mental health AIDS

A Quarterly Update from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) Volume 8, Issue 3 – Spring 2007

Biopsychosocial Update

HIV Prevention News

About Women & Men

Herbst et al. (2007) conducted a systematic literature review and meta-analysis to determine

> the overall efficacy of **HIV behavioral interventions** designed to reduce HIV risk behaviors or incident sexually transmitted diseases (STDs) among **Hispanics residing in the United States or Puerto Rico**. Data from 20 randomized and nonrandomized trials (*N* = 6,173 participants) available through January 2006 were included in this review. Interventions successfully reduced the odds of unprotected sex and number of sex partners, increased the odds of condom use, and decreased the odds of acquiring new STD infections. Interventions successful in reducing the odds of any sex risk behavior used non-peer deliverers; included ... 4 [or more] intervention sessions; taught condom use or problem solving skills; or addressed barriers to condom use, sexual abstinence, or peer norms. Interventions that included the Hispanic cultural belief of *machismo* or those developed based on ethnographic interviews [with the target population to guide the development of intervention content] were successful in reducing the odds of sex risk behaviors among non-drug users. Interventions targeting ... [injecting] drug users (... *N* = 3,569) significantly reduced the odds of injection drug use and the odds of sharing cotton or cookers, but did not significantly reduce the odds of engaging in risky sex behavior or needle sharing. (p. 25)

Herbst and colleagues suggest that "these findings have the potential to inform future HIV prevention planning and intervention development for Hispanics living in the US and Puerto Rico" (p. 27).

About Women

Klein, Elifson, and Sterk (2007) interviewed 250, primarily African American, women "at risk" for HIV infection and living in metropolitan Atlanta, Georgia, "to explore the relationship between **childhood neglect experiences**, self-esteem, attitudes toward condom use, and involvement in HIV-related risky behaviors" (p. 39). "Among the most ... important findings ... are those pertaining to the specific role that childhood neglect experiences play in adversely affecting the outcomes studied. As hypothesized, being neglected led to diminished self-esteem, adhering to more negative attitudes toward condom use, and involvement in a greater number of HIV-related risk behaviors" (p. 48).

The investigators speculate that

> [o]ne of the uniquely harmful aspects of being neglected is the implied message that one does not matter, that one's needs – like oneself – are insufficiently important to be attended to. In situations of neglect, the people who ordinarily would discipline or take care of the child simply do not care enough about that person to invest the physical or emotional energy required to interact with him/her. ... By being treated in a manner that conveys no sense of mattering to others and no sense of worth, many neglected persons fail to develop any true sense of self-esteem (i.e., neither poor nor good self-esteem is developed, since the person becomes disinclined to think in terms of him/herself) and, therefore, invest no value in themselves or their futures. Under such circumstances, it is entirely foreseeable that ... such persons would think of condoms in a negative way, that they would engage in high rates of risky behaviors, and so forth. To them, taking risks and the future are, ostensibly, irrelevant. For such persons, having sex with someone or engaging in other types of risky behavior may be a way of

In This Issue:

Biopsychosocial Update
- HIV Prevention News.....1
- HIV Assessment News.....5
- HIV Treatment News.....14

Tool Boxes
- All That Is Sacred: A Primer on Spiritual Assessment.....6
- Resources.....16
- A Note on Content.....20

establishing a human connection – a way of trying to fill the emotional void created by having been neglected. (p. 49)

Klein and colleagues conclude that "[b]y ... help[ing] persons with low-self-esteem and/or neglect in their backgrounds to deal with their residual emotional and psychosocial issues, ... [clinicians] will, in all likelihood, be more effective at changing the belief and attitude structures that underlie involvement in risky behaviors *and* more effective at bringing about reductions in the risky behaviors themselves" (p. 49).

Cole, Logan, and Shannon (2007) examined **sexual risk behavior** among a sample of 673 women who had obtained **protective orders against violent male partners**.

