# *mental health* AIDS

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## Biopsychosocial Update

### HIV Prevention News

***About Persons With Severe Mental Illnesses***

To assess the influence of treatment in institutional and community care settings on the **sexual networks and HIV risk behaviors** of individuals diagnosed with severe mental illness (SMI), Wright and Gayman (2005) interviewed 401 clients in two state psychiatric hospitals and three community mental health centers. Wright and Gayman found that "community clients are more likely than hospital patients to be currently sexually active and to engage in high-risk sexual behavior whereas hospitalized patients tend to have more transient sexual relationships with partners who also have a mental illness" (p. 341). Regardless of treatment setting, however, a majority of clients who were sexually active reported engaging "in some risky sexual behavior with one or more of their partners during the past 3 months" (p. 349).

Drawing on these findings, the investigators contend that

> mental health treatment settings influence the HIV risk of people with [SMI] primarily by shaping the overall likelihood that clients are sexually active and the composition of their sexual networks. Specifically, ... state hospitals may be facilitating the spread of HIV among individuals with SMI ... [by] concentrat[ing] sexual risk behavior within smaller, and generally closed networks of persons with SMI. ... These findings ... underscore the need for more comprehensive HIV prevention efforts that target state hospital patients ... [and] hint that state-hospital focused HIV prevention programs could potentially have a much broader and longer-term structural impact on the course of the epidemic by limiting the frequency of HIV transmission and/or risk behavior *within* the population of clients and patients with SMI.
>
> In contrast, clients in outpatient care are more likely to be more successful in maintaining longer-term sexual relationships and having relationships with individuals outside of the mental health care system. Community-care clients' success in maintaining longer-term sexual partnerships represents an important strength that could have implications for HIV prevention programming. ... [This finding suggests] that mental health professionals could help to stem the spread of HIV indirectly by helping their clients, regardless of the treatment setting, to develop long-term relationships to meet their sexual needs. More generally, this finding ... [suggests] that prevention programs emphasizing safer-sex negotiation and relationship skills, especially relationship skill-building interventions [1].... may be particularly effective in community care settings because clients' existing sexual partnerships will offer mental health clinicians critical opportunities to counsel clients about HIV and help them practice risk reduction skills. (pp. 349-350)

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

Drawing on data from a diverse sample of 1,910 men who have sex with men (MSM) living with HIV in four U.S. cities, Morin et al. (2005) found that 12.7% of these men engaged in at least one **transmission-risk event** (i.e., "unprotected vaginal or anal sex with a partner who was HIV negative or of unknown status" [p. 226]) within the preceding 3-month period. Of these events, 57% took place with a casual partner; the

[1] Examples of skill-building interventions for persons with SMI are outlined in a **Tool Box** in the Fall 2005 issue of *mental health* **AIDS** entitled "Reducing HIV Risk Among Adults With Severe Mental Illness."

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remainder took place with a steady partner. With casual partners, risk was associated with the use of stimulants (including crystal methamphetamine [meth]) and other drugs, failure to always disclose HIV-positive serostatus, and low coping self-efficacy.[2] With steady partners, stimulant use and nondisclosure of HIV-positive serostatus were associated with risk.

Morin and colleagues observe that these findings

> point to the importance of developing interventions that respond differently to risk of transmitting in the context of primary relationships and risk occurring in casual partnerships. About two-thirds of transmission-risk events among MSM occurred with casual partners. Deficiencies in coping self-efficacy, a construct that can be modified through education and training, proved to be a significant predictor of this kind of risk. ... [R]isk of transmission with casual partners was also associated with using stimulants ... [such as crystal meth] and other drugs. Another third of transmission-risk events occurred with steady partners and were more likely to occur if a participant was younger or had used stimulants. Taken together, these findings suggest that stimulant use, particularly crystal [meth], contributes significantly to risk of HIV transmission and that interventions designed to minimize or eliminate its use should be an important component of primary HIV prevention. (p. 231)

[2] "Coping self-efficacy is a measure of beliefs about one's ability to cope with stress by managing emotional responses and effective problem solving, including making plans to address problems and following them through" (p. 231).

These investigators further observe that "interventions such as coping effectiveness training have been shown to improve coping self-efficacy in HIV-infected MSM and these improvements have been found to be associated with other outcomes, including reduction in perceived stress and burnout. ... Fortunately, cognitive-behavioral and supportive group interventions have both been effective in enhancing coping in men living with HIV ..." (p. 231). Yet, "[f]or the nearly one-third of risk that is occurring in the context of steady serodiscordant couples," Morin and colleagues point out that "additional strategies are needed to respond to the relationship dynamics that are supporting the ongoing risk. Above all, we need to develop and implement these strategies in a way that involves and respects these men, so that they become partners in reducing HIV transmission" (p. 233).

***About Persons Who Use Substances***

Ninety-three **heterosexually active college men** provided LaBrie, Earleywine, Schiffman, Pedersen, and Marriot (2005) with data on more than 1,500 sexual events across a 3-month period. The investigators found that "[t]he men consumed significantly more **alcohol** with new partners, followed by casual partners, and then by regular partners. In contrast, they were more likely to use condoms with new partners than with casual or regular partners. Drinking alcohol decreased condom use, but only with casual partners. Expectancies about alcohol's disinhibiting sexual effects decreased condom use as well" (p. 259). Drawing on these data, LaBrie and colleagues observe that "alcohol consumption does decrease condom use, particularly with casual partners and when drinkers believe alcohol alters sexual disinhibition" (p. 259). They suggest that "[i]mproving knowledge about [the potential for] HIV and other [sexually transmitted disease (STD)] transmission ... [with] casual partners and challenging expectancies about alcohol as a sexual disinhibitor could help decrease the spread of HIV and other STDs" (p. 259). With regard to casual partners, "[e]ncouraging men to treat casual partners as new partners may promote safer-sex behaviors. If participants are capable of using a condom after drinking with a new partner, the same skills should apply with a casual partner" (p. 264).

Stein et al. (2005) conducted a randomized controlled trial involving 109 **active drug injectors** (64% male, 82% white) with a *DSM-IV* diagnosis of major **depression** only (63%), substance-induced mood disorder with depressive features persisting for at least 3 months (17%), or major depression plus dysthymia ("double depression"; 17%). Study participants were assigned to one of two conditions: eight sessions of outpatient cognitive behavioral psychotherapy plus pharmacotherapy over a 3-month period, or an assess-

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ment-only condition. HIV drug risk and depression remission were evaluated at 3, 6, and 9 months.

The investigators found that "[r]eported HIV drug risk scores decreased sharply over the first 3 months and continued to decline throughout the follow-up period. ... However, highly adherent participants had significantly lower HIV drug risk scores at 3 months ..., but not 6 and 9 months. Depression remission was significantly associated with lower HIV drug risk scores at follow-ups" (p. 418). Stein and colleagues conclude that "[c]ombined psychotherapy and pharmacotherapy did not produce a significant reduction in HIV drug risk beyond that seen in an assessment-only control group. The greatest declines in HIV drug risk were found among participants with high protocol adherence and those with depression remission" (p. 418), but relatively few participants reported the remission of their depressive symptoms when follow-up measures were taken. It should, however, be noted that "[a] persistent treatment effect on HIV drug risk behavior did exist for women. There was a treatment by gender interaction effect through the follow-up periods" (p. 429).

