mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Adolescents

In a small-scale, observational study involving 30 adolescents in outpatient psychiatric care and their primary parental caregivers, Wilson and Donenberg (2004) found that adolescents with parents who participated in *less* mutual discussion with them regarding sex and HIV, disagreed with them during these discussions, and, possibly (i.e., a marginally significant finding), were more directive about sexual behavior, engaged in less sexual risk-taking.

> These findings ... are consistent with evidence that increased parental control may protect troubled urban youth from engaging in risky sexual behavior ... . Although positive, open communication among normally developing adolescents may be protective against sexual risk-taking, mutual non-directive discussion with troubled adolescents, whose family relations are strained, may be less effective and even serve to promote risky behavior ... . Without adequate parental guidance and limit-setting, these youth may be less equipped to negotiate sexual decisions and relationships. Greater mutuality in these families, moreover, may represent lack of appropriate boundaries between parent and child ... rather than a healthy level of openness. ... Based on these preliminary results, adolescents may benefit from interventions that strengthen parenting behavior and clarify boundaries between youth and parents. Indeed, family-based interventions for youth in psychiatric care that emphasize parental directiveness, limit-setting, and assertiveness during discussions of sexuality and HIV/AIDS may prove beneficial in strengthening parents' role in promoting responsible sexual behavior among these high-risk teenagers. (p. 393)

About Women

Drawing data from a convenience sample of 139 African-American and Latina women ages 50 and over engaged in outpatient medical care, Sormanti, Wu, and El-Bassel (2004) found that many were involved in some types of heterosexual HIV risk behavior and that these behaviors were associated with a history of intimate partner violence (IPV). "In particular, these data indicate that having multiple partners within the past year and/or having a primary partner who engaged in HIV-risk behavior and/or was HIV-positive were the salient HIV-risk indicators associated with IPV among this sample of older women" (pp. 56-57). The authors encourage clinicians to: 1) screen older women for IPV and HIV risk; 2) help older women feel comfortable disclosing IPV and HIV risk; and 3) "normalize sexuality and empower older women to take positive steps to protect themselves from both HIV and IPV ..." (pp. 57-58).

Harvey, Henderson, and Branch (2004) conducted a telephone survey with a random sample of 371 predominantly white and well-educated female health maintenance organization members in the Pacific Northwest and found that women who used male condoms in combination with a second contraceptive method (i.e., a hormonal method, intrauterine device, or surgical sterilization; "dual use," the optimal protection against *both* pregnancy and disease) were younger, involved with two or more sexual partners during the preceding year, and were highly motivated to avoid HIV and other sexually transmitted diseases (STDs). In addition, "[w]omen who were confident about using condoms without feeling embarrassed or breaking the sexual mood were more likely to use dual methods rather than a single ... method [other than condoms, while] women with confidence in their ability to use condoms correctly are more likely to rely solely on condoms" (p. 28). Noting these variations, Harvey and colleagues suggest that "different prevention strategies may be more appropriate for certain groups of women. For example, for women who are highly motivated to protect against both HIV/STDs and pregnancy but are not confident in their ability to correctly use condoms, interventions promoting a two-method approach may be most appropriate. However, for women who are highly motivated to protect against pregnancy and are confident in their ability to correctly use condoms, a single method approach – consistent condom use – could be emphasized" (p. 40).

About Women & Men

Based on questionnaires completed by 48 individuals living with HIV, Ciesla, Roberts, and Hewitt (2004) report that adults with "insecure" attachment styles (i.e., having negative attachment representations of self; fear-

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ful attachment) were more likely to have multiple sexual partners, including serodiscordant partners. Moreover, these relationships remained significant even after statistically controlling for sexual orientation, depressive symptoms, and self-esteem. "These results suggest that sexual behavior is related to individuals' concepts of self in the context of romantic relationships rather than their global concepts of self devoid of interpersonal context. Specifically, [a] negative [or externalized sense of self-worth] involve[s] feelings of discomfort with the self in intimate relationships, anxiety regarding abandonment, and dependence on others' acceptance and affirmation, rather than global poor self-regard" (p. 119). The authors reason that "interventions for reducing risky behaviors in an HIV+ population should address explicitly the interpersonal context in which high-risk behaviors occur, including issues such as disclosure, assertiveness, and fear of rejection or abandonment" (p. 120).

About Men Who Have Sex with Men

Semple, Patterson, and Grant (2004) compared 156 HIV-positive men who have sex with men (MSM) who engaged in anonymous sex with 161 who reported that they did not. In this predominantly white, well-educated, non-injection drug using (IDU) sample of men, rates of serostatus disclosure with anonymous partners were low, while rates of unprotected oral and anal sex with these partners were high. Moreover, those with anonymous partners had five times as many partners who were HIV-negative or of unknown serostatus when compared to men who reported no anonymous sex. With regard to psychosocial factors distinguishing these two groups, "[m]en who had anonymous partners were more likely to be living alone, had higher scores on disinhibition, used more alcohol and illicit drugs, and scored lower on measures of self-efficacy and outcome expectancies in relation to condom use, negotiation of safer sex and disclosure of seropositivity to sexual partners as compared to men who did not have anonymous partners" (p. 82).

Turning to intervention, Semple and colleagues encourage clinicians to explore these factors as possible triggers for anonymous sex and to promote insight and motivation for change, since several factors might be addressed through motivational interviewing techniques.

> The first step ... is to ... increase ... awareness of the link between ... [psychosocial factors] and having anonymous sex. This process involves eliciting information on the client's current situation and motivations with respect to anonymous sexual encounters. For example, is living alone a surrogate for loneliness or boredom? In turn, is loneliness or boredom an impetus for seeking anonymous partners? Does drug use lead to sexual fantasies that are only satisfied through anonymous encounters? Once client awareness is achieved, time is spent eliciting self-motivated reasons for change. The therapist also helps the client to identify and remove significant barriers to behavior change efforts. Once the client has built sufficient motivation for change, the therapist shifts strategies to strengthen commitment to change. At this stage the therapist helps the client to set goals and develop a feasible plan of action ... .
>
> The modification of self-efficacy for disclosure ... may be ... approached through a skills-based counseling program that utilizes principles of social cognitive theory to enhance self-efficacy and positive outcome expectancies. Problem-solving and role play exercises are major techniques that can be used to ... explore potential problems ... in ... disclos[ing] to anonymous sex partners (e.g., fear of rejection). The therapist models a safer sex encounter by role playing how to broach ... one's HIV status. Role-playing the anonymous partner's expected reaction(s) to a disclosure helps to enhance the expectation of a favorable outcome. The counselor then suggests a role reversal so that the participant plays himself and the counselor plays the sexual partner. ... Alternative choices of behavior can be offered by the counselor, and include avoiding high risk settings (e.g., bathhouse, sex club) ... or making the commitment to always put a condom on oneself in the context of anonymous encounters. (pp. 83-84)

What is the effect of social discrimination on HIV risk behavior? Two studies involving Asian and Pacific Islander (API) gay men sought to address this question:

o Wilson and Yoshikawa (2004) analyzed 166 narrative episodes of social discrimination, along with information on HIV risk behavior drawn from extensive interviews with 23 API gay men. They found that API gay men were subjected to discrimination across a broad range of contexts – "within the family, the Asian, gay, and gay Asian communities, work and school contexts, and in public settings" (p. 78) – and that these

