

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Women

Previous research has suggested that women who use two or more contraceptive methods are less likely to use condoms consistently. Wilson, Koenig, Walter, Fernandez, and Ethier (2003) challenge this finding through an analysis of event-level data. They interviewed 361 sexually active women (both HIV-positive and -negative) six months postpartum and found that 39% used dual contraceptive methods (i.e., male condoms plus another method), while 30% reported that they used condoms alone. Notably, 64% of the dual method users reported *simultaneous* use of methods during all occasions of vaginal intercourse, a practice associated with HIV-positivity, believing that a pregnancy occurring in the next six months would be upsetting, and reporting that they do not use alcohol. Given the enhanced safety of this practice for women living with HIV as well as those at risk, "[d]ual contraceptive users should be encouraged to use methods together at every episode of vaginal sex. Interventions promoting simultaneous use should include pregnancy attitudes and the role of alcohol use, as well as a consideration of HIV serostatus as it impacts on dual use" (p. 809).

Use of protection implies the awareness of risk. Klein, Elifson, and Sterk (2003) studied 250 low-income, urban women – primarily women of color – and found that

women's perceptions of their risk for acquiring HIV and their actual level of behavioral risk are fairly concordant with one another. [And yet, m]ore than half of the women who reported that they had no chance of contracting HIV engaged [in] at least one behavior that

could place them at risk ..., suggesting that denial and insufficient knowledge about HIV transmission may be present. The belief that one could not contract HIV was greatest among women who were older in age, maltreated in a variety of ways during their formative years, *higher* in self-esteem [*italics added*], and less involved in drug use and risky sexual behavior. (p. 60)

In addition to standard recommendations about carefully addressing denial and the issues underlying it (particularly among women who less frequently engage in sex- or drug-related risk behaviors), tailoring HIV education and skills-building, and targeting outreach to older women, Klein and colleagues suggest that "HIV interventionists might conduct brief assessments of perceived HIV risk among women who enter their programs with good self-esteem and/or women whose self-esteem demonstrates considerable improvement as a result of project-related esteem-enhancing components. Those whose higher self-esteem levels also correspond with having a sense of invulnerability to HIV should be assessed carefully for their levels of HIV risk; and behavior-specific educational and intervention components should be provided to address potential problem areas" (p. 60).

In terms of intervention, Hoffman, Exner, Leu, Ehrhardt, and Stein (2003) assessed 360 female family planning clinic clients at risk for HIV/sexually transmitted diseases (STDs) following participation in a gender-specific group prevention intervention that, among other things, introduced the female condom. The women, who were largely African-American, were randomized to one of three conditions – an eight-session group,

a four-session group, or assessment-only (control group) – and were interviewed one, six, and 12 months following the intervention. At one month post-intervention, women in the eight-session group were more than nine times as likely to use the female condom at least once and women in the four-session group were more than four times as likely to do so when compared to controls. Repeated use was associated with a woman's perceived ability to use the female condom, by her own and her partner's satisfaction, by negative views on male condoms, and by having previously used a diaphragm. The authors conclude that "gender sensitive cognitive-behavioral interventions can influence women to try the female condom. To increase long-term use, interventions may need to include self-insertion practice and involvement of male partners" (p. 1897).

Melendez, Hoffman, Exner, Leu, and Ehrhardt (2003) focused on a subsample from this study: 152 women who had experienced physical abuse from their partner during the preceding year. In describing the intervention conditions, Melendez and colleagues note that "[t]he [weekly, two-hour, small group] sessions were cognitive-behavioral and psychoeducational in nature, designed to be fun as well as highly action-

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oriented. Role-playing, problem solving, letter writing, attitude confrontation, story telling, and modeling were among the interactive techniques employed" (p. 501). The four-session version covered the same topics, but allowed less time for role-playing and interactive activities.

Over the short-term, women in both intervention conditions were more likely to employ alternative protection strategies (i.e., refusal of sex, outercourse, or mutual HIV testing), to engage in safer sex discussion with their partners, and to score higher on their intention to negotiate safer sexual practices than those receiving assessment only. Only women in the eight-session group intervention, however, maintained consistent safer sex practices or reduced their number of unprotected sex occasions 30 days and one year postintervention. "It is possible that the eight-session intervention was better able to facilitate change because it provided women with more time to role-play and rehearse ways of effectively dealing with difficult partners and safer sex issues" (p. 509). Importantly, the interventions did not change the incidence of postintervention abuse during the one-year follow-up period.

This intervention ... may have been particularly salient for abused women because it addressed issues relevant to their lives, specifically empowerment in sexual relationships and negotiation of safer sex with a potentially abusive partner. The intervention also focused on

... gender roles], and] dealt concretely with the difficulties often encountered by them, providing non-confrontational guidelines for staying firm and being heard ... includ[ing] deciding beforehand where and when to ask for safer sex (making sure it happens before engaging in foreplay), being clear on strategy, and stating one's needs and feelings. Women also discussed different tactics for dealing with an angry or abusive partner when asking for safer sex, including using self-talk to stay calm and focused, trying to solve the problem jointly, showing empathy and assertiveness and finally, in order to avoid abuse, diverting the topic to something less provocative or removing oneself from the scene. (pp. 508-509)

About Substance Users

The need to develop gender-specific prevention interventions is further highlighted in a study by Logan, Cole, and Leukefeld (2003), who investigated the context of one type of risk behavior – sex exchange – in 148 heterosexual men (64.2% of whom reported buying sex for drugs or money) and 149 women (59.1% of whom reported selling sex for drugs or money) with a history of crack cocaine use. While there were few differences between men involved in sex exchange and those who were not, this was not the case among the women studied. For example, "female crack users who reported sex exchange were more likely to focus on situational and economic factors as their

reasons for exchanging sex. HIV prevention interventions could target impulsive decision making and alternative coping skills for situations in which individuals are more likely to trade sex for more drugs" (p. 459). On the other hand, sex exchange was presented as part of men's developmental trajectory, as most men initiated sex exchange *before* they initiated crack use. It should be noted, however, that nearly half of the men reported trading sex as a matter of convenience, as this was less problematic than dealing with a girlfriend. This "may suggest that some men purchase sex to avoid relationship complications or because of difficulties in initiating an intimate relationship. ... Consequently, prevention interventions could target relationship skills for men, specifically skills to increase social support networks and partner intimacy, which may in turn decrease the motivation of some men to engage in sex exchange" (p. 459).

About Adolescents

Drawing on a clinic-based sample of 411 urban female adolescents, Kershaw, Ethier, Niccolai, Lewis, and Ickovics (2003) discerned that "[f]emale adolescents' sexual risk behavior was significantly related to their perceived risk for HIV. Despite this relationship, there was risk misperception among this ... sample. Of those who engaged in high-risk behavior (e.g., unprotected sex with multiple partners), 65% believed that their behavior was only slightly or not at all risky" (p. 529).