## HIV Assessment News

***Psychiatric Assessment***

Uphold, Rane, Reid, and Tomar (2005) interviewed 226 men engaged in medical care and living with HIV in northern Florida or southern Georgia. Using two different methods to define and categorize area of residency – the U.S. Census Bureau classification and the Office of Rural Health Policy's Rural Urban Commuting Area Codes (RUCAs) – these investigators found that

> [r]**ural and urban men** of various age groups did not differ in socioeconomic factors, travel distance to clinics, use of medications, satisfaction with care, types of severe stressors, and confidentiality concerns. ... [These investigators also] found that rural men as compared to urban men had similar levels of total stress, AIDS-related stress, social support, active coping and avoidance coping, but higher rates of risk for **depression**[, even after controlling for demographic, clinical, and health-related factors]. Rural men had higher levels of non-AIDS-related stress only when the US Census Bureau's categorization was used. (p. 355)

More specifically, Uphold and colleagues "found a high rate of risk for major depression (i.e., 38%) in the total sample and an even higher rate (47%) in the rural subgroup, which markedly contrast ... with national estimates that 14% of primary care patients are at risk for major depression. ... The high rate ... supports the [recommendation] ... that HIV-infected patients, particularly those living in rural areas, need to be carefully screened for depression and treated if depression is detected" (p. 371).

To explore **factors underlying the depression experienced by people living with HIV/AIDS**, Australian investigators (Judd et al., 2005) used self-report symptom measures, a short battery of neuropsychological (NP) tests, and a structured clinical interview to evaluate 129 adults receiving HIV medical care. The investigators noted a high rate of depression among study participants, with 34.8% scoring above the cutoff score for depression on the Beck Depression Inventory (BDI) and 27% meeting *DSM-IV* diagnostic criteria for a current mood disorder. Importantly, Judd and colleagues did not discern depression secondary to, or associated with, the progression of HIV disease in this cohort. "As with medically well cohorts, [the investigators] found depression was associated with higher levels of neuroticism, a past history of psychiatric disorder and aspects of the current psychosocial situation. Family history and illicit drug use were also linked with the presence of depression. Specifically,... [there was] no significant evidence for a distinct subtype of 'organic' [or secondary] depression when [the investigators] tested for correlates between BDI scores and cognitive measures" (p. 830).

Judd and colleagues conclude that "at least for [medically] 'well' people living with HIV/AIDS, there is no distinct subtype of depression and early treatment approaches can be modelled on those used for ... non-HIV groups" (p. 826).

***Neuropsychological Assessment***

Richardson, Morgan, et al. (2005) evaluated the utility of the **HIV Dementia Scale** (HDS) as a screening tool for NP impairment with a sample of 40 adults living with HIV who also had *histories of psychiatric and substance use disorders.* This small sample was 65% male and 55% African American; the average age of participants was 41 years and the average educational level was 12.2 years. When the HDS was administered, "[40%] were identified as at high risk for significant cognitive-motor disorder (HDS total score $\leq$ 10). After controlling for age, education, illness (absolute $CD_4$), and depressed mood, [investigators found that] high-risk participants performed significantly worse on measures of simple and sustained divided attention, psychomotor speed, and working memory. However, only 25 of 40 (63%) were correctly classified based on their performance on traditional tests of [NP] functioning" (p. 1013). The investigators conclude that "the HDS may lack sufficient sensitivity as an independent screen for [NP] impairment, particularly among individuals that present with multiple and overlapping risk factors

for significant cognitive-motor deficits. Intact performance (i.e., above established cut off levels) contributed to a significant number of false negative errors, suggesting that a more complete [NP] test battery should be administered in cases in which subtle neurocognitive deficits are suspected or where multilayer risk factors for such deficits are present" (p. 1019).

Beginning in 1996, Italian investigators (Tozzi et al., 2005) monitored 412 individuals living with HIV and receiving highly active antiretroviral therapy (HAART) over an 84-month period to assess **the association between HIV-associated neurocognitive impairment and survival**. Within this cohort, 54.4% were neurocognitively impaired and 45.6% were neurocognitively unimpaired. At the same time, durable virological suppression under HAART was achieved by 63.3% of those who were unimpaired and by 49.6% of those who were impaired. Over this 7-year period, 47 deaths were recorded, 38 among those who were impaired and 9 among those who were unimpaired.

In their analysis of these data, Tozzi and colleagues "found that [neurocognitive impairment] was independently associated with reduced survival only among the patients experiencing virological failure, while the survival probability of patients with a durable virological suppression was not affected by [neurocognitive impairment]. An additional finding ... was that patients with [neurocognitive impairment] had a poorer virological response to HAART when compared with subjects without [neurocognitive impairment]" (p. 710). According to the investigators, these findings "highlight the importance of fully suppressive antiretroviral therapy in patients with HIV-related [neurocognitive impairment]. Second, since virological failure is common in clinical practice, being reported in 30-70% of patients, the assessment of cognitive function should be used in routine practice not only for its potential to reveal HIV-related [central nervous system] damage, but also for its association with reduced survival in ... patients .. with persistent viremia despite HAART" (p. 712).

## HIV Treatment News

### *Medical Care*

In recent years, scientists have shown that drug-resistant strains of HIV can be transmitted and that drug-resistant virus can reduce rates of virologic suppression when combination therapy is administered. **Genotype resistance testing**, when performed prior to the initiation of antiretroviral therapy, "can lead to selection of a more effective initial antiretroviral regimen and likely longer survival for patients who have drug-resistant virus" (p. 1320). Nevertheless, there has been a "hesitation to employ resistance testing for all individuals with new diagnoses ... [based on] multiple factors, most notably the cost of the test and the absence of controlled data showing that this testing strategy improves outcomes" (p. 1320). To explore this reasoning, Sax et al. (2005) modeled "the clinical impact and cost-effectiveness of genotype resistance testing for treatment-naive patients with chronic HIV infection" (p. 1316) in a hypothetical cohort of such patients and found that "the cost-effectiveness remained favorable through wide variations in baseline assumptions, including variations in genotype cost, prevalence of resistance overall and to individual drug classes, and sensitivity of resistance testing" (p. 1316). "On the basis of the available evidence, and considering both clinical benefits and costs," Sax and colleagues conclude that "genotype resistance testing should be performed for all patients with newly diagnosed HIV infection in the United States, with the results used to guide the choice of antiretroviral regimen when treatment is indicated" (p. 1322).

With regard to antiretroviral regimens, on October 28, the U.S. Food and Drug Administration (FDA)

> approved **a new formulation of Kaletra**. Kaletra (lopinavir/ritonavir) is now available as a film coated tablet (200mg/50mg) that provides advantages over the currently marketed capsule formulation for HIV-1 infected patients. Specifically, the tablet formulation: does not require refrigeration[;] can be administered without regard to meals[;] does not require dose adjustments for concomitant use with certain ... [antiretrovirals] in treatment-naïve patients[; and] has a decreased pill burden compared to the capsule formulation (2 tablets twice daily or 4 tablets once daily in treatment-naïve patients only vs 3 capsules twice daily or 6 capsules once daily in treatment-naïve patients only). (FDA, 2005)

To better characterize the severity and longevity of side effects associated with the use of **efavirenz** (EFV or Sustiva®), Clifford et al. (2005) conducted a randomized, controlled study involving 303 adults living with HIV, 200 of whom received regimens including EFV. The investigators found that recipients of EFV were more likely to discontinue their prescribed regimen because of neurological or psychological complications than those who did not receive EFV. Additionally, recipients of EFV reported more sleep disturbances and "bad dreams" during their first week on an EFV-based regimen than those not receiving EFV. Importantly, no significant differences in depression, anxiety, sleep disturbance, cognitive performance, or neurological symptoms were found between these two groups at weeks 4, 12, and 24. More than 80% of participants in *both* groups, however, re-

## From the Block

**Harlem United**

Harlem United Community AIDS Center, Inc., has been serving Central/East Harlem and the South Bronx communities of New York City since 1988. This nonprofit community-based organization has developed successful strategies for reaching individuals who are difficult to engage and retain in care. Services include adult day health care; scattered-site housing; food and nutritional services; intensive case management; prevention, education and policy services; and pastoral care and bereavement counseling.