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experiences evoked different coping responses from the men. "Homophobia and anti-immigrant discrimination were linked to confrontation and social network-based responses whereas discrimination based in stereotypes of passivity/submission were linked with self-attribution" (p. 68). Importantly, Wilson and Yoshikawa observe that "confrontational and social network-based responses may be associated with less risk behavior. In this way, facing discrimination head-on, either through confronting an oppressor or talking with friends about the oppressive experience, may be a more adaptive coping technique in regards HIV prevention" (p. 79). Conversely, "[API] gay men who respond to discrimination in a manner that prevents them from thinking positively about themselves [(e.g., who denigrate themselves when experiencing discrimination related to stereotypes of passivity/submission)] may be at potential risk for HIV" (p. 80) and these men are better served by a coping style sanctioned by some Asian cultures of "forebearance ..., which is characterized by emotional regulation and/or avoidance [of potentially disagreeable experiences]" (p. 80). Wilson and Yoshikawa encourage clinicians to "increas[e] the response options [API gay men] have at hand when they experience discrimination in different social settings. Confrontational, social network-based, and avoidance responses were all associated with lower HIV risk, suggesting multiple protective processes that, depending on the nature and setting of discrimination, might protect against HIV infection" (p. 81).

o In a related study involving 192 API gay men, Yoshikawa, Wilson, Chae, and Cheng (2004) discovered high rates of depressive symptoms as well as high rates of HIV risk behavior. When the authors statistically controlled for age, ethnicity, income, and relationship status, experiences of racism were found to be associated with higher levels of depressive symptoms (and high risk for clinical depression), while experiences of anti-immigrant discrimination were found to be associated with higher rates of unprotected anal intercourse (UAI) with non-primary partners. On the other hand, "[c]onversations about discrimination ... with family were associated with lower levels of primary-partner UAI. The combination of low levels of discussion with family and discrimination with high levels of experienced discrimination [racism, anti-immigrant discrimination, *and* homophobia] was associated with higher rates of UAI" (p. 84). Yoshikawa and colleagues reason that "fostering discussion about discrimination ... with family and friendship networks ... may prove helpful in reducing HIV risk behavior" (p. 99) and urge clinicians to be particularly attuned to risk behavior in API gay men with low levels of family support.

From the Block

Positive Steps HIV Mental Health Program

The Positive Steps HIV Mental Health Program at the Southern California Alcohol and Drug Programs, Inc. (SCADP) is situated in Downey, California. The program is embedded in a larger system of temporary and transitional shelter services, vocational services, and domestic violence services, all within a frame of residential, day, and outpatient substance abuse treatment settings.

Positive Steps outpatient (substance abuse day treatment) and residential (transitional shelter) services were established in 1994 to offer HIV/AIDS and substance abuse services to African Americans and Latinos(as) living with HIV/AIDS in Service Planning Area (SPA) 7 of Los Angeles County, a region of two million residents. The strategy behind the development of Positive Steps was to "bring HIV services to the suburbs" where they had not previously existed. During the past 10 years, this program has grown from a six-bed, transitional housing program to encompass two residential programs (one for men, another for women) and HIV testing services.

A mental health component was added through CMHS/SAMHSA funding, creating "much-needed" mental health diagnostic and treatment services via on-site clinicians. As a result, Positive Steps is now able to serve more severely disordered clients than was possible when the focus was purely chemical dependency in the context of HIV disease.

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– Compiled by the MHHSC Program Coordinating Center

HIV Assessment News

Psychiatric Assessment

Analyzing data from a survey involving a nationally representative sample of 2,864 adults receiving HIV medical care in 1996, Tsao, Dobalian, Moreau, and Dobalian (2004) found that both anxiety and depression were generally stable over a six-month period and that this stability endured when the authors controlled for key demographic and clinical variables. Further, there was no dramatic increase in cases during the same time frame; in fact, overall prevalence declined, with the exception of participants with probable major depression, who manifested symptoms at baseline and at the six month follow-up. Notably, "[h]aving a high baseline HIV symptom count and a growing number of HIV symptoms significantly increased the likelihood of anxiety and depression persisting to follow-up and of developing new such cases. ... [F]indings indicate that living with HIV does not necessarily lead to increased psychiatric distress but that palliation of HIV symptoms is paramount to patients' mental health" (p. 111).

Baillargeon et al. (2003) reviewed medical records on 336,668 Texas Department of Criminal Justice inmates incarcerated over a three-year period and observed an association between diagnosed HIV infection and elevated rates of six major psychiatric disorders: major depression, dysthymia, bipolar disorder, schizophrenia, schizoaffective disorder, and non-schizophrenic psychotic disorder. This association persisted even when statistical adjustments were made for gender, race, and age. "It appears, based on these data, that addressing the HIV-infected inmates' mental health problems may be an important adjunct to traditional education in modifying HIV risk behaviors" (p. 611).

Erbelding, Hutton, Zenilman, Hunt, and Lyketsos (2004) conducted structured clinical interviews with 201 public STD clinic attendees and found that 45% met criteria for a current *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV) Axis I disorder (predominantly a substance use disorder) and 29% for an Axis II personality disorder (predominantly antisocial personality disorder [ASPD], iden-

tified in 29.4% of the men sampled). While substance use was not associated with the diagnosis of an STD, ASPD was so associated. Like Baillargeon and colleagues, these authors observe that "STD clinic patients have complex psychopathology that could increase HIV risk and compromise prevention interventions. Specialized counseling strategies, particularly targeting personality traits of ASPD, could improve prevention outcomes" (p. 8).

The importance of diagnostic assessment in relationship to medication adherence is highlighted in four recent studies:

o In a sample of 59 men and 16 women with self-identified antiretroviral adherence problems, Safren, Gershuny, and Hendriksen (2003) found that more than half met diagnostic criteria for posttraumatic stress disorder (PTSD) specifically within the context of living with HIV. Additionally, death anxiety in this sample was associated with the severity of PTSD symptoms over and above the influences of depression and social support satisfaction. "For clinicians providing mental health care to patients with HIV, assessing posttraumatic stress, and appropriately modifying one's conceptualization of the therapy, may improve outcomes of mental health, and consequently, medical treatment. Given the association between death anxiety, depression, and social support to PTSD symptoms, and the potential association between these psychosocial variables and self care (e.g., medication adherence, sexual risk taking, excessive substance use) these are all appropriate targets for psychosocial and or psychopharmacological interventions" (p. 663).

o Similarly, Delahanty, Bogart, and Figler (2004) studied self-reported symptoms of PTSD following diagnosis with HIV in a sample of 110 white and African-American HIV-positive persons. They found that, while these symptoms – resulting, in some cases, from a diagnosis that occurred *years* earlier – were associated with reduced adherence to highly active antiretroviral therapy (HAART) and consequent increases in viral load, these symptoms were also associated with *higher* CD4 cell counts, perhaps tied to lower levels of cortisol, an immunosuppressive neurohormone. With regard to adherence, "[i]ntrusive and avoidant thoughts concerning [an HIV] diagnosis were related to more frequently skipping medications and taking medications off-

Tool Box

Methamphetamine on the Brain (Part 1)

Since the late 1980s, crystal methamphetamine – a stimulant drug known as "crystal," "speed," "Tina," or "meth" in street parlance – has been used by gay and bisexual men to initiate, intensify and prolong sexual encounters, has been linked to high-risk sexual behavior and, in turn, has been associated with the transmission of HIV (Halkitis, Parsons, & Stirratt, 2001).