There are three main findings from this study: (1) Severity of physical violence and length of relationship were associated with riskier sexual behavior, after controlling for other factors; (2) Most women with recent partner violence experiences who had obtained protective orders are exposed to risk for HIV through their inconsistent condom use with partners (particularly their abusive partners) who are engaging in high-risk behaviors; and (3) Substance abuse and dependence were positively associated with higher sexual risk behavior. (pp. 108-109)

Interestingly, 22% of the women in this sample engaged in extrarelational sexual activity and "the majority of women who had sex with individuals other than their abusive partner in the past year did not consistently use condoms with those sex partners" (p. 110). Cole and colleagues emphasize that clinicians working

with women who are contemplating leaving partners, or who are in the process of terminating a relationship, or who have recently terminated relationships with abusive partners [should] assess the women's perceptions about level of risk with new partners. Moreover, it is particularly important that women adopt safer sexual practices with partners in the beginning of their relationships because evidence indicates that it is easier to establish a pattern of safer sexual practices at the onset of a relationship than it is to adopt these practices in an established relationship after couples have engaged in riskier behavior ... . (p. 110)

On two occasions spaced 1 year apart, Fitzgerald, Lundgren, and Chassler (2007) assessed factors associated with HIV risk behaviors among 185 **women who had a history of injecting drug use**. Risk behaviors included injecting drugs during the preceding 6 months, sharing needles during the preceding 6 months, and engaging in unprotected sex during the preceding 30-day period. The investigators found that "living with a spouse at year one was significantly and positively associated with high-risk behaviours at both time points. Being prescribed medications for psychological or emotional problems ... [and] testing positive for ... HIV ... were significantly and negatively associated with reporting high-risk behaviours at both time points" (p. 67). These findings

suggest that spousal relationships can expose women to HIV/AIDS risky behaviours[,] while HIV ... testing and prescription of psychiatric medication may help to protect women from these ... risks. Given these findings, future design and implementation of prevention and treatment efforts targeting women at risk for HIV/AIDS should address women's empowerment, social status and interpersonal relationship issues, as well as include comprehensive health services. These comprehensive health services should include appropriate mental health diagnosis and treatment as well as HIV ... testing. (p. 72)

About Persons Who Use Substances

Semple, Zians, Grant, and Patterson (2006) investigated **relationships among methamphetamine** (meth) **use, impulsivity, and sexual risk behaviors** in a sample of 261 meth-using men who have sex with men (MSM) who were living with HIV.

Higher impulsivity was associated with less education, lower income, being unemployed, psychiatric diagnosis, and higher Beck depression scores. Intensity of meth use and sexual risk behavior were significantly correlated. In a multiple regression analysis, more education, greater intensity of meth use and higher levels of impulsivity predicted

mental health **AIDS** is produced four times a year under Contract No. 280-02-0202 with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The content of this publication does not necessary reflect the views, opinions, or policies of the CMHS, SAMHSA, or HHS.

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

more unprotected sex. To test for moderating effects of impulsivity, an interaction term was added to the regression. The interactive effects model was statistically significant. A plot of the interaction revealed that the relationship between intensity of meth use and total unprotected sex was strongest among participants who had higher levels of impulsivity. (p. 105)

Semple and colleagues stress that "these findings [need to] be replicated with more representative samples before any treatment or intervention programs that target impulsivity are implemented" (p. 113). The investigators do, however, reason that

> targeting impulsivity in an intervention context may help to reduce the sexual risk behaviors of those individuals who consume large quantities of meth with high frequency. Interventions to reduce elevated levels of impulsivity among meth users may involve pharmacological and/or psychotherapeutic treatments. Pharmacological treatments are based on the premise that dopaminergic and serotonergic neurotoxicity is the underlying mechanism whereby stimulant use results in elevated levels of impulsivity. ... If deficits in serotonin and dopamine function in the brain can be reversed ..., it may be possible to reduce levels of impulsivity, which in turn may lead to lower levels of sexual risk behavior. Psychotherapeutic interventions might involve self-regulation or management approaches that teach patients how to plan activities, resist temptations, tolerate frustration, and think through the negative consequences of impulsive behaviors. ... They might also focus on general problem-solving skills, emotional self-regulation strategies, and interpersonal skills. ... (p. 112)

In an intervention study conducted by this research group, Mausbach, Semple, Strathdee, Zians, and Patterson (2007) randomly assigned 341 MSM who were living with HIV and *continuing* their meth use to one of two conditions: either **a theory-based safer sex behavioral intervention** (EDGE)[1] or a time-equivalent attention-control condition on diet and exercise. The investigators found that "[p]articipants in the EDGE intervention engaged in significantly more protected sex acts at the 8-month ... and 12-month assessment ... . By 12-months post-baseline, a greater percentage of protected sex acts was observed for EDGE (25.8%) vs. control participants (18.7%) ... . There was [also] a significant time-by-intervention interaction ... for self-efficacy for condom use, suggesting that EDGE participants' self-efficacy demonstrated a greater increase over time compared to control participants[']" (p. 249).