With funding from CMHS/SAMHSA, Harlem United has been able to establish its Mobile Mental Health Program, a cross-agency service model designed to address the mental health needs of Black/African American and Hispanic/Latino(a) individuals living with HIV/AIDS and mental illness. Services include mental health and substance use assessments, crisis intervention, individual and family counseling, psychotherapy, support groups, psychotropic medication consultation/management, treatment adherence evaluation and support, and risk reduction education.

Mental health, substance use, and HIV services are provided to clients in their homes or in other low-threshold or nontraditional settings and are available whenever they are requested. By tailoring services to the needs of the individual, staff members at Harlem United are able to establish the trusting bond necessary to connect clients to care.

The long-term goals of the program are to keep clients engaged in services and to help them move toward higher threshold (i.e., office-based) services and on to recovery from mental illness and substance use, as well as better management of their HIV disease.

The Principal Investigator is Patrick McGovern; the Project Director is Matthew Rofofsky, CSW; and the Clinical Director is Michael Mendola, PsyD. For more information, please call 212/803-2850 or go to http://www.harlemunited.org/.

*– Compiled by the MHHSC Program Coordinating Center*

ported anxiety symptoms throughout the study. Clifford and colleagues conclude that their findings support

> current recommendations regarding [EFV] use: Transient, subjective neurologic effects are frequently experienced but are generally not severe, and forewarned patients may safely continue the drug and anticipate that the symptoms will resolve promptly. Initiation of any therapy for HIV infection, together with the stresses of living with a serious chronic illness, require[s] careful patient monitoring and support, including recognition of substantial anxiety and depression. [EFV], however, does not need to be avoided as a treatment for patients who are experiencing significant anxiety or depression. (p. 720)

***Psychiatric/Psychological/ Psychosocial/Spiritual Care***

Treatment Planning

Reece, McBride, Shacham, and Williams (2005) surveyed 102 providers of HIV-related mental health services working in the southeastern United States, the majority of whom were private practitioners. The survey was designed to solicit the perceptions of therapists regarding "the **minimum number of sessions** that they estimated to be **necessary for a person to return to a normal range of functioning**, without the use of psychotropic medications" (p. 77). Areas of interest included a range of mental health disorders (i.e., specific anxiety disorders, mood disorders, sexual and gender identity disorders, and other disorders) that providers had encountered while serving clients living with HIV and clients without HIV infection. Therapists were also asked their perceptions regarding therapy duration related to five HIV-specific mental health issues (receiving a new HIV diagnosis, HIV disclosure issues, reproductive decision-making, medical treatment compliance, and personal death and dying issues). "Across all mental health issues assessed, therapists indicated a greater need for therapy duration when an HIV diagnosis was also present, and this generally was consistent without regard to therapist education, demographics, or ... [theoretical] orientation" (p. 72).

> The absence of a large number of significant differences in duration estimates according to theoretical orientation suggests that these estimates may be more reflective of therapists' clinical experience and actual differences between populations, making the findings relevant to the diverse population of therapists who provide mental health care to clients living with HIV. Particularly, there are implications for therapists favoring models of brief treatment and those working in agencies with specific care guidelines. When developing realistic and appropriate treatment plans for clients living with HIV, special attention should be given to the complex nature of mental health issues and their impact on treatment timelines. (p. 82)

Reece and colleagues conclude that, "while this study's findings do not represent an absolute, they may be helpful for establishing clinical guidelines for publicly-funded agencies where program effectiveness is often measured through process-oriented deliverables such as number of counseling sessions provided and the extent to which providers are able to retain clients in care" (p. 83).

Neuropsychological Impairment
Richardson, Nowicki, et al. (2005) evaluated NP functioning in a cohort of 220 **women**, of whom 70 were hepatitis C (HCV)-positive/HIV-positive, 27 were HCV-positive/HIV-negative, 75 were HCV-negative/HIV-positive, and 48 were HCV-negative/HIV-negative. Test performance demonstrated that

> NP impairment was significantly higher for HCV-positive women in comparison with HCV-negative women ... [and w]omen co-infected with HCV and HIV demonstrated greater abnormal NP performance than those not infected with either ... . Women who were HCV-positive/HIV-positive and not taking antiretroviral therapy ... were more likely ... to demonstrate NP impairment than those who were HCV-negative/ HIV-negative. In analyses controlling separately for education, intelligence quotient, depression, sedating drug use, head injury, ethnicity, and history of substance use, HCV continued to significantly predict NP impairment. ... After testing for an interaction between age and infection status, ... [the investigators] conducted age-stratified analysis and showed a significant effect of infection status for those aged under 40 years. (p. 1659)

In closing, Richardson, Nowicki, and colleagues comment on the cross-sectional design of this study, which limits their conclusions "to the observation of a strong statistical association between NP function and HCV, ... [and the suggestion] that **the combined effect of HCV and HIV** is greater than either alone in terms of NP impairment" (p. 1665). Regarding the practical significance of these findings, the investigators point out that

> [t]he limitations found in speed of information processing requiring divided attention or set shifting have significant implications for impairment in performance of daily activities. The ability to concentrate, perform multiple tasks, and learn new information can lead to interference in driving, self care, employment, and adherence with therapy regimens for HIV and/or HCV. When co-infection occurs, ... [clinicians] should be especially sensitive to the possibility that the patient may be at increased risk of problems with treatment adherence. (pp. 1665-1666)

Adherence to Treatment
Wrubel et al. (2005) analyzed the responses of 71 maternal caregivers of **children living with HIV** to questions about the stresses involved in caring for these children. The purpose of this study was to examine "the **mothers' perspective** on medications and the interaction around giving or supervising medication in order to describe their **impact on adherence practices**" (p. 2431). The investigators found that "adherence practices were impacted in a positive way by mothers' commitment to adherence, and in a negative way by feelings of stigma and guilt, by the effects of bereavement on children and by children adopting their mothers' attitudes about medications. The interactive process of giving medication was shaped by children's behavior, mothers' developmental expectations for children, and, for mothers with HIV, their adherence for themselves" (p. 2423).

By approaching pediatric adherence "as an interactive process in which the life context of mothers' experiences, attitudes and feelings strongly impact their adherence practices for their children with HIV ..., [the investigators] were able to show that even aspects of adherence that seem discrete, like side effects, have a component of interactive significance[,] with mothers feeling emotional pain over having to force their children to do something aversive. For some mothers, this emotional pain led them to occasional non-adherence" (p. 2430).