[F]emale adolescents used the context of their sexual relationships when assessing risk. ... [Those] who engaged in unprotected sex felt they were at little risk if they were with a long-term partner. ... [They] equated long-term relationships with trust and safety even when the evidence did not support such an assumption. ... Targeted interventions for those who underestimate their sexual risk (among both slight- and high-risk individuals) should [therefore] focus on risk assessment within the context of long-term ... relationships. ...

In addition to longer partnerships, high-risk participants who underestimated their risk had less risk knowledge and

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less perceived pressure to have unprotected sex. ... Interventions that stress the behavioral consequences of unprotected sex may help to increase the accuracy of risk assessments among these female adolescents. (p. 530)

From the Block **DAYAM**

The Division of Adolescent and Young Adult Medicine (DAYAM) of the New Jersey Medical School, located in Newark, New Jersey, has been engaged in clinical service, teaching, and research since 1976.

In addition to comprehensive medical and psychosocial services, DAYAM offers specialized programming to address a range of issues affecting adolescents and young adults, including: HIV/AIDS, sexually transmitted diseases, violence prevention, rape and sexual abuse, adolescent parenting, health promotion, substance use and abuse, truancy, school failure, and delinquency.

With CMHS/SAMHSA funding, culturally competent mental health services are now being embedded in the continuum of "wellness care" historically provided by DAYAM (i.e., case management/advocacy, outreach and engagement, housing assistance, emergency assistance, and transportation services). These multi-modal, comprehensive mental health services are being tailored to the individual needs of African-American and Latino adolescents and young adults living with HIV. Service delivery occurs through the integration of mental health services into existing primary care services, with which they are co-located; through outreach into non-traditional settings; and by providing services during off-hours as well as traditional hours.

The Principal Investigator is Robert L. Johnson, MD, FAAP; the Clinical Director is Drew Johnson, CSW. For more information, please call 973/972-0192 or visit www.umdj.edu/pedsnweb/day/index.html.

— *Compiled by the MHSC Program
Coordinating Center*

Lucenko, Malow, Sanchez-Martinez, Jennings, and Dévieux (2003) measured levels of depressive affect in a culturally diverse, inner-city sample of 363 substance abusing adolescent offenders, divided the sample on the basis of high and low negative affect, and found that the former group, when compared to the latter, reported: a

greater number of sexual partners, more unprotected sex, and greater use of alcohol, marijuana, and cocaine. Interestingly, while they demonstrated better condom use skills, these high negative affect teens also reported less favorable attitudes towards condom use, less knowledge regarding the transmission of HIV, and lower sexual self-efficacy when compared to their low negative affect peers. The authors conclude that "HIV risk reduction programs targeting sites such as juvenile detention centers and related court-ordered treatment programs would benefit by screening and intervention approaches which explicate more focus on symptoms of negative affect (e.g., anger, depression) in addition to the traditional emphasis on risk behavior" (p. 12).

About Women & Men

Tubman, Gil, Wagner, and Artigues (2003) interviewed a multiethnic community sample of 1,803 young adults in urban South Florida and found sexual risk behavior to be associated with lifetime and past-year psychiatric diagnoses. "Participants reporting the most maladaptive patterns of sexual risk behaviors (i.e., multiple partners, extensive substance use before or during sex, significant proportions of unprotected intercourse) were significantly more likely to be assigned multiple lifetime psychiatric diagnoses, and in particular diagnoses of substance abuse or dependence, conduct disorder, and anti-social personality disorder" (p. 491).

How to best intervene with this population? In part, Tubman and colleagues state:

[A] growing body of empirical evidence supports the efficacy of motivational interventions for HIV risk reduction among populations often considered difficult to engage, including youth with histories of psychiatric disorders. Furthermore, the adaptability and flexibility of motivational interventions ... allow[s] them to be provided in a culturally congruent and developmentally sensitive manner, enhancing the[ir] effectiveness ...

A proactive agenda of early, intensive, and ongoing selected prevention programming is needed to encourage HIV testing, behavioral risk assessment and

HIV risk reduction among vulnerable youth populations. ... It is essential that HIV risk reduction modules be fully integrated into services accessed routinely by youth in this population (e.g., health care, counseling and psychotherapy, substance abuse treatment and juvenile justice). Failure to exploit early opportunities to engage this elusive ... population may constrain significantly desired reductions in HIV-related morbidity and mortality. (pp. 495-496)

HIV Assessment News

Psychiatric Assessment

In a cohort consisting of 335 injecting drug users (IDUs) living with HIV in France, Marimoutou et al. (2003) found that 32 (14.3%) of 223 hospitalizations occurring over a 24-month period involved a "depressive syndrome." The authors observe that, "[i]n the [highly active antiretroviral therapy (HAART)] era, [depressive syndromes] represent an important cause of hospitalization of HIV-infected [IDUs], mainly concerning patients presenting no stable relationship and signs of social instability" (p. 729). They go on to link hospitalization to delays in accessing psychiatric care and urge clinicians to address undetected and untreated depression in the HIV primary care setting. "Scheduled psychiatric consultations should be more systematically offered to socially vulnerable patients in order to identify major depression before [the] occurrence of hospitalization or suicide attempts" (p. 733).

Douglas and Perrin (2003) compared psychiatric diagnoses charted by medical providers with scores on the Symptom Checklist-90-Revised (SCL-90-R); correct diagnoses, over-diagnoses, and missed diagnoses were identified through use of the Medical Outcomes Study (MOS) 36-Item Short Form (SF-36), which assessed mental functioning. In this study, providers over-diagnosed psychiatric disorders in 23% of cases and missed a psychiatric diagnosis in 9% of cases. The authors note that "[t]he SCL-90R had a higher correlation with mental functioning than did the providers' diagnoses, suggesting that such instruments may increase the correct detection of mental illness in the HIV population" (p. 523).

(Biopsychosocial Update is continued on Page 6)

Tool Box

Opening the Minds of Men Who Have Unsafe Sex with Men

The Centers for Disease Control and Prevention (CDC, 2003) recently reported that, between 1999 and 2002, new HIV cases in the U.S. increased by 5.1% in the 29 states conducting name-based HIV/AIDS surveillance. While the report revealed that African Americans continue to be disproportionately represented among new HIV cases (at 55%) and observed a remarkable 26% increase in new HIV cases among Hispanics over that four-year period, it was also noted that new HIV cases increased by 17% among men who have sex with men (MSM) during the same period.