Mausbach and colleagues conclude that this study

> demonstrates the efficacy of a behavioral skills intervention for increasing safer sex behaviors in a sample of HIV-positive, [meth]-using MSM. Specifically, helping members of this population increase their knowledge, self-efficacy, and positive outcome expectancies for skills such as condom use, negotiation of safer sex practices, and disclosure of HIV serostatus to sex partners can produce long-term change in safer sex practices despite ongoing [meth] use, which in turn may reduce the transmission of HIV. Finally, it is possible that augmenting this intervention with ongoing substance abuse treatment can produce even larger gains in safer sex behaviors. (p. 256)

In yet another study from this research group (Semple, Grant, & Patterson, 2006), 230 heterosexually identified meth users who were not infected with HIV were asked about the **perceived drug use and sexual risk behaviors of** their **social network members**. "The highest ratings of risk behavior within participants' social networks were associated with meth use and non-use of condoms. Friends received the highest ratings in terms of overall perceived involvement in drug and sexual risk behaviors" (p. 405). Further analysis revealed that "participants whose social network members were perceived to engage in more sexual risk behavior had lower intentions to use condoms" (p. 411).

> In terms of behavioral intervention, the inverse relationship between perceived risk behavior of social network members and intentions to use condoms could be used to motivate individuals to engage in AIDS preventive behaviors. For example, from a motivational interviewing perspective ..., the ... therapist would lead the individual through an exploration of how the perceived behavior of social net-

[1] "The intervention consisted of 5 weekly individual counseling sessions (90-min each) followed by 3 booster sessions at three-week intervals (90-min each), which were designed to reinforce behavior change. ... [S]kill-training was used to help participants increase their knowledge, self-efficacy, and positive outcome expectancies in relation to a number of critical areas such as condom use, negotiation of safer sex practices (including sexual assertiveness), and disclosure of HIV serostatus to sex partners. The mechanisms of behavioral change involved observation, role modeling, skill performance (i.e., practice and rehearsal), positive feedback, reinforcement, and the development of supportive referents. The intervention was not designed to arrest or abate drug use. Instead, the focus was to reduce high risk sexual practices of [meth]-using HIV-positive MSM. Therefore, the behavioral strategies mentioned above were placed in the context of drug use. For example, the participant and counselor discussed how the use of [meth] interferes with motivation and preparedness for safer sex. Participants problem-solved ways in which they could be prepared to practice safer sex or how they could lower risk levels in the context of drug use (i.e., ... seeking out HIV-positive partners, practicing oral sex instead of anal sex, limiting number and type of sex partners)" (p. 251).

work members affects his/her ... choices regarding sexual risk behavior. Focusing the individual on the discrepancy between the perceived behavior of social network members and personal goals of behavior change will help to move the individual toward a higher state of change where s/he is willing to take steps toward reducing risk behavior ... . Cognitive-behavioral techniques may also be effective in terms of behavior change, particularly within group interventions. For example, role-playing problem situations, peer/counselor modeling of behaviors, and the management of emotions through cognitive-behavioral techniques have demonstrated effectiveness in terms of reducing HIV-related injecting behaviors ... .