Wrubel and colleagues suggest that their findings "point to promising avenues for intervention, such as addressing unresolved guilt over infecting one's child or changing expectations for child's responsibility for the regimen" (p. 2431). "The practice that appeared to support adherence was that of sharing the responsibility for the medications before adolescence.

## Tool Box
### Resources

Books & Articles:

Bien, M.B. (2005). Art therapy as emotional and spiritual medicine for Native Americans living with HIV/AIDS. *Journal of Psychoactive Drugs, 37*(3), 281-292.
"This article describes the intricate challenges of bringing mental heath services to isolated, guarded urban HIV-positive Native Americans suffering from chronic trauma-related illnesses and imbalances, depression, anxiety, substance abuse, thought disorders and trauma-based characterological disorders. It explores the integration of art therapy, Bowen Family Systems Therapy and in-home therapy in the .... attempt to provide support to a population that has profound distrust for 'services and treatment,' and no historical context for psychotherapy. Changing the paradigm of thought is essential to providing services that respect culture and history as well as addressing current presenting issues" (p. 281).

Cournos, F., McKinnon, K., & Sullivan, G. (2005). Schizophrenia and comorbid human immunodeficiency virus or hepatitis C virus. *Journal of Clinical Psychiatry, 66*(Suppl. 6), 27-33.
"Patients with schizophrenia are at significantly increased risk for infection with ...HIV ..., hepatitis C virus, or both. Several factors underlie this increased risk, including substance abuse and high-risk sexual behavior. ... Comorbidity of schizophrenia

... Possibly, as younger children grow into adolescence, the adherence practice of sharing responsibility for medication might evolve into the children['s] gradually assuming more and more of the responsibility themselves" (p. 2431).

Paradoxically, from a clinical perspective, the impact of *successful* pediatric adherence on the caregiving mother's well-being bears examination.

Seen from the point of view of the caregiving mothers' daily life experiences, consistent adherence often came at an emotional cost to those mothers. Even if mothers are fully committed, have resolved guilt feelings, and are not concerned with stigma, they may still have to deal with negative feelings twice a day over having to cause their children pain. They may have to suppress repeatedly their feelings of frustration, or, they may feel worn down by their children's repetitive resistance to taking the medications. In addition, these mothers' lives play out against a backdrop of the painful knowledge that their children have a potentially fatal illness. Persistent or recurring negative emotions could ultimately take a toll on the mothers' mental or physical well-being. The negative effect on mothers' well-being can, in turn, impact their children's depressive mood ..., families' quality of life ..., and, ... [quite possibly], mothers' adherence practices. (p. 2431)

How well *do* adolescents adhere to antiretroviral regimens? Murphy et al. (2005) assessed antiretroviral adher-

and life-threatening viral illnesses incurs a worse prognosis for both conditions. Nevertheless, effective pharmacotherapy exists, and antipsychotics and highly active antiretroviral treatments for HIV can be used together successfully. The clinical challenge is to encourage adherence to treatment and to coordinate the clinical services needed to address the diverse psychiatric and medical problems that coexist in this population" (p. 27).

Joseph, J., Stoff, D.M., & van der Horst, C. (Eds.). (2005). HIV/hepatitis C virus co-infection: Basic, behavioral and clinical research in mental health and drug abuse. *AIDS, 19*(Suppl. 3), S1-S237.
"Within the past two decades, hepatitis C virus (HCV) has emerged as the second major viral epidemic after HIV. ... The assembled articles in this special issue ... [have been organized] into five sections. These include: (i) vulnerable populations; (ii) neurocognitive and neuropsychological studies relating to HIV/HCV co-infection; (iii) neurological and neuropsychiatric complications of HIV/HCV co-infection; (iv) virological studies relating to HCV infection of the central nervous system (CNS); and (v) treatment, treatment services and prevention" (p. S3).

Raines, C., Radcliffe, O., & Treisman, G.J. (2005). Neurologic and psychiatric complications of antiretroviral agents. *Journal of the Association of Nurses in AIDS Care, 16*(5), 35-48.
This review highlights "the involvement of the CNS in HIV infection and in HAART regimens. It ... focuses on currently used drug combinations, their effectiveness in suppressing HIV infection in the blood and CNS, and their potential for causing neurologic, psychologic, and systemic complications" (p. 36).

Sacktor, N.C., Wong, M., Nakasujja, N., Skolasky, R.L., Selnes, O.A., Musisi, S., Robertson, K., McArthur, J.C., Ronald, A., & Katabira, E. (2005). The International HIV Dementia Scale: A new rapid screening test for HIV dementia. *AIDS, 19*(13), 1367-1374.
The International HIV Dementia Scale "does not require knowledge of the English language, can be performed briefly in 2-3 min by non-neurologists in an outpatient setting, and requires no special instrumentation other than a watch with a second hand" (pp. 1371-1372). Individuals found to be at risk for HIV dementia through this screening test should be offered "[f]ull neuropsychological testing ... to confirm a diagnosis of HIV dementia" (p. 1367).

Sprouse, D.S., Ogletree, S.L., Comsudes, M.M., Granville, H.G., & Kern, R.M. (2005). An Adlerian model for alliance building. *Journal of Individual Psychology, 61*(2), 137-148.
"Alliance building within a brief therapy context is a topic rarely addressed in Adlerian research. The Creating Alliance using BASIS-A Linking Early Recollections (CABLE) model was used with an urban, HIV-positive population in a major city located in the southeastern United States. The model, which uses the BASIS-A Inventory ..., is illustrated with a case study" (p. 137).

Tobias, C., Brown, K., Rajabiun, S., Drainoni, M.-L., & Young, S.R. (2005). *A Kaleidoscope of Care* for HIV-infected substance users. *Journal of HIV/AIDS & Social Services, 4*(2), 27-43.
"*A Kaleidoscope of Care* is a cross-disciplinary curriculum in HIV and substance use, designed to train HIV health care and substance abuse treatment professionals in providing better care to the clients they share in common. It applies adult learning principles to engage diverse professionals in building skills to promote health and adherence, engagement and retention in care, harm reduction, and interdisciplinary collaboration. Early evaluation of the curriculum indicates that it has enhanced knowledge and built skills in serving HIV-infected substance users among providers from multiple disciplines" (pp. 27-28). To download this curriculum, go to http://www.hdwg.org/projects/hivtac.htm.

Internet Resources:
The National Alliance of State & Territorial AIDS Directors (NASTAD) collaborated with the American Psychological Association (APA) Office on AIDS to develop a July 2005 "mental health issue brief" entitled "HIV and mental health: The challenges of dual diagnosis." Profiles of programs in California, Colorado, and Rhode Island, as well as resource listings, are included in this brief, located at http://www.nastad.org/documents/public/NASTAD_Mental_Health_final.pdf.

*– Compiled by Abraham Feingold, Psy.D.*

ence at 3-month intervals in a cohort of 231 **adolescents** from 13 cities throughout the United States who were living with HIV. Study participants were largely female (72.7%) and African American (74.9%); their average age was 18.4 years. The investigators found that,

> [a]t the initial visit, approximately 69% of the adolescents reported being adherent to antiretroviral therapy. Adolescents in the later HIV disease stage were less likely to be adherent compared with those in the earlier disease stage. Less alcohol use and being in school were associated with adherence by adolescents on weekends and over the preceding month. Longitudinal adherence was investigated among 65 subjects initially adherent with available information for at least 4 consecutive visits. The median time to nonadherence was 12 months, and failure to maintain adherence was significantly associated with younger age and depression. Among adolescents who attained an undetectable viral load, only about 50% maintained an undetectable viral load for the year. (p. 764)

Drawing on these disturbing findings, Murphy and colleagues characterize the types of interventions that may promote antiretroviral adherence among adolescents.