Psychological Underpinnings of Sexual Risk

Australian investigators (Kippax et al., 2003) interviewed 92 gay men regarding their attributions around becoming HIV infected and found that "[w]ithin regular relationships, breakdown of negotiated safety, love and intimacy, and fatalism were among the explanations given. Seroconversion attributed to casual sexual encounters was more likely to be explained in terms of pleasure, lack of control, and with reference to particular sexual settings" (p. 839). "In almost all the narratives there was some reference to the notion of control – in relation to both self and partners. Control is attenuated in some cases by a sense of being overwhelmed by love, fate, lust, or drugs/alcohol" (p. 845). "[W]hile some of the men identify 'being out of control', in all but a few cases, ... [c]ontrol ... is something rescinded or relinquished rather than something lost. This 'giving up of control' may contain [some suggestion of] sexual sensation seeking, but these data suggest that physical pleasure becomes entwined with desire in complex and multiple ways that resist singular attribution of singular causes" (p. 849).

These authors go on to observe that, "Risks are taken in particular contexts and measured relative to other factors such as pleasure, intimacy or dislike of condoms. Many men regard risks as an unavoidable consequence of life and, rather than attempt to avoid risk completely, some employ personal and collective knowledge about HIV to reduce the level of risk, while others leave the outcome to chance or fate. While a few men may, after the fact of seroconversion, regard their actions as stupid, many regard their actions as informed and rational" (p. 850).

Kippax and colleagues conclude that, "Health promotion that takes account of the ways in

which men understand risk are more likely to be successful in sustaining safe sexual practice than health promotion developed with little reference to men's lived experience" (p. 850).

Assuming Responsibility

Utilizing a targeted sampling approach, Wolitski, Bailey, O'Leary, Gómez, and Parsons (2003) interviewed 250 MSM living with HIV in the New York and San Francisco metropolitan areas (70% of whom were men of color) regarding their sense of responsibility to protect sex partners from infection with HIV. Within this sample, self-perceived responsibility did indeed appear to be associated with sexual decision-making. Of the 72% who discussed responsibility, 63% verbalized a personal responsibility to protect others, 24% indicated that it was the partner's responsibility to protect himself, and 12% advocated mutual responsibility. Personal responsibility was motivated by such factors as altruism, personal standards, and self-interest, but could vary based on characteristics of the partner (e.g., known seronegativity or presumed seropositivity; age; perceived frequency of sexual activity; not identifying as gay; intoxication), respondent characteristics (e.g., personal moral, ethical, or religious values; fear of rejection; strong sexual arousal; substance use; perceived riskiness of sexual practices), contextual factors (e.g., venue), and HIV status disclosure, which

sometimes led to a shift in responsibility from the participant to his partner. In part, this shift in responsibility reflects a belief that unimpaired adults should have the freedom, and an obligation, to make informed decisions about the level of risk that they are comfortable taking. ... [And so, a]lthough HIV-seropositive persons may have ethical and legal obligations to disclose their HIV status to potential sex partners, it cannot be assumed that disclosure will decrease the risk of HIV transmission. Prevention programs should stress the need to protect the health of all sex partners who may be HIV-seronegative (including those whose HIV status is not known) regardless of whether the person who is HIV-seropositive has disclosed his status. (p. 370)

In another paper by this same research group involving an ethnically diverse convenience sample of 367 MSM living with HIV in the New York and San Francisco metropolitan areas who reported sex with a nonprimary partner in the three months preceding the study, Parsons, Halkitis, Wolitski, Gómez, and the Seropositive Urban Men's Study Team (2003) found that the 58.9% who reported no unprotected anal sex also reported less temptation for unsafe sex,

less nitrate inhalant (popper) use, and fewer partners who were HIV-negative or of unknown status. The 22.6% who reported unprotected insertive anal sex (UAI) perceived less responsibility to protect partners from infection, while the 14.2% who reported only unprotected receptive anal sex (UAR) presented with less anxiety than the other two groups. Those reporting UAR did, however, reveal greater depression than those reporting no unprotected anal sex and greater loneliness than those reporting UAI. The authors write:

Clearly, perceived responsibility to protect partners from HIV infection has an impact on the sexual risk behaviors of HIV-positive MSM. In our sample, men who reported UAI scored lower on this measure than those reporting only UAR as well as those reporting no unprotected anal sex. Men reporting UAR also reported lower levels of anxiety compared with both other groups. It is likely that men engaged in UAI feel some level of anxiety due to their participation in a behavior that could result in transmission of HIV, and perhaps adopting a harm reduction practice of engaging in UAR rather than UAI reduces anxiety. It is also possible that adopting responsibility for preventing HIV transmission is a protective factor against experiencing such anxiety. What is unclear, however, is why HIV-positive MSM who reported no unprotected anal sex would have higher levels of anxiety than those reporting UAR. (p. 396)

Antidotal Risk Taking

One possible explanation may be derived from a recent study by Bancroft et al. (2003), which assessed 589 gay men to examine the relationship between sexual risk taking and three aspects of personality: sexual arousability (as well as propensities toward its inhibition in the context of risk or threat), negative mood, and sensation seeking. The authors identified two patterns of association: unprotected anal sex and unprotected oral sex were associated with low sexual response inhibition and low trait anxiety, while frequent cruising and a high number of casual sex partners were associated with *increased* interest in sex when feeling depressed and a greater propensity toward experiencing sexual excitement. Higher risk over the long-term was associated with low sexual response inhibition and with tendencies toward erectile dysfunction (i.e., condoms may be avoided since their use may enhance erectile difficulties). Disinhibition was also associated with all types of sexual risk investigated by Bancroft and colleagues.

Why study relatively immutable personality characteristics as factors relevant to sexual risk reduction? In part, the authors have this to say:

[P]ersonality characteristics may play a crucial role in designing appropriate one-on-one interventions. Thus, for example, interventions with individuals who have a tendency to take sexual risks when depressed, or who use sex as a form of mood regulator, could initially employ a behavioral analysis of the relation between mood and sexual behavior (e.g., using daily diaries) to confront the individual with this pattern and focus motivation for change, followed by a cognitive-behavioral approach to develop and maintain alternative methods of mood regulation. ... [T]his approach is particularly relevant to those gay men who cruise for casual sexual partners. As the negative mood in such men is driving them to go out and look for partners, interventions should focus on redirecting that sequence early, before the contact with a partner is made. The individual who appears to take more risk during the sexual interaction, because of the persistence of sexual arousal in the face of risk, needs to take this aspect of his personality into account when anticipating or planning sexual encounters, and take steps to build safe procedures, such as condom availability, into the sequence. ... The individual who is reluctant to use condoms because of concerns about his erectile function should be guided to use other methods of maintaining erectile function, such as Viagra, rather than avoid condom use. (p. 569)

Resonating Risk-Reduction Messages

Morin et al. (2003) conducted 12 focus groups in five California cities involving a multiethnic sample of 113 MSM to learn more about factors leading to greater risk taking and to assess risk-reduction messages. This sample of convenience associated three factors with increases in HIV risk taking: 1) more effective therapies leading to the perception that HIV is not the threat it was in the past; 2) MSM communicating less about HIV, coupled with a reduction in social support for safer sex; and 3) unsafe sex becoming more acceptable, representing a shift in community norms.

