Unpublished treatment manual, Columbia University.

Mitrani, V.B., Szapocznik, J., & Robinson-Batista, C. (2000). Structural ecosystems therapy with sero-

positive African American mothers. In W. Pequegnat & J. Szapocznik (Eds.), *The role of families in preventing and adapting to HIV/AIDS* (pp. 243-279). Thousand Oaks, CA: Sage.

Mkanta, W.N., Mejia, M.C., & Duncan, R.P. (2010). Race, outpatient mental health service use, and survival after an AIDS diagnosis in the highly active antiretroviral therapy era. *AIDS Patient Care & STDs*, 24(1), 31-37.

Najavits, L.M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

Outlaw, A., Naar-King, S., Janisse, H., Parsons, J.T., & the Adolescent Trials Network for HIV/AIDS Interventions. (2010). Predictors of condom use in a multisite study of high-risk youth living with HIV. *AIDS Education & Prevention*, 22(1), 1-14.

Safren, S.A., Traeger, L., Skeer, M.R., O'Cleirigh, C., Meade, C.S., Covahey, C., & Mayer, K.H. (2010). Testing a social-cognitive model of HIV transmission risk behaviors in HIV-infected MSM with and without depression. *Health Psychology*, 29(2), 215-221.

Sales, J.M., Lang, D.L., Hardin, J.W., DiClemente, R.J., & Wingood, G.M. (2010). Efficacy of an HIV prevention program among African American female adolescents reporting high depressive symptomatology. *Journal*

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/Hepatitis/STD/TB Prevention News Update* (<http://www.cdcnpin.org/news/NewsList.asp>); *Kaiser Health News* (<http://www.kaiserhealthnews.org/>); and information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

of Women's Health, 19(2), 219-227. Szapocznik, J., Feaster, D.J., Mitrani, V.B., Prado, G., Smith, L., Robinson-Batista, C., Schwartz, S.J., Mauer, M.H., & Robbins, M.S. (2004). Structural ecosystems therapy for HIV-seropositive African American women: Effects on psychological distress, family hassles, and family support. *Journal of Consulting & Clinical Psychology*, 72(2), 288-303.

Trevino, K.M., Pargament, K.I., Cotton, S., Leonard, A.C., Hahn, J., Caprini-

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., & Gallant, J.E. (2007). *Medical management of HIV infection, 2007 edition*. Baltimore: Johns Hopkins University, Division of Infectious Diseases.

Fernandez, F., & Ruiz, P. (Eds.). (2006). *Psychiatric aspects of HIV/AIDS*. Philadelphia: Lippincott Williams & Wilkins.

Faigin, C.A., & Tsevat, J. (2010). Religious coping and physiological, psychological, social, and spiritual outcomes in patients with HIV/AIDS: Cross-sectional and longitudinal findings. *AIDS & Behavior*, 14(2), 379-389.

Wulfert, E., & Wan, C.K. (1993). Condom use: A self-efficacy model. *Health Psychology*, 12(5), 346-353.

– Compiled by
Abraham Feingold, Psy.D.

HIV/AIDS Education, Prevention, and Services Programs
Division of Prevention, Traumatic Stress, and Special Programs
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
One Choke Cherry Road, Suite 2-1009
Rockville, MD 20857
Web site: <http://www.samhsa.gov/>



mental healthAIDS is available online!
Go to: <http://mentalhealthAIDS.samhsa.gov>