> [I]ntervention should include assisting adolescents in problem-solving issues concerning substance use and lowered adherence. This may include teaching them to plan their medication-taking schedule for times when they will not be drinking and/or using drugs, or referral to substance use treatment for those adolescents with problematic levels of use. In addition, intervention should include teaching adolescents to maintain a consistent schedule during the week to assist in facilitating adherence. Moreover, adolescent patients with advanced HIV disease are likely to need more intervention support than do patients in an earlier disease stage. Finally, many adolescent patients may need intervention that focuses on dealing with depression over time. Patient-level intervention, health care provider-level interventions, and health care system modification may all be necessary if the challenge of antiretroviral medication adherence by adolescents with HIV is to be successfully surmounted. (p. 769)

Speaking specifically to the treatment of depression, Murphy and colleagues note that,

> [i]n the past, adolescents have had a relatively poor response to antidepressants that are typically efficacious with adults. ... However, the Treatment [for] Adolescents [With] Depression Study[3] ... has recently compared fluoxetine, cognitive behavioral therapy, a combination of both, and a placebo medication – the first comparison in adolescents – and found support for antidepressant therapy with adolescents, especially when combined with cognitive behavioral therapy. Thus, there are now better avenues of treatment for adolescent depression. Adolescents being considered for ... HAART should be screened for depression. Those who are depressed may need both treatment for depression as well as interventions to assist them in adhering to their new treatment regimen for successful long-term adherence. (pp. 768-769)

Adolescents, children, and their caregivers are not the only subpopulations in need of assistance with adherence. Kalichman, Cherry, and Cain (2005) designed a two-session-plus-one-booster-session approach to supply a nurse-delivered HIV treatment adherence intervention for antiretroviral users with **lower health literacy**. The intervention, which was pilot tested with 30 men and women living with HIV,

> succeeded in delivering [pictographic] educational information about HIV disease processes and medication mechanisms, and increased knowledge was retained over a 3-month period. In addition, the intervention was delivered in a motivational interviewing style that may have contributed to increases in intentions to adhere to medication schedules. The intervention sessions also delivered focused and interactive behavioral skills-building activities that likely resulted in the observed increases in medication adherence self-efficacy. In addition, ... the ... intervention reduced the number of nonadherence events that occurred over the follow-up period. These findings ... converge to suggest that a brief two-session plus one booster session nurse-delivered counseling intervention may have a substantial benefit for medication adherence among people living with HIV who have lower health literacy skills. (pp. 13-14)

Encouraged by the results of this small pilot study, Kalichman and colleagues believe that further research on this intervention is warranted.

Coping, Social Support, & Quality of Life

Henderson, Safa, Easterbrook, and

[3] Treatment for Adolescents With Depression Study (TADS) Team. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association, 292*(7), 807-820.

Hotopf (2005) assessed an ethnically diverse sample of 148 individuals receiving HIV medical care in south London. They found that 65% experienced **fatigue**, which was associated with "[s]ignificant psychological distress ..., functional impairment ... and a higher CD4 count" (p. 347). Importantly, the presence of fatigue was "most strongly associated with psychological factors and not with more advanced HIV disease or the use of [HAART]" (p. 347).

> The strong association between psychological distress and markers of quality of life has implications for the clinical management of fatigue in HIV-infected patients. Firstly, it suggests that <u>the symptom of fatigue should elicit not only a search for physical mechanisms, but also detailed questioning about depression and anxiety</u>. Secondly, the high rates of psychological distress described here suggest that a proportion of patients ... may benefit from specific interventions such as <u>antidepressant medication</u>, which <u>may also improve fatigue</u>. Thirdly, there is growing evidence that <u>nonpharmacological treatments such as cognitive behaviour therapy and graded exercise therapy are effective in the treatment of medically unexplained fatigue</u> occurring in chronic fatigue syndrome ... . <u>Such treatments aim to help improve functioning by giving patients strategies for managing fatigue</u>. Given the high prevalence, and apparently serious consequences for functional capacity, of fatigue in individuals with HIV infection, there is a need for further evaluation of these interventions in the HIV-infected patient population. (p. 350)

In France, Funck-Brentano et al. (2005) monitored 30 perinatally HIV-infected adolescents (between the ages of 12.0 and 17.4 years) receiving care in a Paris clinic over a period of 2 years: 10 who agreed to participate in **supportive group therapy** (group 1), 10 who declined participation (group 2), and 10 who lived too far from Paris and were not invited to participate (group 3). The psychodynamically oriented group therapy met in 90-minute sessions once every 6 weeks for 26 months.

> At baseline, the three groups had similar characteristics overall. ... After 2 years, worries about illness had decreased in group 1, whereas the scores had increased or remained the same for the other adolescents ... . The adolescents in group 1 had less negative perception of treatment at 2 years than those in groups 2 and 3 ... . After intervention, the percentage of adolescents with an undetectable viral load had increased in group 1 from 30 to 80% ($P$ = 0.063) but was unchanged in groups 2 and 3. Considering the three groups altogether, the decrease in ... viral load correlated with improvement ... [in perceptions of HIV treatment]. (p. 1501)

As Funck-Brentano and colleagues see it, "[t]his pilot study suggests that the <u>peer support group [therapy] had a beneficial effect on the adolescents' acceptance and perceptions of their HIV infection</u>. The findings even suggest that this improvement in well-being could have a positive influence on biological variables" (p. 1506).

On this point, Ashton et al. (2005) looked at **satisfaction with social support** and **the use of maladaptive coping strategies** (specifically, mental disengagement, behavioral disengagement, and the venting of emotions) **as predictors of HIV-related health symptoms** in a sample of 65 primarily low-income men and women living with HIV/AIDS who were diverse with regard to gender, ethnicity, and sexual orientation. Coping strategies, social support satisfaction, and HIV-related health symptoms were assessed at baseline; HIV-related health symptoms were reassessed at 3, 6, and 12 months following the baseline measurement. Ashton and colleagues found that

> even after controlling for baseline CD4 T cell count and number of HIV-related physical health symptoms, participants' use of venting as a strategy for coping with HIV stress predicted greater increase in HIV-related physical health symptoms during the next year. ... [They] also found that when satisfaction with social support was considered, this overshadowed venting as a significant predictor of change over the next year in the number of HIV-related physical health symptoms, with more satisfaction predicting greater decline in number of physical health symptoms. (p. 596)

The investigators are quick to point out that "[a]dditional factors not examined in this study such as antiretroviral treatment adherence, regular follow-up and preventive care clinic visits, recreational drug use, and sexual risk behavior may be affected by poor coping and in turn cause a faster increase in physical health symptoms" (p. 596). Despite these limitations, Ashton and colleagues conclude that the results "are consistent with the possibility that the use of maladaptive coping strategies and satisfaction with social support affect HIV disease progression. These results build on those of <u>a growing number of studies that suggest that interventions to improve social support and coping strategies can promote better health</u>" (p. 596).