... [The following strategies] may be useful in terms of addressing negative social network influences in the context of sexual risk reduction interventions for heterosexual meth users ...: (1) identifying support buddies to help the client avoid high risk situations; (2) teaching the client ways to respond to social network members who do not support safer sex goals; and (3) developing a new social network consisting of individuals who support safer sex goals ... . (p. 411)

About Adolescents & Young Adults

LaSala (2007) interviewed a diverse sample of 30 young gay men (between the ages of 16 and 25 years) in the northeastern United States and one or both of their parents to explore **the role of family relationships and interactions in decisions to avoid unsafe sexual practices**. According to LaSala, "[m]ost of the youths reported feeling obliged to their parents to stay healthy, and these feelings of obligation were important factors in their decisions to avoid unsafe sex. Youths who reported no parental influence came from families in which parents had historically been preoccupied with personal or marital problems or in which there was a history of parental rejection" (p. 49). LaSala encourages clinicians

to consider family influence as yet another resource to be used to persuade gay youths to consistently engage in safer sex. Practitioners ... need to ask ... [young gay men] about family relationships, and if the youths are out[, clinicians] ... are advised to consider engaging parents in their efforts. Alternatively ... [clinicians] could engage at-risk gay youths through their parents. ... [Clinicians] could then assess parent-child relationships and coach parents and children to discuss this awkward but important subject in a caring manner that decreases parental fear as well as youths' defensive "shut downs" or ineffective reassurances. Such parent-child dialogue could stimulate or enhance a gay youth's feelings of obligation to his parents to stay healthy and remind him that his sexual behavior has implications for the people who love him. Practitioners could also prompt parents to encourage their sons to avoid unsafe sexual behavior by periodically asking them about their sexual activity and ensuring that they have enough condoms.

Practitioners should not automatically assume that parents of gay youths are either unaware of or hostile toward their sons' sexuality and therefore unavailable as a resource in HIV prevention efforts for this population. Although more research is needed, parental involvement has the potential to ... diminish high-risk sexual behavior among gay male youths ... . (pp. 54-55)

Lightfoot, Tevendale, Comulada, and Rotheram-Borus (2007) conducted additional analysis of data generated in the study of an intervention that was efficacious in reducing HIV transmission risk among **young people living with HIV** (YPLH; Rotheram-Borus et al., 2004). This earlier paper examined **the delivery format of the intervention** (telephone or in-person) and reported that, overall, in-person delivery was associated with reductions in sexual risk behavior. The current investigators sought to determine if there were some youths who would derive greater benefit from the telephone delivery format of this intervention.

When examining the factors that moderate increasing the percentage of protected sex [acts], [the investigators found that] use of antiretroviral medications (ARV), time since HIV diagnosis, and mental health were important. YPLH who were not taking ARVs, reported lower emotional distress, and had know[n] their HIV diagnosis for a longer period of time were more likely to benefit from the in-person intervention [and did not appear to benefit from the telephone intervention]. ... These youth are likely to be difficult to engage because they are not highly motivated by their current context to seek ... help[,] as illustrated by [their] not taking medications, not needing mental health services and having lived with the virus for a long time. However, ... these youth can benefit from preventive interventions. ... Emphasizing the benefits of in-person sessions,... [such as] the opportunity to decrease isolation ... and ... to discuss life challenges with others, ... [may increase] the motivation of youth to attend in-person sessions.

In contrast, ... [t]hose YPLH who were taking ARVs and reporting more emotional distress were

more likely to benefit from the telephone intervention ... [and increase their percentage of protected sex acts. Moreover,] while the telephone intervention was useful for youth recently diagnosed and those taking ARVs, these youth did not benefit from the in-person intervention. This is surprising because it would be expected that recently diagnosed youth would be most in need of in-person communication and interaction. However, recently diagnosed youth may be experiencing heightened affect such as depression or anxiety which would interfere with their ability to engage in an interpersonal setting. This is consistent with the finding that YPLH with heightened emotional distress benefited most from the telephone intervention. It is less clear why those youth taking ARVs did not benefit from the in-person intervention. ... It may be these youth are overwhelmed or overloaded by the ongoing in-person interaction [with providers] and conveying preventive information may require less interpersonally demanding modalities.

... [Data describing] reductions in the number of sexual partners ... suggest that mental health status is an important consideration for the success of the intervention. For YPLH who were experiencing high levels of emotional distress or anxiety, the in-person intervention was most effective in reducing the number of sexual partners. ...