While not the root cause of the 17% increase in new HIV infections among men who have sex with men (MSM) between 1999 and 2002 in the 29 U.S. states conducting name-based HIV/AIDS surveillance (Wright, 2004)[1], "[g]ay and bisexual male [meth] users represent the core of the AIDS epidemic on the West Coast" (Reback, Larkins, & Shoptaw, 2004, pp. 95-96).

Of course, meth use is not confined to MSM, having been noted as well among both heterosexual teens and adults (Gibson, Leamon, & Flynn, 2002). This summary will, however, focus on the use of this substance among gay and bisexual men in the U.S., where the problem is most acute and growing. According to Halkitis, Parsons, and Stirratt (2001), "gay [meth] users have much higher seroprevalence rates than either heterosexual injection drug users or gay and bisexual men who do not inject drugs ..." (p. 26).

This is the first in a two-part series. Part 1 offers a medical and psychiatric overview of meth use and explores the physiological and psychological factors underlying sexual risk among users. Part 2 (to be presented in the Summer 2004 issue of *mental health* **AIDS**) will expand on sexual risk and its assessment, treatment approaches, and special concerns at the interface of meth and HIV.

Crystal "Light"

A great deal of scientific literature has emerged in response to this growing phenomenon. For the clinician engaged in mental health practice, however, the medical and psychiatric basics (as recapped by Urbina & Jones, 2004) are as follows:

o Crystal meth may be injected, smoked, snorted, or swallowed; it may also be delivered by syringe through the rectum when mixed with water. Effects of the drug are experienced at variable rates, based on the route of administration (i.e., about five minutes after snorting, 20 minutes after swallowing, and almost immediately when smoked or injected).

o The drug's half-life is approximately 12 hours and it can be detected in urine for as long as three to five days, varying again based on the route of administration.

o The amount of drug generally consumed by those who are substance dependent is between 0.7 and 1.0 gram/day.

o Meth use causes the release of dopamine and, to a lesser extent, norepinephrine. This results in an increase in heart rate and breathing, elevations in blood pressure and body temperature, and an excitation of the central nervous system (CNS) not unlike that experienced with cocaine.

o Toxic levels of meth can induce a variety of cardiovascular events (including the narrowing or inflammation of blood vessels) and a syndrome known as rhabdomyolysis, in which injured skeletal muscles leak intracellular contents into the plasma; acute kidney failure is the most serious complication of this syndrome.

o Long-term use of meth can lead to grinding of the teeth, gum disease, heart attacks and stroke, while smoking of meth has been associated with the acute narrowing of the pulmonary artery and enlargement of the heart muscle.

o Acute lead poisoning has been reported as a result of "cutting" the drug with contaminating substances.

o While intoxicated, users report "alertness, euphoria, and an increased sense of well-being. Psychiatric effects include personality changes, restlessness, tension, irritability, insomnia, appetite suppression, and weight loss. Verbally threatening behavior and physical aggression have also been observed ..." (p. 892).

o "Continual use of the drug, with little or no sleep over a period of 2 - 5 days, can lead to an extremely irritable and paranoid state ... . In ~ 10% of persons, heavy, long-term abuse can lead to psychosis, which is characterized by paranoia, impaired reality testing, and vivid visual, auditory and tactile hallucinations ... . Am-

[1] These findings are highlighted in the Winter 2004 issue of *mental health* **AIDS**; see "Opening the Minds of Men Who Have Unsafe Sex with Men."

schedule. Avoidance symptoms, in particular, were related to taking medications off-schedule and missing medical appointments, supporting the hypothesis that HIV-positive individuals might avoid taking medications because they can serve as stressful reminders of their diagnosis. ... [T]hese results underscore <u>the importance of assessing and treating PTSD in HIV-positive</u>

phetamine-produced psychoses mimic schizophrenia ..." (p. 892).

o As use continues, tolerance develops and engenders greater use, resulting in dependence. Withdrawal begins 24 hours after the drug is last administered; symptoms include depressed mood, fatigue, anhedonia, and suicidal ideation. These symptoms resemble those experienced during major depression.

o There is, at present, no research evidence to guide the use of psychiatric medications with meth users. Acute psychotic symptoms are generally treated with neuroleptics and, if necessary, hospitalization. "[P]sychiatrists treating HIV-infected patients [who are meth users] use bupropion [Wellbutrin®], an antidepressant with noradrenergic and dopminergic activity, to treat depressive symptoms, although it is not useful for management of acute stimulant withdrawal ..." (p. 893).

o "Overall findings suggest that, although acute psychosis tends to resolve, depressive symptoms tend to persist ..." (p. 893).

o Animal studies suggest that meth accumulates in the brain and is toxic to the CNS. "[Meth] causes neurodegeneration in the dopaminergic and the serotonergic nerve terminals in animals ... . Human studies provide evidence that [meth] use leads to a reduction of dopamine transporter (DAT) levels, which are markers of dopamine cell terminals. ... [S]ignificant reductions in DAT levels ... [have been] associated with neuropsychiatric testing evidence of impaired motor function and impaired verbal learning. In [some cases], DAT levels ... [decrease] to within the range seen for low-severity Parkinson disease" (p. 892).

In Part 2 of this series, the medical and psychiatric interface of meth and HIV will be highlighted.

What effect does abstaining from meth have on cognitive capacities? In a small study, Wang et al. (2004) noted that "protracted abstinence and proper rehabilitation may reverse some [meth]-induced alterations in brain function" (p. 247) and that these alterations are "associated with improved performance in motor and verbal memory tests" (p. 242). Nevertheless, some seemingly long-lasting changes in brain activity "could account for the persistence of amotivation and anhedonia in detoxified [meth] abusers" (p. 242).

<u>"Baby, If I'm the Bottom ...</u>

What is it about meth that increases sexual risk behavior? According to Halkitis, Parsons, and Stirratt (2001), "Certain psychological effects of [meth], such as hypersexuality, euphoria, a lowering of sexual inhibitions, increased self-esteem, and increased confidence, may be perceived as appealing[.] ... It has been argued that the drug has aphrodisiac qualities, as [meth] affects the subjective pleasure of sexual experience, independent of any effect on libido or sexual drive ... . In fact, use of the drug has been directly linked to the increased likelihood of impulsive sexual behavior due to the psychological implications of use ..." (p. 21).

> [Meth] use is related to risky sexual practices in other ways. In higher doses, [meth] has been reported to increase sexual pleasure at the same time that its physiological effects preclude the ability to obtain a full erection. Anecdotal evidence also suggests increased anal sensation. A direct result of this phenomenon is the creation of "instant bottoms," a term applied by gay and bisexual men to refer to drug users who undertake the receptive role during anal intercourse ... . [Meth] use may, therefore, increase the practice of receptive anal sex, which is the most risky sexual behavior for HIV transmission ... . Because of the sensory effects and associated decrease in sexual inhibitions, use of [meth] is also directly linked to longer periods of continuous sexual intercourse ... . (p. 25)

The upshot on meth is that "users find themselves in a highly charged sexual state and engaging in unprotected sexual behaviors with partners of unknown HIV status. [Meth] use by [MSM] may, therefore, work to perpetuate the AIDS epidemic ... by creating a patchwork of complex, interrelated behaviors related to sexual risk taking within its users" (p. 28).