Tarakeshwar et al. (2005) conducted semistructured interviews with a con-

## Tool Box

### Men Misunderstood: Straight Talk About HIV & Depression

*"The tendency for women to signal distress and to expose their need for help or support seems to be inversely matched by men's internalized avoidance of, or aversion to, showing signs of weakness or vulnerability. Thus, gender differences in depression appear to lie not in the 'experience' of depression per se (both men and women experience depression similarly), but in the 'expression' of depression. What men 'do' has (unfortunately) been associated with 'men behaving badly' ... rather than associated with men being depressed."*

— Brownhill, Wilhelm, Barclay, & Schmied, 2005, p. 928

Over the past decade, portions of edited volumes (e.g., in Good & Brooks, 2005; in Pollack & Levant, 1998), and even entire books (Cochran & Rabinowitz, 2000), have been dedicated to "the problem of undiagnosed and untreated depression in men" (Cochran & Rabinowitz, 2003, p. 132). Particular emphasis has been placed on "[d]epression in men [that] seems to be hidden in antisocial and risk-taking behaviours[,] including drug and alcohol abuse, deliberate self-harm, suicide, road rage, sexual encounters, gambling, binge drinking, aggression and violence[,] often referred to as 'depressive equivalents' or 'masked depression'" (Brownhill, Wilhelm, Barclay, & Schmied, 2005, p. 926). Furthermore, "constrained emotional distress ... is likely to make depression even more difficult to detect or measure in men because of its latent or arbitrary nature beyond the '2-week' period established by DSM-IV criteria ..." (Brownhill, Wilhelm, Barclay, & Schmied, 2005, p. 927).

On the HIV front, in recent reports that evaluated depressive symptoms in gay and heterosexual men living with HIV who were African American (Coleman & Hummel, 2005) or Chilean (Vera-Villarroel, Pérez, Moreno, & Allende, 2004), *heterosexual* men were found to have higher levels of depressive symptoms than their gay counterparts.

In another recent report, investigators in London (Orr, Catalan, & Longstaff, 2004) conducted a retrospective case-controlled study and found that heterosexual men who engaged in HIV primary care services were "almost three times less likely to be referred for specialist mental health care than HIV-positive gay men" (p. 592) and "were less likely to be given a diagnosis of a depressive illness, but ... were more likely to have a substance misuse diagnosis" (p. 592). Of note as well was the finding of "no differences ... in terms of problems and social difficulties except, rather surprisingly, that heterosexual men, who are HIV-positive, had more problems with bereavement than gay men" (p. 592).

In discussing the differential pattern of referral, Orr and colleagues point to the large proportion of black African heterosexual men in this study. The investigators suggest that "it is possible ... that differing social and cultural expectations of the roles of doctors and patients will influence the presentation of psychological distress, and adverse emotional experience, leading to different interpretations on the part of medical practitioners" (p. 593) and, presumably, different types of referral. An alternative explanation hinges on the presentation of "depressive equivalents" (i.e., substance misuse) that medical practitioners accepted at face value, even among men experiencing problems with bereavement.

Because "depression in men can often be hidden, overlooked, not discussed or 'acted out'" (Brownhill, Wilhelm, Barclay, & Schmied, 2005, p. 921), "efforts to enhance clinicians' sensitivity and skills in assessing and treating depression in men are warranted" (Cochran & Rabinowitz, 2003, p. 132).

*"[C]ultural prohibitions placed on men against the experience of mood states directly related to depression (e.g., sadness) and the behavioral expression of these mood states (e.g., crying) make clear and simple descriptions of male depression difficult ... . Furthermore, racial, ethnic, and social class norms concerning emotional expression add to this difficulty."*

— Cochran & Rabinowitz, 2003, pp. 132-133

**Knowing Depression When You See It**

Although the primary symptoms and eventual course of depression are similar in both men and women, a number of researchers have identified important masculine-specific modes of experiencing and expressing depression. ... Many of these ... modes ... do not conform to criteria used to diagnose depression detailed in the *DSM-IV* ... . In general, these masculine-specific features of depression are consistent with a tendency for men to use externalizing defenses ... , to engage in ruminative responses that may lead to alcohol abuse ... , and to express irritation, anger, and withdrawal in response to narcissistic vulnerability or injury ... . These externalized symptom clusters may be the outward manifestations of a covert or hidden mood disorder in men sometimes referred to as *masked depression* ... . When a clinician

venience sample of 28 women living with HIV who had experienced **childhood sexual abuse** (CSA) for the purpose of "examin[ing] the challenges and coping strategies related to CSA among women and the impact of their HIV diagnosis on these coping strategies. ... [The investigators] also asked the women whether they perceived a connection between their CSA and their HIV infection" (p. 666).

The interviews revealed that CSA raised challenges in four areas: disclosure of the abuse, sexual problems, relationship difficulties, and psychological distress. The women used two strategies to cope with their CSA: illicit substances to numb their emotional distress and sexual activity, and alienation to gain control in relationships. When diagnosed with HIV, the women initially coped with their illness by using these two strategies. The women re-

encounters any of these symptoms in a male client, she or he should carefully assess for the presence of a coexisting mood disorder. (Cochran & Rabinowitz, 2003, p. 133)

Defining depression broadly to encompass "the full range of depressive disorders as well as the spectrum of emotions including grief and sadness that are often triggered by loss" (p. 132), Cochran and Rabinowitz (2003) offer the following **guidelines for the gender-sensitive assessment of depression in men**:

**Review established *DSM-IV* criteria for major depression.** "Men who meet formal diagnostic criteria ... for depression exhibit the following symptoms, in descending order of frequency: (a) dysphoria, (b) thoughts of death, (c) appetite disturbance, (d) sleep disturbance, (e) fatigue, (f) diminished concentration, (g) guilt, (h) psychomotor change, and (i) loss of interest in typical activities ..." (Cochran & Rabinowitz, 2003, p. 133).

**Evaluate *masculine-specific* modes of experiencing and expressing depression** "derived from empirical reports, qualitative inquiry, and clinical case reports" (Cochran & Rabinowitz, 2003, p. 133). These can include:

- o An increase in conflict/anger in interpersonal relationships (substituting for sadness), with expression ranging from social withdrawal to violence;
- o An increase in the use of alcohol/mood-altering substances as a form of self-medication;
- o An increase in somatic complaints (e.g., headaches, digestive disorders, and chronic pain; Rochlen, Whilde, & Hoyer, 2005, p. 189);
- o A decrease in concentration and motivation tied to school, employment, or leisure activities;
- o An increase in worries over productivity and level of functioning in school or work;
- o A decrease in sexual interest *without* a corresponding decrease in sexual activity; and
- o An increase in the tension between gender-role-related expectations and performance, particularly with regard to emotional expression and conflict between commitments to work and family.

**Assess culturally salient features of depression.** These often include:

- o Familial norms and expectations related to the expression of emotions;
- o Cultural norms related to the expression of depressive affect; and
- o Within-group (e.g., social class) expectations related to the expression of depressive affect.

**Assess and manage the risk of suicide**, including:

- o Client's level of ideation, the specificity of plans, the availability of means, and the intention to act;
- o Client's capacity for self-control and his ability to cooperate with the therapist; and
- o The strength of environmental supports (e.g., family, friends, employer, therapist) in comparison with conditions exacerbating suicidality (e.g., relationship conflict, drug or alcohol use).

Cochran and Rabinowitz (2003) conclude that "[a] clinician using gender-sensitive assessment strategies ... will be more likely to detect depression ... by linking ... anger, hostility, alcohol use, concern with work performance, and isolation to the client's mood disturbance. Moreover, careful history and evaluation of symptoms will frequently reveal a more complete symptom picture, including sad mood, tearfulness, sleeping difficulties, withdrawal, and suicidal thoughts" (p. 135).