With regard to risk-reduction messages, those thought to have the least potential for success were those delineating medical conditions associated with HIV disease as well as those that reinforce existing messages that advise men to use condoms. Most highly ranked were mes-

sages that urge MSM to seek the social support of friends (e.g., "Friends can be good medicine"). "A close network of friends and family can serve as a buffer to illness and is often used as a prevention intervention in promoting mental health ... as well as physical health. ... [This prevention] message addresses the "why" rather than the "how" to practice safer sex" (p. 360).

This focus on "why" is echoed by Patterson, Shaw, and Semple (2003), who randomly assigned 387 people living with HIV – mostly gay men – who reported engaging in unprotected intercourse with partners who were HIV-negative or of unknown serostatus to one of four brief counseling interventions.¹ They note that, across conditions, study participants were provided with two messages: "practice safer sex and protect others," and "unsafe sex may lead to infection with other [sexually transmitted diseases (STDs)], which may further harm your health"; both messages appeared to be effective in reducing sexual risk behavior in people living with HIV.

Additional Clinical Considerations

Parsons and colleagues offer the following advice to clinicians:

Interventions targeting HIV-positive MSM should address clearly the [efforts] some men appear to be making ... to reduce the risk of HIV transmission through engaging in UAR rather than UAI with partners. The relative risk of UAI versus UAR should be openly discussed such that HIV-positive MSM clearly understand that UAR can and does pose risk for HIV transmission. Furthermore, men should be cautioned against making assumptions about the serostatus of their partners, particularly with anonymous partners or when HIV status has not been explicitly discussed. Content of intervention programs might benefit from highlighting issues such as perceived responsibility to protect partners from HIV; providing skills-building activities focused on reducing temptation for unsafe sex; and making efforts to reduce loneliness, depression, and other negative mental states. (p. 397)

Semple, Patterson, and Grant (2003), who studied sexual risk behavior in 322 MSM living with HIV who reported unprotected anal intercourse with a partner who was HIV-negative or of unknown status during the preceding four-month period,² offer the following recommendations to clinicians addressing sexual risk behavior in HIV-positive MSM:

¹ See the Summer 2003 issue of *mental health AIDS* for details.
² See the Spring 2003 issue of *mental health AIDS* for details.

- 1) engage in problem-solving exercises that emphasize the benefits of safer anal sex and downgrade the reinforcing properties of unprotected intercourse;
- 2) eroticize the (non-simultaneous) use of "male" and "female" condoms when engaging in anal intercourse;
- 3) motivate men to maximize the effectiveness of highly active antiretroviral therapy (HAART) by avoiding potential reinfection with drug-resistant strains of HIV or other STDs;
- 4) explore and highlight the link between substance use and unsafe sex;
- 5) promote increased intimacy (i.e., more touching and hugging) in steady partnerships, "disentangle emotional issues from sexual needs and desires, increase relationship-specific communication skills and focus on the reinforcement value associated with protecting one's partner and feeling good about one's self" (p. 12);
- 6) enhance positive outcome expectancies regarding safer sex negotiation and condom use "through observations, role modeling, skill performance, positive feedback and reinforcement techniques" (p. 12); and
- 7) alert men to the small, but possible risk to self and others associated with unprotected oral sex.

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--Compiled by Abraham Feingold, Psy.D.

HIV Treatment News

Medical Care

On October 20, 2003, the U.S. Food and Drug Administration (FDA) approved fosamprenavir (Lexiva™), a new protease inhibitor (PI) for use in combination with other antiretrovirals to treat adults living with HIV. Chemically, fosamprenavir is similar to amprenavir (Agenerase®). It may be taken with or without food and may be given with or without ritonavir [RTV or Norvir®] as a booster. The most common side effects include diarrhea, nausea, vomiting, headache, and rash, although these are generally mild to moderate in severity (GlaxoSmithKline, 2003).

As reported in the Fall 2002 issue of *mental health AIDS*, increasing awareness of the activity and toxicity of current antiretrovirals prompted the International AIDS Society-USA Panel (Yeni et al., 2002) to recommend that treatment be delayed until CD4 cell counts fall to between 200 and 350 cells/mm³. And yet, within that range, the question of optimal timing to initiate HAART remains open. Recent findings addressing this issue come from Wood et al. (2003), who followed a cohort of 1,422 British Columbians receiving HAART through March 2002 and report that "[d]elaying HAART until the CD4⁺ cell count falls to [200 cells/mm³] does not increase the mortality rate in HIV-infected patients with good medication adherence. Mortality rates increase if HAART is initiated below [200 cells/mm³]. Also, nonadherent patients have higher mortality rates than adherent patients with similar CD4⁺ cell counts. Above a CD4⁺ cell count of [200 cells/mm³], medication adherence is the critical determinant of survival, not the CD4⁺ cell count at which HAART is begun" (p. 810).

A related question: What is the optimal HAART regimen with which to initiate treatment? One response comes from two multicenter, randomized clinical trials, the first comparing three-drug HAART regimens with one another (Robbins et al., 2003) and the second comparing three-drug regimens with four-drug regimens (Shafer et al., 2003) over a minimum of 48 months in 620 and 980 antiretroviral-naïve individuals respec-

tively. This international study team found that the combination of zidovudine (ZDV, AZT or Retrovir®), lamivudine (3TC or Epivir®), and efavirenz (EFV or Sustiva®) was superior both to selected three-drug regimens and no better than selected four-drug regimens studied. An added advantage to this three-drug combination is that it preserves the class of PIs for later use. It should also be noted that these authors warn against including both didanosine (ddl or Videx®) and stavudine (d4T or Zerit®) in an initial HAART regimen with antiretroviral-naïve individuals, as this combination of drugs was found to be less potent and to engender more side effects than other combinations studied.

Additionally, based on findings from a recent clinical trial demonstrating a high rate of early virologic non-response and the emergence of nucleoside reverse transcriptase inhibitor (NRTI)-associated resistance mutations among therapy-naïve adults receiving a once-daily triple-NRTI regimen with ddl enteric-coated beadlets (Videx EC®), 3TC, and tenofovir (TDF or Viread®), health care providers have been told that "[TDF] in combination with [ddl] and [3TC] is not recommended when considering a new treatment regimen for therapy-naïve or experienced patients with HIV infection. Patients currently on this regimen should be considered for treatment modification" (FDA, 2003). This study, among others, "demonstrate[s] a lower response rate in patients on a triple NRTI regimen. Furthermore, [these studies] indicate that patients who achieve viral suppression on a triple NRTI regimen have a higher rate of virologic failure" (FDA, 2003).