<u>... You're the Top!</u>"

As noted earlier, crystal meth use in high doses can affect a man's ability to obtain an erection. Several recent reports suggest that expanding recreational use of sildenafil (Viagra®) in conjunction with meth is contributing to increases in rates of HIV, syphilis, and other sexually transmitted diseases (STDs) among MSM in the U.S:

o In a study involving 388 MSM (Mansergh, 2004), 16% reported using meth and 6% reported using sildenafil during their most recent episode of anal intercourse. Meth users were twice as likely as nonusers to have engaged in unprotected *receptive* anal intercourse and sildenafil users were 6.5 times more likely to report having had unprotected *insertive* anal intercourse; sildenafil use did not, however, appear to increase unprotected *receptive* anal intercourse.

o Wong (2004) reported that MSM who used meth and sildenafil in combination were 6.1 times more likely to be diagnosed with syphilis than those who abstained from these drugs.

o In a study involving 1,263 MSM seeking STD clinic services (Mitchell, 2004), 17.4% reported using meth during the four preceding weeks. When compared to nonusers, those who used meth were more than two times as likely to be living with HIV, 4.9 times as likely to be diagnosed with syphilis, and 1.7 times as likely to be diagnosed with gonorrhea.

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--Compiled by Abraham Feingold, Psy.D.

patients[,] ... focus[ing] on avoidant behaviours [that reduce] adherence ..." (p. 256).

o Palmer, Salcedo, Miller, Winiarski, and Arno (2003) studied an ethnically diverse, urban convenience sample of 107 "triply diagnosed" men and women living with HIV and engaged in methadone maintenance treatment. Among the 69% taking antiretrovirals, they found that borderline personality disorder as well as serious social/family problems were associated with nonadherence. "[T]hese findings give us more information about the psychiatric and social predictors of nonadherence, and ultimately more specific areas to target in the treatment of triply diagnosed populations" (p. 641).

o Through interviews and questionnaires completed by 120 adults taking combination antiretrovirals, as well as a review of their medical records, Ingersoll (2004) determined that use of crack cocaine in the preceding six months and having ever used heroin were associated with nonadherence. Conversely, screening positive for

> any anxiety disorder reduced the risk of failing to take medications as directed, probably due to increased, self-protective vigilance about following directions. ... It is possible that some level of anxiety can be motivational for some types of adherence behaviour, while more severe anxiety presents a barrier to adherence. In fact, a specific type of anxiety, social phobia, increased the risk of running out of medications. ... [To address] the impact of social phobia on maintaining prescriptions[, c]linicians should consider taking steps that reduce the stress of normal procedures for such patients, such as providing prescriptions in advance, calling in several months' worth of medication at a time, or providing mailed or phoned reminders about renewing medications. (pp. 208-209)

In summary, Ingersoll states that, "Clinicians caring for patients with HIV should screen for non-adherence using multiple behavioural indicators, and assess and treat substance use and anxiety disorders to reduce the risk of non-adherence" (p. 199).

On the subject of substance use, Ehrenstein, Horton, and Samet (2004) administered up to seven structured interviews over a 36-month period to 345 people living with HIV who had a history of alcohol problems. They found that 38% of these individuals reported inconsistent condom use at baseline. Among *active* IDUs, a high level of alcohol consumption was associated with inconsistent condom use, while these factors were not associated in study participants who did not inject. Inconsistent use was also more likely among female interviewees, among those who felt that condoms were "a hassle," and among those living with their sex partner. "These findings bolster the argument for routine assessment of alcohol use in HIV-infected patients, particularly in those with a history of [IDU]" (p. 165).

What screening tools might be used to assess alcohol use? Samet, Phillips, Horton, Traphagen, and Freedberg (2004) administered the four-item CAGE screening test for alcohol problems[1] to a sample of 664 adults initiating HIV primary care services. Forty-two percent of these individuals responded in the affirmative to two or more of the CAGE items, suggestive of problems with alcohol. Among 141 individuals screening positive for alcohol problems, 95% met DSM-IV criteria for a lifetime history of alcohol abuse or dependence. Samet and colleagues conclude that the CAGE screening test is useful in the HIV primary care setting.

HIV Treatment News

Neuropsychological Impairment

Green, Saveanu, and Bornstein (2004) explored the potential effect of HIV infection and a history of alcohol (ETOH) abuse, both separately and together, on cognitive functioning by performing neuropsychological (NP) testing on four groups of male subjects (12 HIV-/ETOH+, 21 HIV+/ETOH+, 18 HIV-/ETOH-, and 29 HIV+/ETOH-). They found that "HIV infection and a history of alcohol abuse have independent effects on some aspects of higher cognitive function but may have synergistic effects on other cognitive domains" (p. 249). While no differences in cognitive function were noted among HIV-negative participants, whether or not they presented with a history of alcohol abuse, those HIV-positive participants who had a history of alcohol abuse demonstrated poorer performance on measures of verbal intelligence, verbal reasoning, and reaction time than their counterparts who did not have a history of alcohol abuse.

> [T]hese data suggest that alcohol abuse may lead to a subthreshold alteration of brain function. Although this alteration in brain function may be insufficient to lead to overt cognitive dysfunction, there may be a vulnerability to the impact of a second, independent process (e.g., HIV infection). ... Thus, interventions directed toward reduced alcohol consumption in subjects at risk for HIV infection may become an important approach in prevention of factors that contribute to cognitive dysfunction in the setting of HIV infection. In relation to clinical management of HIV-infected individuals, it may be important for health care providers to be aware that a past history of alcohol abuse, regardless of current use, may be associated with a greater risk of cognitive impairment. (p. 253)

Rabkin, McElhiney, Ferrando, Van Gorp, and Lin (2004) examined patterns of employment in the context of conducting comprehensive, semiannual assessments on 141 men living with HIV/AIDS over a 30-month period. In general, they found that men who were working at baseline continued to work, while men who were unemployed at baseline, even if their health improved, did not resume working. "The major parameters consistently associated with unemployment or partial employment, in order of influence, were financial ([reluctance to relinquish] disability benefits), psychiatric (past/current diagnosis of major

[1] The CAGE screening test consists of four items:

C – Have you ever felt you should *cut down* on your drinking?
A – Have people *annoyed* you by criticizing your drinking?
G – Have you ever felt bad or *guilty* about your drinking?
E – Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (*eye opener*)?

©1974, American Psychiatric Association

depression and/or dysthymia), medical (physical limitations), cognitive (executive function[2]), and education. In contrast, age, ethnicity, laboratory markers of HIV illness status, vocational rank, and past or current substance dependence did not predict work status" (p. 72). The authors observe that, "[r]eturning to work is evidently difficult, and clinicians may keep this in mind when recommending leaving work unless medically necessary" (p. 72).

Adherence to Treatment

Swiss investigators (Young et al., 2004) conducted a prospective study involving 3,736 outpatient HAART recipients and found that a stable partnership was associated with slower progression to AIDS or death in this cohort. The authors "can only speculate about the reasons why a stable partnership is associated with a slower rate of disease progression for people with HIV. The increased rate of progression to a CD4 cell increase and to viral suppression in patients who have stable partners may be linked to drug adherence. People with a stable partner may have less depression, a risk factor in many other chronic diseases" (pp. 17-18). Such speculation, however, suggests that clinicians serving people living with HIV who do not have a steady partner might pay particular attention to support needs that can enhance medication adherence as well as the presence of depressive symptomatology that requires treatment.