*"[C]linicians who can appreciate the contribution of gender role socialization to men's cognitive distortions will be better able to understand contributing factors to men's presenting problems, respond more empathically to their male clients, and anticipate the types of messages male clients internalize that may contribute to their depression, anxiety, and rigid self-defeating interpersonal relationships ... . Such gender informed interventions might help reduce gender role strain in clients, and break some of the connections between societal gender role stereotypes and men's feelings of adequacy and self-worth."*

— Mahalik, 1999, p. 339

**Empirically Supported & Innovative Interventions**

When depression is detected, Cochran and Rabinowitz (2003) advise clinicians to employ "empirically supported treatments as well as innovative psychotherapies developed specifically for men[, as these approaches] show great promise in treating depression in men" (p. 135). While granting that group therapy and marital/couples therapy are modalities that have a place in the clinician's treatment repertoire during work with men who are depressed, Cochran and Rabinowitz focus their recommendations on models for individual psychotherapy. Two empirically supported individual psychotherapeutic interventions for mild-to-moderate unipolar depression that they highlight are **cognitive-behavioral therapy** and

(Tool Box is continued on Page 12)

ported that, over time, they were able to accept their HIV illness, seek social support, find alternative sources of significance, and use spirituality to sustain their growth. However, they continued to suffer psychological distress related to their sexual trauma. Further, most of the women did not perceive any connection between the two traumas. (pp. 655-656)

When women were able to identify a connection between the traumas, however, they

were able to integrate the psychological impact of their sexual trauma with their lifestyle that placed them at risk for HIV infection. For women who are to cope with the traumas of sexual abuse and HIV infection, such an understanding can help them identify aspects for their life that need attention (e.g., increasing self-

worth, having relationships with men) and process the ways ... [these traumas have] impacted or continue ... to impact their everyday life. Further, this has implications for HIV secondary prevention interventions, which assume that women have the power to enforce preventive measures such as condom use. ... [These] findings suggest that for those who have suffered from sexually traumatic experiences, this assumption is questionable. (p. 667)

Tarakeshwar and colleagues discuss the implications of their findings at length:

First, they highlight the significance of the setting and the manner in which women are informed of their HIV status. As such, <u>women diagnosed with HIV who also report a sexual abuse history can be provided with appropriate resources to help them recognize healthier patterns of cop-</u>

(Tool Box -- continued from Page 11)

**interpersonal therapy**; each was found to work equally well with men and women. They also describe three innovative, gender-sensitive, masculine-specific treatment approaches. These include:

o **Mahalik's cognitive-behavioral approach** (1999), which

> integrates aspects of masculine gender role strain into a description of maladaptive cognitions that a therapist would expect to encounter when working with depressed men. ... The [cognitive] distortions Mahalik proposed (e.g., "I must be successful to be happy and fulfilled" or "If I can't do it myself, people will think I'm inept") relate specifically to men's vulnerability to episodes of depression when certain gender role expectations are not fulfilled. ...
>
> This approach focuses on a review of the validity of each masculine-specific cognitive distortion, a weighing of the costs of the distortion in terms of emotional health, and development of a behavioral strategy designed to challenge the validity of the distortion. Because cognitive-behavioral approaches to treating depression have been verified as effective with men, the benefit of a perspective that is sensitive to the masculine gender role is likely to enhance the effectiveness of this particular approach. Although untested as a specific component of therapy, the gender role strain from which these cognitive distortions are assumed to arise has been related in a number of empirical investigations to increased levels of both depression and psychological distress .... (Cochran & Rabinowitz, 2003, p. 135)

o **Pollack's psychodynamic/self-psychology model** (in Pollack & Levant, 1998), which

> focuses on identifying and working through present-day derivatives of a discontinuity in a man's early childhood emotional "holding environment." This discontinuity, derived from a cultural tendency to eschew dependency and maternal connection in little boys, produces a masculine-specific vulnerability to relational abandonment and narcissistic wounding. Current-day life experiences of loss, rejection, or abandonment recapitulate this early experience of loss and thus render a man vulnerable to feelings of abandonment and the development of an acute depressive episode. In utilizing this approach, a gender-sensitive therapist would work with a male client toward repairing this underlying vulnerability to abandonment depression by providing a sustained therapeutic holding environment in which the male client can develop and strengthen his own capacity for self-soothing while integrating split-off or repressed experiences of grief. (Cochran & Rabinowitz, 2003, p. 135)

o **Cochran and Rabinowitz's psychodynamic/self-psychology model** (2000), which

> emphasize[s] how men are culturally programmed to repress the affective aspects of loss experiences. Gender-sensitive therapists utilizing this model would work with a male client to identify these frequently repressed experiences of loss that have accumulated across the life span. Some common experiences of loss include early maternal disconnection, boyhood experiences of rejection by peers on the playground, experiences of rejection and loss in relationships, failure in occupational achievement, and loss of physical health due to the aging process. This particular conceptualization of psychotherapy with men allows for an expanded view of loss (beyond interpersonal loss or bereavement) that encompasses loss experiences of men at all stages in the life span and of all sexual orientations and cultural backgrounds ... .
>
> Often, men may find that historical experiences of loss resonate with a current triggering event. If left unresolved, accumulation of these losses may render a man vulnerable to a full-blown depressive episode. Empathic responding to these experiences of loss may help identify the source of a depressed mood and lay the groundwork for more adaptive ways to manage depressed moods. (Cochran & Rabinowitz, 2003, p. 136)

*"[S]ome men who are depressed can experience a trajectory of emotional distress manifest in avoidant, numbing and escape behaviours which can lead to aggression, violence and suicide."*
— Brownhill, Wilhelm, Barclay, & Schmied, 2005, p. 921

**<u>Taking Control ("in a tragically masculine fashion")</u>**[1]

According to Cochran and Rabinowitz (2003), "[m]anagement of suicide risk in depressed men is a significant issue for therapists who treat men for depression" (p. 138).

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[1] Cochran & Rabinowitz, 2003, p. 137

ing much earlier in the course of their illness. Second, assessments of sexual abuse among women who have HIV are important and should be part of routine diagnostic interviews when women test for HIV serostatus. ... Third, given that women are more likely to seek health care for their HIV disease ... than sexual abuse, HIV health providers could be ideal points of triage for identifying women who have experienced sexual abuse and making appropriate referrals. Finally, given that HIV is now a manageable chronic disease, addressing the ways women who have HIV cope with distress related to sexual trauma becomes important, especially for sustaining successful management of their HIV illness and from a public health perspective, preventing further transmission of HIV infection. ... [This] study's findings indicate that even if medications are available for women who have HIV, those who have experienced sexual abuse may continue to suffer from psychological distress related to their sexual trauma. Consequently, their ability to adhere to HIV secondary prevention treatment may be affected ... .