Psychiatric/Psychological/ Psychosocial/Spiritual Care Neuropsychological Impairment

Marcotte et al. (2003) followed 74 individuals whose dates of seroconversion could be estimated and who presented with normal cognition at baseline (about one year following seroconversion) until such time as neuropsychological (NP) impairment became evident in an effort to find early markers that might be used to identify those at increased risk for HIV-associated cognitive impairment. They found that "early evidence

of poor virological control and immunocompromise predicted earlier incidence of neurocognitive impairment. Subjects with plasma levels of HIV RNA of greater than 4.5 log₁₀ copies/mL and CD4 counts less than 400 cells/μL in the year after seroconversion were 6 times more likely to become cognitively impaired. Inclusion of additional demographic and treatment variables did not significantly alter the finding. In most ... subjects (7/9 [78%]), cognitive impairment occurred before the development of an AIDS-defining condition" (p. 1409). "Clinicians should be vigilant to possible neurocognitive complications in individuals with early immunological and virological changes. ... [P]atients with high HIV RNA levels and low CD4 counts early after infection should be aggressively treated to prevent immunological decline and cognitive deterioration" (p. 1411).

Dolan et al. (2003) formally assessed neurocognitive functioning in 57 women and 24 men living with HIV and involved in longitudinal treatment studies of AIDS wasting. Among the women, performance in the areas of verbal learning, visuospatial abilities, and motor coordination fell significantly below normal limits while, among the men, performance was below average in the areas of verbal learning and visual construction. "Reduced cognitive function and decreased verbal memory, particularly in women, may impair health care, leading to difficulties in following complicated medical regimens, assessing rational choices in health care, or understanding the implications of deleterious behavior. Clinicians caring for HIV-infected men and women with weight loss should anticipate that a large number of such patients may have trouble with learning and memory and that this may affect health care utilization" (p. 163).

Finally, Pukay-Martin, Cristiani, Saveanu, and Bornstein (2003) studied stressful life events and cognitive functioning in 333 individuals (251 HIV-positive, 82 HIV-negative) and found, after controlling for age, education, depression, and anxiety, that "negative" stressful life events were associated with deficits in specific aspects of NP performance (i.e., executive function, attention, and information processing speed) and

"positive" stressful life events were associated with better performance in these same cognitive areas, *but only among the HIV-positive study participants*. "The ... data ... suggest that although stress is not associated with cognitive dysfunction in immunocompetent individuals, the potential adverse effects of stress on the brain [are] expressed in the setting of a compromised immune system" (p. 440). The authors suggest that stress management interventions may have the potential to alleviate cognitive dysfunction in people living with HIV.

Adherence to Treatment

Reback, Larkins, and Shoptaw (2003) interviewed 23 gay and bisexual men living with HIV who were participating in an outpatient drug treatment research project on methamphetamine (meth) abuse, all of whom acknowledged that meth use interfered with their adherence to antiretrovirals. *Unplanned* nonadherence was associated with meth-related disruptions in eating and sleeping, while *planned* nonadherence was identified as a strategy to address the recognition that a rigorous treatment schedule would not be maintained while using meth or else was related to participating in sexual activities (as often accompanies meth use) or to concerns about mixing meth and HIV medications. It is important to note that,

[e]ven though the [men] did not take their medications according to prescribed directions, they did not interpret skipping, stretching, or modifying their medication doses as non-adherence. These medication adjustments were viewed as a positive coping strategy that served to create a sense of control over their lives. ... [T]hese men ... believed that if they caught up with missed doses by increasing their dosage for perhaps 2 or 3 days following a drug- and sex-related interruption, they would still qualify as medication adherent. [Clinicians] should be aware of this distortion when substance-using patients discuss their medication taking. (p. 781)

Are there simple clues to possible problems with adherence? In a study of 997 individuals participating in the New York State Treatment Adherence Demonstration Program,

Weiss et al. (2003) found that responses to five true/false questions reflecting HIV-related knowledge were associated with self-reported antiretroviral adherence; those with fewer than four correct answers were more likely to report missing medication dosages. The authors suggest that "clinicians should include questions focused on knowledge of HIV and its treatment in their assessments of HAART readiness and need for adherence support. Similarly, providers should be diligent with respect to patient education, ensuring that each patient has the information needed to support reasoned decision making and adequate adherence" (p. 678).

In France, Goujard et al. (2003) randomly assigned 326 people living with HIV to one of two intervention conditions – a personalized educational program focused on identified adherence problems ($n = 168$) or standard care ($n = 158$) – and followed them over an 18-month period. They found that the educational program affected both knowledge and adherence at six months and that gains were maintained at 12 and 18 months postintervention. Interestingly, a delayed increase in adherence was also observed in the standard care group at 12 months. Further, neither intervention was found to affect quality of life, CD4 cell counts, or viral loads. With these improvements in adherence and global health status, however, the authors stress that "[e]ducational interventions must be carried out early in the course of treatment, before drug resistance arising from nonadherence develops and alters the ultimate therapeutic prognosis in an irreversible way" (p. 194).

In a study comparing an adherence-oriented educational intervention with routine counseling, Rawlings et al. (2003) conducted a 24-week open-label clinical trial involving 195 adults from populations typically underrepresented in research (e.g., women [35%], people of color [92%], IDUs [20%]) who were living with HIV and taking a twice-daily HAART regimen that consisted of AZT/3TC administered in the form of Combivir® (COM) plus abacavir (ABC or Ziagen®). Participants were randomized either to a four-module "Tools for Health and Empowerment" HIV education intervention (EI) plus routine counseling (RC) or to RC alone.

Overall, when tested in a rigorous way, the EI in this 24-week clinical trial did not affect the virologic response or [Medication Event Monitoring System (MEMS)]-determined adherence to COM + ABC to any greater degree than RC alone in underrepresented patients, perhaps because the prime focus of the intervention was limited to patient empowerment and improving knowledge about HIV and its treatment. To have more impact, EIs for use in underrepresented patients with HIV infection may need to address additional adherence-impairing factors, including inadequate social support, poor health literacy, and concurrent health problems specific to underrepresented patients, especially ethnic minorities. (p. 182)

Continuing the investigation of an association between HIV drug resistance and relatively high rates of adherence to HAART (discussed in the Fall 2003 issue of *mental health AIDS*), Sethi, Celentano, Gange, Moore, and Gallant (2003) followed 195 HAART recipients over a one-year period and found that "missing 11% - 30% of HAART doses after achieving viral suppression is associated with the greatest risk of viral rebound with clinically significant resistance. ... Recently missing a scheduled clinic visit also predicted subsequent viral rebound with resistance, indicating the need for clinic staff to assess the underlying reasons for missed appointments and to find ways to improve clinic attendance rates. [These] findings emphasize the need to set high adherence goals to achieve a durable response to HAART and to preserve options for future therapy" (p. 1118).