And yet, having a steady partner may not, in all cases, promote adherence. Johnson et al. (2003) used a computerized interview to assess adherence in a diverse sample of 2,765 men and women living with HIV in four U.S. cities. During the preceding three-day period, 32% of this sample reported an adherence rate lower than 90%. Multivariate analyses revealed that reduced adherence was associated with the following factors: current crack cocaine use, a history of IDU, African-American ethnicity, *being in a primary relationship*, homelessness during the preceding year, a greater number of daily medication doses, greater bother from HIV symptoms, lower adherence self-efficacy, difficulty managing side effects, an inability to fit medication-taking into daily routines, being tired of medication-taking, and not believing that nonadherence can increase the strength of the virus. "Results support the need for multi-focused interventions to improve medication adherence that address logistical barriers, substance use, attitudes and expectancies, as well as skills building and self-efficacy enhancement. Further exploration of issues related to adherence for African Americans and men in primary relationships is warranted" (p. 645).

In an exploratory study, British investigators (Horne et al., 2004) surveyed 109 HAART recipients regarding their beliefs about HAART and their reported medication adherence and found that "low adherence may be the result of an implicit 'risk-benefit' analysis in which beliefs about the *necessity* of HAART for maintaining health now and in the future are balanced against concerns about perceived adverse effects. Low adherence may be an attempt to moderate the perceived risks of HAART by taking less" (p. 43). The authors suggest that

> [t]he necessity-concerns construct may be a useful framework for eliciting patients' beliefs about HAART in clinical practice. As a first step in supporting patient adherence to HAART, clinicians might ask themselves two questions: 'Have I provided this patient with a clear rationale for the necessity of HAART?' and 'Have I elicited and addressed their concerns about potential adverse effects?'. ... Eliciting and taking account of patients' personal beliefs about HAART may improve patients' ... degree of involvement in decisions about their treatment ... [and] lead to a more open dialogue about adherence, avoiding the situation where the patient does not report non-adherence for fear of offending the clinician ... ." (p. 44)

Pain Management

Evans, Weinberg, Spielman, and Fishman (2003) administered the Inventory of Negative Thoughts in Response to Pain (INTRP) to 85 men and women with mild to moderate, HIV-related peripheral neuropathic pain and found negative thoughts to be associated with pain intensity, interference with daily functioning, and distress among those sampled. Moreover, "self-blame significantly predicted pain interference and negative social cognitions predicted depressive symptoms. ... [S]elf-recrimination and shame are problems that HIV-positive patients struggle with and these results point to the relationship between these types of negative thoughts and pain interference and distress" (p. 243).

Regarding intervention, Evans and colleagues suggest that

> cognitive-behavioral treatments aimed at identifying and restructuring patterns of dysfunctional thoughts may have a significant impact on the suffering associated with chronic pain conditions. The aim of these interventions is not to discount the reality of the pain but to have the patient realistically reappraise the meaning of the sensations. For example the thought, "my pain is getting worse" which suggests low personal control may have a direct effect on level of activity and mood functioning. Through the process of Socratic questioning, the patient may conceive alternative ways of looking at their pain e.g. "I can still do some things despite the pain". Furthermore, critically examining and restructuring distorted and dysfunctional attitudes about self and others around being HIV-positive and having pain may lead to a reduction of suffering and interference. (pp. 243-244)

Serostatus Disclosure

Clark, Lindner, Armistead, and Austin (2003) conducted four assessments with 98 African-American women who were HIV-positive and 146 who were HIV-negative over a six-year period. When comparing HIV-positive to HIV-negative women in this sample, Clark and colleagues found that the former group perceived greater AIDS-related stigma than the latter at each point of assessment. Importantly, among the women

[2] "For the total sample, Trail Making B was a consistent predictor, and for the working sample ..., the Stroop Color and Word Test was a consistent predictor. Poorer performance on either of these measures of frontal lobe/subcortical function was associated with fewer hours worked, ... [suggesting that] specific impairments in speed of information processing and frontal lobe functions are key domains that could potentially serve as barriers to return to work or full-time work in a person who is HIV+" (pp. 76-77).

Tool Box

Out of Africa: Addressing HIV in Sub-Saharan Immigrant Populations

There has, to date, been scant focus in HIV research literature on sub-Saharan Africans relocating to Western nations. While considerable thought has gone into *future* research agendas with African migrant communities, particularly in the United Kingdom (e.g., Kesby, Fenton, Boyle, & Power, 2003), published studies available now are largely descriptive and offer clinicians little more than tidbits to inform their approach to this vastly heterogeneous population.

The European Scene
Dutch investigators (Wiggers, de Wit, Gras, Coutinho, & van den Hoek, 2003) conducted a cross-sectional study of 537 Surinamese, Antillean, and sub-Saharan African heterosexual men and women, a community sample of migrants to Amsterdam, The Netherlands, and found that inconsistent condom use was reported in 82% of primary relationships and in 25% of casual relationships. While perceived behavioral control over one's sexual behavior and subjective norms regarding condom use (i.e., perceiving that salient others favored condom use) were associated with consistent condom use, other factors also assumed importance, including gender (with men reporting more sexual activity and more casual partners); type of relationship (as noted earlier, condom use is more likely to occur in casual than in primary relationships); partners' ethnicity (condom use was more likely when the partner was born in The Netherlands); having previously been tested for HIV; and knowledge regarding HIV transmission and prevention. While it cannot be determined whether this sample is representative of Amsterdam's migrant population more generally, the authors suggest that

> interventions seeking to promote condom use in ethnic minority communities, notably those with Surinamese, Antillean, and sub-Saharan African backgrounds, should specifically address subjective norms and perceived behavioral control related to condom use. ... [P]roviding relevant HIV/AIDS-related information to ethnic minority communities may also contribute to the increase of consistent condom use ... [as well as targeting] risk taking with primary partners and with partners from individuals' own ethnic group. In addition, women and persons who have not previously been tested for HIV may particularly benefit from support in consistent condom use offered by targeted interventions. (pp. 445-446)

What about black African migrants living with HIV? Utilizing self-report measures and interviews, British investigators (Anderson & Doyal, 2004) attempted to understand more about the needs and experiences of 62 women from 11, largely east and central African countries, who were receiving HIV medical care in five London hospitals. While differences were noted, attributed to variations in nationality, educational level, income, and legal status, similarities were also seen, centered on illness-related stigma (both actual and perceived and, in particular, within the *African* community) and the need to constantly manage this information about themselves. This, in turn, had an impact on their utilization of health and social support services. Notably, the resilience of these women appeared to be rooted in their religious faith.

Coming to America
Rosenthal et al. (2003) surveyed 309 black immigrants from more than 20 African nations (including people from Nigeria, Ethiopia, Ghana, Somalia, and Eritrea) to Houston, Texas. On the whole, these individuals were highly educated (70.9% had education beyond high school) and understood how HIV is transmitted, with those of Christian background demonstrating greater knowledge in this area than those of Muslim background. *Despite high levels of educational attainment,* 36.3% revealed that they had never used a condom, and 79.5% perceived themselves to be at low risk for contracting HIV. Moreover, 16.3% of the women and 29.9% of the men were not aware that HIV could be transmitted from mother to child and 20.1% engaged in ritual body scarring or tattooing. While raising general awareness of HIV risk in this population is critical, the authors highlight "the importance of exploring the role of tribal cultural rituals among members of particular immigrant groups" (p. 577) when assessing risk.