... [These] results also inform potential topics for psychological interventions with women who have HIV and a history of CSA. The finding that the HIV diagnosis intensified their feelings of powerlessness, betrayal, and victimization, and that CSA continued to be a source of distress despite adaptive coping with HIV infection underscores the importance of attending to sexual abuse among HIV-infected women. Such attention includes validating the women's experiences of sexual abuse, raising awareness of the emotions and coping patterns triggered by their abuse and other traumatic experiences in their life, and examining ways that these emotions and coping patterns may be linked to their HIV risk behaviors and their current functioning. ... [This is not to suggest] that there is a causal relationship between CSA and HIV infection – only that the sexually abusive experiences increase vulnerability to HIV infection. Further, as the physical health of these women is intertwined with their psychological well-being, attention should be given to the ways the women are managing their HIV infection and related stressors (e.g., side effects, financial problems) and

[M]**asculine-specific risk factors for suicide in men** ... have been identified in various empirical studies of attempted and completed suicides. These include active alcohol or drug abuse, a coexisting antisocial personality disorder, and a co-occurring psychiatric disorder (schizophrenia, panic disorder, or major depression). In addition, a family history of conduct disorder, sexual abuse, violence, or suicide further increases suicide risk. Finally, in older men, physical illness is a significant risk factor for suicide. Any male client who is being treated for depression and who fits into any of these categories should be considered at increased risk for suicide.

Even though a male client may deny ongoing suicidal ideation or intent, if he fits into any of these empirically derived categories of elevated risk, responsible risk-management strategies should be considered. Typical **risk-management strategies** may include removal of the means for committing suicide, increase in frequency of sessions, practical strategies for increasing client tolerance for depressed mood, elimination of influence of alcohol or other drugs that reduce impulse control, activation of external support systems that might include family members or friends, and psychiatric consultation with the option of brief hospitalization. Applied in the context of a strong therapeutic alliance, one or more of these strategies may ultimately make the difference between life or death for a male client who is suffering a severe depression and who may be contemplating ending his life by committing suicide. (Cochran & Rabinowitz, 2003, p. 137)

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*– Compiled by Abraham Feingold, Psy.D.*

connecting them with the appropriate resources. The remarks made by women who identified a link between their sexual trauma and HIV infection make ... it necessary for interventions to examine the power held by women in their relationships ... , especially to enforce HIV prevention such as condom use. The study's findings also raise our attention to the resilience displayed by these women in the face of trauma. Interventions must explore resources, such as their spirituality and their social support, that provide the motivation, strength, and support to find alternative sources of significance and help women to sustain them. Perhaps integrated medical and mental health treatment for individuals who are living with HIV provides us an opportunity to intervene and facilitate positive growth. (pp. 668-669)

To evaluate "**an interpersonal model of depression symptom trajectories tailored to the experiences of women with HIV**" (p. 678), Milan et al. (2005) "examined how bereavement, maternal role difficulty, HIV-related social isolation, and partner conflict predicted change in depressive symptoms over 5 years in 761 women with HIV, controlling for sociodemographic and clinical health factors" (p. 678). Milan and colleagues found that more than half of the women sampled reported heightened depressive symptoms when compared with the general population, and that there was little change *at the group level* in these symptoms over this 5-year study period. Among the women who reported a significant change in depressive symptoms over that time, partner conflict was the strongest predictor of this change of the four interpersonal factors studied.

Reflecting on this finding, Milan and colleagues observe that

> [p]artner conflict may have a particularly strong impact on mental health in women with HIV because the disease influences women's physical, economic, and social needs ... and therefore may increase their vulnerability or dependence within relationships. In addition, HIV can alter the nature of partnerships. As examples, HIV may change the sexual relationship between a woman and her partner, influencing this mode of intimacy. For HIV-concordant couples, the disease may be associated with blame or may be a shared experience resulting in additional social support. Finally, positive HIV status may lead some women to remain in a conflictual relationship because they believe the disease limits options for alternative partners. (p. 686)

Although the investigators are careful to note that "the magnitude of effects was not large and the practical significance of results cannot be determined without more treatment outcome research focusing on women with HIV," (p. 686), they suggest that these findings

> highlight the potential utility of therapies with an interpersonal focus ... and the importance of focusing on current relational issues, particularly the quality of intimate relationships. This might be accomplished by incorporating topics such as conflict resolution, communication skills, or anger management into therapy modalities often used to treat depression, in a manner that is culturally appropriate. Women in longer term relationships may also benefit from dyadic approaches. In addition, because partner conflict was associated with worse outcomes regardless of initial depression levels, offering such programs in settings other than mental health facilities (e.g., medical clinics, social service agencies) for women with HIV who are not currently depressed

## From the Block

**Milwaukee Health Services, Inc.**

Milwaukee Health Services, Inc. (MHSI), was founded in 1989 as the Isaac Coggs Health Connection by community leaders seeking to provide primary health care services for the African American population on the north side of Milwaukee's inner city. As a Federally Qualified Health Center, MHSI today offers medical (adult and pediatric), dental, behavioral health, benefits assistance, and pharmacy services.

With funding from CMHS/SAMHSA, MHSI's Behavioral Health Services Center (BHSC), in partnership with the AIDS Resource Center of Wisconsin (ARCW), has expanded mental health service delivery to African American and Hispanic/Latino(a) clients living with HIV in southeastern Wisconsin. ARCW, established in 1985, is the largest provider of HIV prevention and treatment services for people with HIV/AIDS and their families in Wisconsin.

The partnership between BHSC and ARCW has augmented the resources of each program. Services for this initiative may be accessed at the Isaac Coggs Health Center and at ARCW locations in Milwaukee and Kenosha. Services include individual, couple/family, and group therapy, as well as psychiatric evaluation and medication management. Clients may also be referred to case management services and/or primary and specialty medical care.

The Principal Investigator/Project Director is Michael Bell, MD; the Clinical Director is Gary Hollander, PhD. For more information, please call 414/286-8886 or go to http://www.mhsi.org/.

*– Compiled by the MHHSC Program Coordinating Center*

may have preventive benefits. (p. 686)

Altering depression symptom trajectories experienced by women living with HIV may have additional benefits. Evans et al. (2002) studied 63 HIV-positive and 30 HIV-negative women and found an **association between depression** in the women who were living with HIV **and alterations in** two components of innate cellular immunity: **natural killer** (NK) **cells** and CD8 T lymphocytes. Findings "suggest that depression may decrease [NK] cell activity and may lead to an increase in activated CD8 T lymphocytes and viral load" (p. 1757). For reasons such as these, depression has been associated with more rapid HIV disease progression.

More recently, this research team (Cruess et al., 2005) extended this work through a 2-year study of 57 women living with HIV for whom these investigators had "complete NK cell activity and depression data measured at two time points" (p. 2125). "Among the 57 HIV-seropositive women, improvements in the diagnostic status of depression and decreases in ... [depressive symptomatology] were significantly associated with increases in NK cell activity over time ... . Eleven women (19.3%) had a major depression diagnosis that resolved over time, and this group also had a significant increase in [NK] cell activity ... during this period" (p. 2125).

Referencing their earlier work, Cruess and colleagues conclude that these findings

> provide the first evidence that resolution of major depression is associated with significant increases in NK cell activity over time in HIV-seropositive women. These results extend previous findings demonstrating depression-associated decrements in NK cell numbers and function and suggest that these alterations are reversible with the resolution of the depressive episode. Increasing evidence suggests that depression may have a negative impact on the progression of HIV disease, and chronic depression has been associated with mortality in HIV-seropositive women. Given the role that innate immunity plays in the host's defense against HIV infection, further studies assessing antidepressant treatment effects could shed light on the relationship and underlying mechanisms of depression, immunity, and the progression of HIV disease. (p. 2129)

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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 information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

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

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

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