Care for Caregivers

Through interviews and surveys involving 64 HIV/AIDS caregivers and 46 recipients of care, Australian investigators (McCausland & Pakenham, 2003) found that poorer social and psychological adjustment among caregivers was positively associated with distress on the part of the care recipient, the caregiver's appraisal of threat and use of a passive avoidant coping style, and negatively associated with social support and reporting a greater number of caregiver benefits. Interestingly, caregiver

adjustment was unrelated to use of problem-focused coping, appraisals involving controllability and challenge, and severity of illness in the care recipient. Benefit finding by caregivers was positively associated with their more frequent use of social support, their seeking of social support as a coping strategy, and their use of problem-focused coping. As for clinical response, McCausland and Pakenham observe that "interventions could employ cognitive restructuring techniques to reduce threat appraisals and enhance benefit finding. Cognitive behavioural techniques could also be used to discourage reliance on passive avoidant emotion-focused coping strategies and maximize social support resources. Results suggest that interventions should address the association between caregiver adjustment and care recipient distress by intervening at the dyadic level" (p. 867).

Coping, Social Support, & Quality of Life
Chesney, Chambers, Taylor, Johnson, and Folkman (2003) randomized 149 gay and bisexual men living with HIV and reporting depressed mood to one of three conditions: a 10-week, theory-based coping effectiveness training (CET) intervention¹, an active informational control (HIV-Info) condition, or a waiting-list control (WLC) condition. The first two group interventions were provided over a three-month period (128 individuals completed this phase of the study), with six maintenance sessions offered over the following nine months. When comparing CET and HIV-Info participants after the initial three-month period, the former reported greater reductions in perceived stress and burnout than the latter, mediated by increases in coping self-efficacy. When comparing CET and WLC participants after the initial three-month period, the former reported greater reductions in anxiety than the latter, mediated by increases in positive states of mind. Increases in positive morale in the CET group were maintained at

¹The CET intervention ... is grounded in the cognitive theory of stress and coping, incorporates elements of stress management interventions and provides a framework for choosing among coping strategies to promote adaptive coping and reduce distress. The framework converts the major tenets of stress and coping theory into a series of practical ... steps, and emphasizes 'fitting' the coping strategy to the extent to which stressful situations can be changed" (p. 1040).

six and 12 months, while optimism increased in both the CET and HIV-Info groups throughout the study's maintenance phase. Although conducted prior to the introduction of HAART, and therefore in need of replication with individuals receiving today's standard treatments, Chesney and colleagues conclude that "CET can be an effective strategy for managing psychological distress and improving positive psychological states in patients confronting chronic illness" (p. 1038).

Continuing with the topic of positive psychological states, Farber, Mirsalimi, Williams, and McDaniel (2003) analyzed self-report data from 203 individuals living with symptomatic HIV disease and AIDS. "[F]indings showed that individuals who ascribed more positive meaning to their illness ... reported higher levels of psychological well-being and lower levels of depressed mood. In addition, meaning of illness contributed independently to predicting both psychological well-being and depressed mood even after the contributions of social support and problem-focused coping were taken into account" (p. 489).

The[se] results provide empirical support for the idea that therapeutic attention to HIV-related meaning in the context of a comprehensive biopsychosocial treatment approach may help increase psychological well-being and reduce distress. Psychotherapists can help their patients explore the personal significance and effects of HIV/AIDS and encourage construals of HIV-related realities that allow for pursuit of realistic options and choices within the acknowledged limits imposed by the disease. In this context, therapists may actively challenge HIV-related appraisals of their patients that are too rigidly or loosely held or applied too narrowly or broadly. It is also important to assess controllability of HIV-related stressors, since a clinical focus on meaning might be particularly relevant when the stressor is uncontrollable, whereas controllable stressors might suggest a therapeutic focus that facilitates problem-focused coping activities along with meaning-focused coping. In addition,

meaning-related themes regarding life purpose and commitment in the context of living with HIV disease can be explored in treatment. (p. 490)

On the subject of stress, Jones, Beach,

Tool Box
Resources
<p>Books & Articles: Corcoran, C.P. (2003). Neuropsychiatric changes in HIV/hepatitis C coinfecting patients undergoing interferon therapy. <i>Journal of the Association of Nurses in AIDS Care</i>, 14(5 Suppl.), 80S-86S. "This article discusses the mechanism and prevalence of interferon-induced depression and the debate regarding appropriateness of treatment in certain segments of the HIV population. The role of antidepressants as both treatment and a prophylaxis against interferon-related depression is reviewed" (p. 80S). Fragon, J.J., & Piliero, P.J. (2003). Drug interactions associated with HAART: Focus on treatments for addiction and recreational drugs. <i>AIDS Reader</i>, 13(9), 433-434, 437-441, 446-450. "HIV health care providers should be aware of the potential interaction of recreational drugs and addiction treatments with HAART because of the potential for significant adverse effects for their HIV-infected patients. This article provides a review of the literature on drug interactions among addiction therapies, recreational drugs, and HAART" (p. 433). Feist-Price, S., & Wright, L.B. (2003). African American women living with HIV/AIDS: Mental health issues. <i>Women & Therapy</i>, 26(1-2), 27-44. Feist-Price and Wright explore "issues related to African American women with HIV/AIDS. Careful consideration is given to the stages of adjustment and related mental health challenges that women might experience. Also explored are the reciprocal impact of children, other family members and significant others on the mental health status of African American women living with HIV/AIDS. Implications for clinical practice are also identified" (p. 27). Grusky, O., Marelich, W.D., Erger, J., Mann, T., Roberts, K.J., Steers, W.M., & Damesyn, M. (2003). Evaluation of a brief low-cost intervention to improve antiretroviral treatment decisions. <i>AIDS Care</i>, 15(5), 681-687. Grusky and colleagues piloted use of a \$2.00 laminated card to assist providers in "walking" clients through antiretroviral treatment decision-making in an organized fashion. "The</p>

Forehand, and Foster (2003) followed 72 low-income, African-American women living with HIV in the inner-city over a period of 15 months and found that family stressors contributed to a decline in self-reported health status, although this association was mediated by depressive symptoms. "[F]indings ... suggest that family stress is associated with increases in both somatic and cognitive/affective symptoms of depression. ... Th[is] ... suggests that practitioners ... target family stress, potentially reducing de-

pressive symptoms. ... [A]melioration of family stress and/or depressive symptoms has additional implications for the reduction of physical health complaints and, of importance, the reduction of physical symptoms has potentially important consequences for issues inhibiting collaboration, service delivery, and multisite evaluation as identified by members of the U.S. Centers for Disease Control and Prevention/Health Resources and Services Administration Corrections Demonstration Project (CDP)" (p. 535).

visual aid checklist consisted of a two-page coloured diagram and explanation of key concepts (T-cell, viral load and resistance) and a checklist of the benefits and risks of antiretroviral therapy" (p. 681).