Diamonds in the Rough
While these studies are both interesting and provocative, the studies that, perhaps, have the greatest potential to inform the work of mental health professionals serving sub-Saharan immigrant populations come from Africa itself. As Roberts, McNair, and Smith (2004) observe, "Despite cultural differences between specific nationalities and ethnic groups, Blacks living in Africa and America share many experiences related to HIV prevention and care" (p. 6).

Based on interviews with a convenience sample of 22 men and 28 women from 10 villages in a region of high HIV prevalence in southwest Uganda, a team of American investigators (Christopher M. Wilk and Paul Bolton) have begun to qualitatively assess the impact of HIV on rural Ugandan communities and the ways in which these communities view the relationship between HIV and mental health problems among their community members:

o With regard to the impact of HIV on Ugandan communities (Bolton & Wilk, 2004), identified problem areas included: 1) a lack of able-bodied adults; 2) a lack of child care; and 3) both social unrest and mental health issues. The latter included "'Hatred of Self, Life and God and Desire for Vengeance on the World' among those with HIV. This latter problem, as well as 'Loss of Hope' and 'Worry and Self-Pity', were described by some respondents as a loss of impulse control related to an increased apathy toward oneself and others" (p. 126). Bolton and Wilk wonder if these issues are contributing to sexual risk behavior among those living with HIV in Uganda.

o Delving deeper into these indigenous mental health issues and their relationship to Western concepts of mental disorder, Wilk and Bolton (2002), while unable to discern local syndromes that approximated posttraumatic stress disorder (PTSD), did discover two independent, but frequently co-occurring, depression-like syndromes – *Yo'kwekyawa* (or "hating oneself") and *Okwekubaziga* (or "pitying oneself") – viewed by their informants as resulting from the HIV epidemic that, together, include all nine major criteria for a DSM-IV diagnosis of major depressive disorder. "Among the symptoms shared by both local syndromes, suicidal thoughts and feeling no interest were central to *Yo'kwekyawa*, whereas sadness was more emblematic of *Okwekubaziga*. Other shared symptoms (e.g., crying easily, feeling lonely, worrying too much, feeling worthless, and irritability) appear to be equally characteristic of both local syndromes. Both local syndromes also included symptoms that are not part of the DSM-IV criteria for depression. For *Yo'kwekyawa*, these symptoms were 'hating the

who were living with HIV, as the level of perceived stigma increased, psychological functioning decreased among women with high levels of disclosure. "Since non-disclosure may compromise one's ability to receive social support and potentially could also further the spread of HIV, [women contemplating disclosure] may best be served by examining the balance between risk of stigmatization and potential benefits to disclosure, advocating for disclosure only after carefully considering resources, close

world' and 'bad, criminal, or reckless behavior.' 'Unappreciative of assistance' was the only non-DSM-IV symptom identified as a symptom of *Okwekubaziga*" (pp. 395-396).

The authors preliminarily conclude that depression occurs among Ugandan people hard-hit by HIV and is perceived "to be a direct consequence of the mortality and social and economic impact of HIV" (p. 396).

Techniques for Addressing Sub-Saharan Immigrants Living with HIV

o "Joining with patients from different cultures may take several meetings. The use of maps, genograms and some knowledge of a country, its tribes and customs can facilitate conversation. Careful attention to ... words is a way of being respectful and learning about different cultures, beliefs and practises" (p. 298).
o "By and large, African women have said they would prefer to be seen by female staff. African men also seem to connect more easily with female counsellors, and often with those who are older. Both associate talking about personal matters with a mother, aunt or elder sister. Most have said they do not wish to be seen by professionals or voluntary workers from their country of origin or nearby country, and explain that ... their need for privacy would not be respected" (pp. 298-299).
o Introduce hypothetical future-oriented questions: "If your mother was here, what advice might she give you about the decision whether or not to test your child for HIV?"; "What advice would your mother give you about who should care for the children in this country if you were unable to do so?" (p. 295).
o Reframe through self-disclosure: "In my experience, being away from one's country, culture and extended family gives one an opportunity to do things a bit differently. Might this be the same for you?" (p. 296).
o Take a position of "not knowing" and express curiosity: "In your family, who would make decisions about the care of your children if you became too ill to do so?" (p. 296).
o Request feedback to ensure that the clinical approach is on-target: "From the time we have spent together today, what one thought might you take away from our conversation?" (p. 300).
o Engage in regular case discussion as a source of support and creativity (p. 299).

From: Miller, R., & Murray, D. (1999). The impact of HIV illness on parents and children, with particular reference to African families. *Journal of Family Therapy, 21*(3), 284-302.

Corroborating this high prevalence of mood disorders, Olley et al. (2003) evaluated 149 black South Africans recently diagnosed with HIV/AIDS and receiving outpatient medical care in Cape Town. They found that 56% met DSM diagnostic criteria for a psychiatric disorder (major depression, 34.9%; dysthymic disorder, 21.5%; PTSD, 14.8%; and alcohol dependence, 10.1%), with alcohol abuse or dependence a more common diagnosis among the men (who also engaged in greater sexual risk behavior) and PTSD more common among the women. The authors noted that these South African women tended to use planning and religious activities as coping strategies to manage their illness.

It Takes a Village

Bolton et al. (2003) returned to the 30 rural villages that participated in their earlier studies to conduct a cluster randomized, controlled clinical trial of a manualized, time-limited, group-based interpersonal psychotherapy (IPT) for depression.[1] Since sex-segregated groups were found to be more culturally acceptable than mixed groups, 15 villages were randomly assigned for the formation of men's groups and 15 for the formation of women's groups. Individuals who self-identified or were identified by others as suffering from *Yo'kwekyawa* and/or *Okwekubaziga* were screened for DSM-IV major depression or subsyndromal depression as well as functional impairment. In eight of the male villages and seven of the female villages, between eight and 12 villagers were assigned to 16-week, 90-minute IPT groups by decreasing order of symptom severity until all groups were filled. In the remaining villages, study participants went about their usual healing practices. In all, 108 men and 116 women completed the study and follow-up interview within two weeks of the IPT intervention.

Post-intervention analysis revealed that 6.5% of study participants receiving IPT met DSM-IV diagnostic criteria for major depression at the conclusion of the study (86% met these diagnostic criteria at baseline), compared to 54.7% of control group participants (94% of whom met these criteria at baseline). The authors conclude that, while both groups experienced reductions in depression over time, group interpersonal psychotherapy appeared to be "highly efficacious in reducing depression and dysfunction" (p. 3117) and is worthy of further study.

[1] "Interpersonal psychotherapy makes no assumption about etiology but uses as a critical point for intervention the connection between symptom onset and current interpersonal problems. The therapist begins with a careful diagnostic assessment, then explains the diagnosis and works with the patient to identify the problem areas associated with the onset of current symptoms. Difficulties in 4 interpersonal areas are considered triggers of depressive episodes, and 1 or more these form the treatment focus: grief (due to death of a loved one), interpersonal disputes (disagreements with important people in one's life), role transition (changes in life circumstances), and deficits (persistent problems in initiating or sustaining relationships)" (p. 3120).

The IPT manual may be obtained from the authors by writing to mmw3@columbia.edu or kfclougherty@aol.com.

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Wilk, C.M., & Bolton, P. (2002). Local perceptions of the mental health effects of the Uganda acquired immunodeficiency syndrome epidemic. *Journal of Nervous & Mental Disease, 190*(6), 394-397.