Hoffman, R.G., Cohen, M.A., Alfonso, C.A., Weiss, J.J., Jones, S., Keller, M., Condemarin, J.R., Chiu, N.-M., & Jacobson, J.M. (2003). Treatment of interferon-induced psychosis in patients with comorbid hepatitis C and HIV. *Psychosomatics*, 44(5), 417-420.

The authors present the first case series of patients with comorbid HIV and hepatitis C who developed new-onset psychosis during treatment with interferon α and offer recommendations for psychiatric intervention.

Horowitz, S.M. (2003). Applying the transtheoretical model to pregnancy and STD prevention: A review of the literature. *American Journal of Health Promotion*, 17(5), 304-328.

Based on a systematic review of peer-reviewed studies published prior to December 31, 2001 (32 in all) on use of the transtheoretical ("stages-of-change") model (TTM) to reduce the risk of pregnancy and/or to prevent STDs, Horowitz finds "moderate to strong support for the validity of the individual constructs of the TTM and moderate support for the use of stage-matched interventions as they apply to pregnancy and STD prevention" (p. 327). However, "because of the wide-ranging differences in methodologies and samples, no strong conclusions about its effectiveness can yet be made" (p. 304).

Huprich, S.K., Fuller, K.M., & Schneider, R.B. (2003). Divergent ethical perspectives on the duty-to-warn principle with HIV patients. *Ethics & Behavior*, 13(3), 263-278.

"This article presents the case of an HIV-positive client who reported having sexual relations with an unknowing partner. ... The case is analyzed from an ethical framework; t]wo opinions are presented, each leading to different conclusions about whether the therapist should inform the unknowing partner" (p. 263).

Koenig, L.J., Doll, L.S., O'Leary, A., & Pequegnat, W. (Eds.). (2004). *Child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention*. Washington, DC: American Psychological Association Press.

"In this singular volume, leading researchers and clinicians ... identify the theory and research-

ated by depressive symptoms. "[F]indings ... suggest that family stress is associated with increases in both somatic and cognitive/affective symptoms of depression. ... Th[is] ... suggests that practitioners ... target family stress, potentially reducing de-

based cognitive, affective, social, and behavioral consequences of trauma that influence both sexual health and sexual risk behaviors in adulthood. The volume also highlights new approaches that begin to translate these findings into interventions for people who have experienced [childhood sexual abuse]."

Manfrin-Ledet, L., & Porche, D.J. (2003). The state of science: Violence and HIV infection in women. *Journal of the Association of Nurses in AIDS Care*, 14(6), 56-68.

"The purpose of this article is to review the state of science that exists in linking the phenomena of violence and HIV infection in women. ... The literature review consists of 44 research articles that examine risk factors for violence and HIV, violence associated with HIV/AIDS disclosure, history of violence and HIV/AIDS, forced or coercive sex and HIV/AIDS, and violence associated with HIV self-protection conduct. Implications for ... [clinical] practice ... are presented" (p. 56).

Odo, R. (2003). Hidden epidemic: HIV/AIDS among the seriously and persistently mentally ill. *Social Work in Mental Health*, 1(3), 19-34.

Odo "focuses on the interplay of mental illness, HIV infection, and service provision through a review of the literature and the presentation of a case study. ... The importance of comprehensive community-based services specifically designed to address the multifaceted needs of this population is highlighted" (p. 19).

Piotroski, S.S., & Chapin, M.G. (2003). Human immunodeficiency virus social work program at the Walter Reed Army Medical Center: A historical perspective. *Military Medicine*, 168(9), 698-701.

Piotroski and Chapin recount "the development of a comprehensive medical/psychosocial assessment and treatment program for HIV-infected service members and their families at the Walter Reed Army Medical Center" (p. 698), with particular attention to the integral role played by social work services in this endeavor.

Robillard, A.G., Gallito-Zaparanik, P., Arriola, K.J., Kennedy, S., Hammett, T., & Braithwaite, R.L. (2003). Partners and processes in HIV services for inmates and ex-offenders. Facilitating collaboration and service delivery. *Evaluation Review*, 27(5), 535-562.

"The purpose of this study is to document is-

pressive symptoms. ... [A]melioration of family stress and/or depressive symptoms has additional implications for the reduction of physical health complaints and, of importance, the reduction of physical symptoms has potentially important consequences for issues inhibiting collaboration, service delivery, and multisite evaluation as identified by members of the U.S. Centers for Disease Control and Prevention/Health Resources and Services Administration Corrections Demonstration Project (CDP)" (p. 535).

Roldán, I. (2003). The experience of the Puerto Rican family when a member has HIV/AIDS. *Families in Society*, 84(3), 377-384.

Roldán summarizes findings from a qualitative study of meanings the Puerto Rican culture assigns to AIDS, with particular emphasis on protecting self and family from *bochinche* (malicious gossip).

Smith, K.Y., Brutus, A., Cathcart, R., Gathe, J. Jr., Johnson, W., Jordan, W., Kwakwa, H.A., Nkwanyu, J., Page, C., Scott, R., Vaughn, A.C., Virgil, L.A., & Williamson, D. (2003). Optimizing care for African-American HIV-positive patients. *AIDS Patient Care & STDs*, 17(10), 527-538.

"This paper describes HIV infection patterns among African-Americans, identifies special considerations for treating HIV patients from the African-American community, recognizes new approaches to initiating and maintaining therapy, and explains the issues and management approaches to African-Americans with HIV/hepatitis C coinfection" (p. 528).

Williams, P.B. (2003). HIV/AIDS case profile of African Americans: Guidelines for ethnic-specific health promotion, education, and risk reduction activities for African Americans. *Family & Community Health*, 26(4), 289-306.

Williams "recommends and discusses culturally sensitive and ethnic-specific intervention strategies for the prevention and control of HIV/AIDS among African Americans" (p. 289).

Internet Resources:

The newly reconfigured *AIDSinfo* Drug Database (<http://www.aidsinfo.nih.gov/drugs/drugsearch.asp>) consists of regularly updated fact sheets on both FDA-approved and investigational HIV/AIDS drugs, as well as drugs used to treat common opportunistic infections. The "Technical" versions are designed for health care professionals, while the "Non-technical" versions, also available in Spanish, are written for a general audience.

--Compiled by Abraham Feingold, Psy.D.

the health care of HIV-infected women, including health care utilization, as well as improved quality of life for the infected woman and her family" (p. 593).