--Compiled by Abraham Feingold, Psy.D.

relationships, and the potential consequence of disclosure. Useful interventions could focus on decreasing AIDS-related stigma among HIV-infected women, as well as on educating their families and partners, and thereby improving social support ..." (p. 68). The authors reiterate that "mental health professionals would be wise ... not to encourage ... individuals blindly to disclose their status, even in close relationships, without ... psychological preparation [and the] assessment of safety" (p. 68).

Coping, Social Support, & Quality of Life
Heckman et al. (2004) evaluated 329 people living with HIV in 13 Eastern and Midwestern states (74% were self-identified gay men) who enrolled in a randomized clinical trial of a telephone-delivered, coping improvement group intervention. Among these "nonmetropolitan" intervention-seekers, Heckman and colleagues noted that 60% reported moderate to severe levels of depressive symptomatology. Moreover, "participants who experienced high levels of emotional distress also reported more severe HIV symptomatology, less social support, and greater use of avoidance coping. In addition, ... lower levels of social support [and use of avoidance coping] ... were associated with higher perceptions of discrimination and greater rejection by family members. These findings underscore the need for culturally contextualized mental health interventions that can reduce the physical sequelae of HIV disease, foster more adaptive coping strategies in response to HIV-related distress, and increase access to social support resources [among nonmetropolitan persons living with HIV]" (p. 98).

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Ciesla, J.A., Roberts, J.E., & Hewitt, R.G. (2004). Adult attachment and high-risk sexual behavior among HIV-positive patients. *Journal of Applied Social Psychology, 34*(1), 108-124.

Clark, H.J., Lindner, G., Armistead, L., & Austin, B.-J. (2003). Stigma, disclosure, and psychological functioning among HIV-infected and non-infected African-American women. *Women & Health, 38*(4), 57-71.

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Tool Box

Resources

Books & Articles:

Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, HIV Medicine Association of the Infectious Diseases Society of America, & the HIV Prevention in Clinical Care Working Group. (2004). Recommendations for incorporating human immunodeficiency virus (HIV) prevention into the medical care of persons living with HIV. *Clinical Infectious Diseases, 38*(1), 104-121.
CDC, HRSA, NIH, and the HIVMA of the IDSA have collaborated on the development of evidence-based recommendations "for incorporating HIV prevention into the medical care of persons living with HIV. ... The recommendations are categorized into 3 major components: (1) screening for HIV transmission risk behaviors and sexually transmitted diseases (STDs); (2) providing, and referring for, behavioral risk-reduction interventions and related services; and (3) facilitating notification, counseling, and testing of infected persons' partners" (p. 104).

Grossman, H.A., Sullivan, P.S., & Wu, A.W. (2003). Quality of life and HIV: Current assessment tools and future directions for clinical practice. *AIDS Reader, 13*(12), 583-590, 595-597.
"The purpose of this review is to discuss the [health-related quality of life (HRQOL)] issues particularly relevant to patients with HIV/AIDS, to provide an overview of the more common research-based HRQOL assessment tools used in this patient population, and to evaluate the applicability of these tools for routine use in clinical practice for the HIV/AIDS population" (p. 583).

Harper, G.W., Hosek, S.G., Contreras, R., & Doll, M. (2003). Psychosocial factors impacting condom use among adolescents: A review and theoretical integration. *Journal of HIV/AIDS Prevention & Education for Adolescents & Children, 5*(3/4), 33-69.
"This article reviews published research studies that have examined the impact of psychosocial factors on condom use among adolescents, and offers recommendations regarding the examination of psychosocial variables in future research and HIV prevention program development for adolescents" (p. 33).

Ka'opua, L.S.I., & Mueller, C.W. (2004). Treatment adherence among Native Hawaiians living with HIV. *Social Work, 49*(1), 55-63.
Ka'opua and Mueller studied adherence to HAART among Native Hawaiians and offer tips for developing culturally competent interventions that will support adherence.

Normand, J.L., & Lambert, E.Y. (Eds.). (2003). HIV acquisition and transmission among drug-using populations: Future research strategies. *Journal of Urban Health, 80*(4 Suppl. 3), iii1-iii105.
In this December 2003 special supplemental issue, scientists focus on "identifying and understanding some of the dynamic factors involved in the sexual transmission of HIV among drug-using populations" (p. iii1).

Roberts, G.W., McNair, L.D., & Smith, D.K. (Eds.) (2004). Enhancing research and clinical responses to HIV/AIDS in African Americans: Social, psychological, and contextual issues. *Journal of Black Psychology, 30*(1), 5-160.
This special February 2004 issue summarizes current research knowledge on HIV prevention and treatment in the African-American community "and highlight[s] meaningful behavioral, social, clinical, and structural areas in which interventions are needed" (p. 6).

Robin, L., Dittus, P., Whitaker, D., Crosby, R., Ethier, K., Mezoff, J., Miller, K., & Pappas-DeLuca, K. (2003). Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: A decade in review. *Journal of Adolescent Health, 34*(1), 3-26.
A review of 24 articles on "adolescent sexual risk-reduction programs that were evaluated using quasi-experimental or experimental methods and published in the 1990s. ... Analysis ... suggest[s] four overall factors that may impact program effectiveness including the extent to which programs focus on specific skills for reducing sexual risk behaviors; program duration and intensity; what constitutes the content of a total evaluated program including researchers' assumptions of participants' exposure to prior and concurrent programs; and what kind of training is available for facilitators" (p. 3).

Sandelowski, M., & Barroso, J. (2003). Motherhood in the context of maternal HIV infection. *Research in Nursing & Health, 26*(6), 470-482.
Sandelowski and Barroso offer a research integration of findings pertaining to motherhood from 56 reports of qualitative studies involving women living with HIV as a foundation for evidence-based care programs.

Sherman, A.C., Mosier, J., Leszcz, M., Burlingame, G.M., Ulman, K.H., Cleary, T., Simonton, S., Latif, U., Hazelton, L., & Strauss, B. (2004). Group interventions for patients with cancer and HIV disease: Part I: Effects on psychosocial and functional outcomes at different phases of illness. *International Journal of Group Psychotherapy, 54*(1), 29-82.
"The current article, the first in a series of four special reports, critically evaluates the efficacy of group interventions led by professional or trained facilitators for individuals confronted by cancer or HIV, across the spectrum of illness from elevated risk through advanced disease. We examine psychosocial and functional outcomes for different interventions directed toward different patient subgroups, trace common themes, highlight limitations, and offer rec-

Posttraumatic stress disorder symptoms, salivary cortisol, medication adherence, and CD4 levels in HIV-positive individuals. *AIDS Care, 16*(2), 247-260.

Ehrenstein, V., Horton, N.J., & Samet, J.H. (2004). Inconsistent condom use among HIV-infected patients with alcohol problems. *Drug & Alcohol Dependence, 73*(2), 159-166.

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Heckman, T.G., Anderson, E.S., Sikkema, K.J., Kochman, A., Kalichman, S.C., & Anderson, T. (2004). Emotional distress in nonmetropolitan persons living with HIV disease enrolled in a telephone-delivered, coping improvement group intervention. *Health Psychology, 23*(1), 94-100.

Horne, R., Buick, D., Fisher, M., Leake, H., Cooper, V., & Weinman, J. (2004). Doubts about necessity and concerns about adverse effects: Identifying the types of beliefs that are associated with non-adherence to HAART. *International Journal of STD and AIDS, 15*(1), 38-44.

Ingersoll, K. (2004). The impact of psychiatric symptoms, drug use, and medication regimen on non-adherence to HIV treatment. *AIDS Care, 16*(2), 199-211.

Johnson, M.O., Catz, S.L., Remien, R.H., Rotheram-Borus, M.J., Morin, S.F., Charlebois, E., Gore-Felton, C., Goldsten, R.B., Wolfe, H., Lightfoot, M., Chesney, M.A., & the NIMH Healthy Living Project Team. (2003). Theory-guided, empirically

ommendations for further research" (p. 30).

Simoni, J.M., Frick, P.A., Pantalone, D.W., & Turner, B.J. (2003). Antiretroviral adherence interventions: A review of current literature and ongoing studies. *Topics in HIV Medicine, 11*(6), 185-198.
"In this review, we examine antiretroviral therapy adherence intervention studies and reviews published through January 2003 as well as abstracts of ongoing National Institutes of Health-funded research projects aimed at enhancing antiretroviral therapy adherence. The 21 published studies we located utilized 4 intervention strategies: cognitive-behavioral, behavioral, directly observed therapy, and affective. Most of these were pilot or feasibility studies. However, the 4 randomized controlled trials conducted with adequate methodologic rigor suggest some promising yet preliminary effects of a pharmacist-led individualized intervention, a cognitive-behavioral educational intervention based on self-efficacy theory, and cue-dose training when combined with monetary reinforcement. The 39 ongoing federally funded studies offer superior methodologic sophistication and include some innovative strategies, such as the use of handheld devices, two-way pagers, and alarmed medication vials, along with enhancement of social and emotional support" (p. 185).

Stoff, D.M., Khalsa, J.H., Monjan, A., & Portegies, P. (Eds.). (2004). HIV/AIDS and aging. *AIDS, 18*(Suppl. 1), S1-S98.
"This supplement ... is dedicated to research on CNS-related comorbidities and complications in HIV-infected older adults as discussed at the National Institute of Mental Health workshop ('Mental Health Research Issues in HIV Infection and Aging') held in Washington, D.C., in April, 2002" (p. S1).

Stone, V.E. (2004). Optimizing the care of minority patients with HIV/AIDS. *Clinical Infectious Diseases, 38*(3), 400-404.
In this brief article, Stone spells out strategies that programs can employ to optimize HIV care for minority patients. These include: "using a cultural competence framework, enhancing patient-provider communication, diversifying ... clinical staff, proactively enhancing receipt of HAART, and being attentive to issues related to adherence to HAART" (p. 400).

Strug, D.L., & Burr, C.K. (2004). Service needs of male caretakers of HIV-infected and affected children: Policy and practice implications. *Social Work in Health Care, 38*(2), 73-92.
Strug and Burr present the views of providers from 25 Ryan White CARE Act Title IV programs on the support service needs of male caretakers (biological fathers and other men) of HIV-infected and -affected children.

Tinsley, B.J., Lees, N.B., & Sumartojo, E. (2004). Child and adolescent HIV risk: Familial and cultural perspectives. *Journal of Family Psychology, 18*(1), 208-224.
Tinsley, Lees, and Sumartojo "review and integrate theory and research focused on the impact of the family, within a cultural perspective, on HIV prevention in childhood and adolescence" (p. 208).

Vidrine, D.J., Amick, B.C. III, Gritz, E.R., & Arduino, R.C. (2004). Validity of the Household and Leisure Time Activities questionnaire (HLTA) in a multiethnic HIV-positive population. *AIDS Care, 16*(2), 187-197.
"The HLTA, ... an 11-item questionnaire consisting of two scales designed to assess an individual's ability to perform routine home activities (household functioning scale) and to participate in leisure time activities (leisure-time functioning scale), ... [was found to be] appropriate for use with multicultural low-income HIV/AIDS patients" (p. 187).

Vinh-Thomas, P., Bunch, M.M., & Card, J.J. (2003). A research-based tool for identifying and strengthening culturally competent and evaluation-ready HIV/AIDS prevention programs. *AIDS Education & Prevention, 15*(6), 481-498.
"This article surveys the various ways that the concept of cultural competence has been studied, extends the concept to the field of HIV/AIDS prevention, and presents a simple-to-use instrument that operationalizes the concept for use with HIV/AIDS prevention programs. The article also explores the idea of evaluation readiness among HIV/AIDS prevention programs in the hope of eventually enlarging the pool of minority-focused HIV/AIDS programs demonstrated as effective" (p. 481).

Internet Resources:

Family Health International and the Program for Appropriate Technology and Health have developed a new manual entitled, "Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences," located at: http://www.fhi.org/en/HIVAIDS/Publications/index.htm.

The Fall '03/Winter '04 newsletter of the AIDS Community Research Initiative of America (ACRIA), a non-profit community-based AIDS research and treatment education center, contains a detailed, user-friendly overview of all currently approved antiretrovirals. To view this issue of the newsletter, go to: http://www.criany.org/treatment/treatment_edu_fall03-win04update.html.

The Cochrane Collaborative Review Group on HIV Infection and AIDS has analyzed more than 60 systematic reviews and meta-analyses of high methodological quality to produce an "Evidence Assessment: Strategies for HIV/AIDS Prevention, Treatment and Care." The January 2004 update may be found at: http://www.igh.org/Cochrane/pdfs/HIV_AIDS_Evidence_Assessment.pdf.

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Safren, S.A., Gershuny, B.S., & Hendriksen, E. (2003). Symptoms of posttraumatic stress and death anxiety in persons with HIV and medication adherence difficulties. *AIDS Patient Care & STDs, 17*(12), 657-664.

Samet, J.H., Phillips, S.J., Horton, N.J., Traphagen, E.T., & Freedberg, K.A. (2004). Detecting alcohol problems in HIV-infected patients: Use of the CAGE questionnaire. *AIDS Research & Human Retroviruses, 20*(2), 151-155.

Semple, S.J., Patterson, T.L., & Grant, I. (2004). Psychosocial characteristics and sexual risk behaviours of HIV+ men who have anonymous sex partners. *Psychology & Health, 19*(1), 71-87.

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Tsao, J.C.I., Dobalian, A., Moreau, C., & Dobalian, K. (2004). Stability of anxiety and depression in a national sample of adults with human immunodeficiency virus. *Journal of Nervous & Mental Disease, 192*(2), 111-118.

Wilson, H.W., & Donenberg, G. (2004). Quality of parent communication about sex and its relationship to risky sexual behavior among youth in psychiatric care: A pilot study. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 45*(2), 387-395.

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Young, J., De Geest, S., Spirig, R., Flepp, M., Rickenbach, M., Furrer, H., Bernasconi, E., Hirschel, B., Telenti, A., Vernazza, P., Bettegay, M., Bucher, H.C., & the Swiss HIV Cohort Study Group. (2004). Stable partnership and progression to AIDS or death in HIV infected patients receiving highly active antiretroviral therapy: Swiss HIV Cohort Study. *British Medical Journal, 328*(7430),15-18.

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Tool Box

A Note on Content

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

Bartlett, J.G. (2003). *The Johns Hopkins Hospital 2003 guide to medical care of patients with HIV infection, 11th edition.* Philadelphia: Lippincott Williams & Wilkins.

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

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mental health **AIDS** is also available online!
Go to: http://www.aidsetc.org/aidsetc?page=et-12-00