On the flip side, what about the absence of family or close friends? Schrimshaw and Siegel (2003) interviewed 63 individuals aged 50 and over who were living with HIV and found that 42% reported that they did not receive adequate emotional support from friends and family, while 27% were in need of more practical assistance. Interviewees identified the following barriers to obtaining support: HIV status nondisclosure, HIV fears among friends and family, their own wish to be independent and self-reliant, not wanting to burden friends and family, family being unavailable, having lost friends to AIDS, and ageism. The authors suggest that

[s]ome of the[se] barriers ... might be addressed in psychosocial interventions, support groups or individual therapy. For example, working through fears and realistically appraising the risks and benefits of disclosure to different individuals can open new avenues of support. Similarly, interventions could address older adults' need to remain self-reliant and avoid imposing on others by helping [them] realize that others may be happy to have the opportunity to offer assistance and may not feel burdened by the chance to do so. Identifying opportunities for some form of reciprocity may also ease the psychological conflict many older adults feel in asking for help. ... [In addition], interventions designed to create new and larger social networks – e.g. through involvement with volunteer 'buddies' or in support groups – might be very helpful in eliminating ... social isolation In the absence of reducing these barriers, professional[s] ... may need to actively reach out to older adults, offering them support and assistance ... (p. 750)

Mizuno, Purcell, Dawson-Rose, Parsons, and the SUDIS Team (2003) collected data from an ethnically diverse sample of 137 community-recruited IDUs living with HIV in

New York and San Francisco and found that perceived social support and having a consistent venue for HIV medical care were associated with reduced levels of depressive symptoms, while having a history of mental health difficulties and using multiple non-injection drugs were associated with increased levels of depressive symptoms.

From the Block

ACE

The Alliance for Community Empowerment (ACE), founded in 1989 as a faith-based community service organization, has evolved into a multi-site, multi-service HIV/AIDS-related organization addressing those of greatest need on Chicago's South Side.

ACE characterizes itself as "non-traditional," in that many of its services are delivered at clients' homes, in libraries, coffee shops, churches, and two community-based hospital clinics. ACE currently offers case management; intake assessment; primary medical care; psychological counseling for adults, couples, and families; as well as residential care for adolescents who have "aged out" of foster care. With CMHS/SAMHSA funding, ACE has expanded its mental health services through the addition of ongoing mental health treatment, on-site psychiatric evaluation, psychopharmacologic treatment, and long-term follow-up and monitoring. Services are closely integrated with primary medical care, substance abuse treatment, health education, and community outreach.

The Principal Investigator is John Overton, MSW; the Project Director is Mike Gibson, MSW; the Clinical Director is Esmarie Elliott, MS, LCSW. For more information, please call 312/326-3525.

– *Compiled by the MHSC Program
Coordinating Center*

Furthermore, perceived social support and non-injection polydrug use were found to interact, such that perceived social support lessened the association between non-injection polydrug use and depressive symptoms. In addition to the multiple benefits derived from linking HIV-positive IDUs to HIV primary care services, Mizuno and colleagues also suggest that enhancing social support may reduce depressive symptoms as well as the harmful effects of non-injection polydrug use.

Neff, Amodei, Valescu, and Pomeroy (2003)

interviewed 32, predominantly Mexican-American, Latinas living with HIV and receiving medical care in South Texas and found that "mastery and self-esteem were inversely related to both depression and anxiety" (p. 66), suggesting that "individual resources (or in this case, positive beliefs regarding self-worth and ability to control one's fate), appear more salient than specific coping strategies with regard to adjustment to HIV status among Latina women in [this] sample" (p. 67). They encourage clinicians working with this population to "focus their efforts on developing interventions that bolster self-esteem and self-mastery and that secondarily address the acquisition of coping mechanisms such as problem-solving. Moreover, ... aggressive outreach and education about treatment may be a requisite first step – particularly educational interventions emphasizing mastery, self-efficacy and empowerment" (p. 67).

Reece (2003) also addresses the question of engaging clients in care following their initial mental health assessment. He prospectively collected data on 132 individuals living with HIV who presented for services at an inner-city HIV mental health clinic and found that those not returning for care reported higher levels of perceived barriers to receiving mental health care, higher levels of HIV-related stigma, were more likely to be people of color, and had lower CD4 cell counts. Reece elaborates on the topic of perceived barriers impeding client engagement:

[P]roviders are generally aware of the need to assess barriers and to strategize with programme participants to reduce barriers ... to increase access to, and continuation in, services. However, in the context of HIV and with services that may be unfamiliar or daunting to clients, providers may need to examine the extent to which they include measures of both tangible (i.e. lack of transportation, job-related barriers, lack of child care) and intangible (i.e. embarrassment and anxiety about psychotherapy) barriers into ... initial assessments The initial assessment process may need to be expanded to include brief therapeutic interactions that

address these barriers ... to increase the likelihood that the participant will return for subsequent care. (p. 713)

Expanding on this point, Reece urges clinicians to assess and address stigma associated with HIV, enrollment in HIV-related services, and enrollment in mental health services. Moreover, he encourages clinicians to learn the language of HIV medical care to allow for an informed discussion regarding clients' psychological distress related to their physical health status and to strengthen the continuum between HIV-related medical and mental health care. Finally, he suggests that clinicians pay particular attention to factors that may influence perceptions regarding the need for and potential benefits of psychotherapy. "It may... be important ... to consider, and perhaps address, the client's perceptions of the ability of the therapist to understand issues that the client perceives as highly associated with their social and cultural background" (p. 714).

Analyzing transcripts from nine focus groups involving 52 individuals living with HIV in Detroit who varied in terms of gender, ethnicity, sexual orientation, and class, Sankar and Luborsky (2003) likewise contend that "understanding the experience of chronic illness requires that we expand our analytic frame to include variables and perspectives created by the beliefs, behaviors, context, and culture of the participants" (p. 153). They further "show that expressions of needs related to the lived experience of HIV vary among racial and ethnic groups and between genders, resulting in an experientially distinct set of needs" (p. 153). As an example, "[f]or men, African American [men who have sex with men (MSM)] in particular, making sense of why they contracted the disease was an essential aspect of coping with the disease. For women, adequate and appropriate health care was far more significant than for men. For white MSM ..., the domain of nonhealth-related needs was dominated by the need to maintain their middle-class identity by paying bills. For Hispanics, the domain of nonhealth-related needs was also important, but for them it referred to securing adequate housing" (p. 163).

Across all groups, however, a core commonality to living with HIV is "the overwhelming need to cope with the experience of stigma" (p. 163). "Indeed, failure to appreciate the existential aspect of HIV-related need leads to considerable dissatisfaction with the service delivery system ... From the perspective of people with HIV, the system [fails] to address their main need: to control and reduce the threats to their humanity. Individuals' attention to monitoring and managing threats to their adult personhood comprise a large area of engagement in living with disability and disease Service delivery agencies and the policies that guide them must acknowledge the need of people with HIV to have their humanity recognized and sustained in the face of stigma" (p. 164).

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Tool Box

A Note About Content

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

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of information are identified when appropriate.

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

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