This finding contrasts with the results indicating YPLH experiencing high levels of emotional distress benefited from telephone delivery to increase the percentage of protected sex [acts]. It may be that ... YPLH who become connected to healthcare services or interventions delivered in-person ... reduce contact with potential sex partners. On the other hand, emotionally distressed youth who are not connected to services and who benefit from telephone[-]delivered intervention may seek social support and continue to have sex partners; however, with intervention, they may increase the percentage of protected sex [acts] with those partners. (pp. 68-69)

As these complex findings suggest, "[w]hen deciding which delivery strategy is ... [more] appropriate and beneficial for an individual young person, [clinicians should give] consideration ... to the types of services the youth currently accesses and the youth's mental health" (p. 69).

Regarding the mental health of young people, Smith, Leve, and Chamberlain (2006) investigated the utility of a diagnostic trauma measure (i.e., the Diagnostic Interview Schedule for Children) and experiential trauma measures[2] in predicting adolescent offending and adolescent health-risking sexual behavior. Among 88 girls between the ages of 13 and 17 who had been court mandated to out-of-home care and referred to treatment for chronic conduct problems, 16% met full diagnostic criteria for **post-traumatic stress disorder** (PTSD) and 46% met partial diagnostic criteria for PTSD. Interestingly, it was "the experiential measures of trauma (cumulative and composite trauma scores) [that] significantly predicted adolescent offending and adolescent health-risking sexual behavior, whereas the diagnostic measures of trauma (full and partial diagnostic criteria) did not" (p. 346).

These findings highlight the potential for identifying girls who are at the highest risk for delinquency and health-risking sexual behavior outcomes and who appear to need trauma ... services even though they do not meet criteria for trauma diagnoses. Although many studies of trauma intervention identify participants based on PTSD diagnoses, ... [these] findings suggest that delinquent girls who have experienced high rates of trauma but who are not currently exhibiting PTSD symptoms might also benefit from trauma ... services. (p. 351)

HIV Assessment News

HIV Counseling & Testing

Stevens and Hildebrandt (2006) conducted a longitudinal study involving a diverse, community-based sample of 55 **women who had** received HIV testing and **learned of their positive serostatus**. "Women's immediate reactions upon hearing that they were infected with HIV were devastation, shock, and indignation. Long-term responses included depression, submersion of the HIV infection diagnosis, escalated drug and alcohol use, shame, and suicidality. It was usually months and sometimes years before women could extricate themselves from these patterns of response" (p. 207). In the view of these investigators, "[i]t is critical to make HIV infection diagnosis the first intervention in a protocol of seamless support that sees women through the initial trauma of being diagnosed until longer term primary care and social services can be activated" (p. 207). More specifically,

[w]ith a first responder crisis intervention protocol set into motion by a positive HIV test result, a crisis interventionist would come on scene, be introduced by the diagnosing practitioner, and

[2] "Childhood trauma was measured with eight indicators representing a multiagent perspective on childhood abuse: (a) lifetime trauma (Traumatic Stress Schedule) ..., (b) documented physical abuse, (c) documented sexual abuse, (d) self-reported sexual abuse (Childhood Sexual Experiences Questionnaire) ..., (e) the witnessing of domestic violence, (f) the experience of parent incarceration, (g) the number of parental transitions, and (h) the number of our-of-home placements" (p. 348).

Tool Box

All That Is Sacred: A Primer on Spiritual Assessment

"The sacred is what distinguishes religion and spirituality from other phenomena. ... The sacred is the common denominator of religious and spiritual life."

—— Hill & Pargament, 2003, p. 65

Loue and Sajatovic (2006) analyzed data drawn from 41 Puerto Rican women living with severe mental illness (SMI) in northeastern Ohio and found that "[a] large proportion of the participants reported that their religious or spiritual beliefs were critical to their coping, had influenced them to reduce [HIV] risk, and/or provided them with needed social support" (p. 1168). According to the investigators, these data

> suggest that including a spirituality/religio[usness] ... component in [secular] HIV prevention programs designed for Latinas may be critical to the initiation and maintenance of risk reduction behaviors, e.g., reducing the number of sexual partners and abstaining from drug use.
>
> Including a spiritual component in such programs may encourage Hispanic [women with] SMI ... to utilize their religious and spiritual beliefs in coping. Coping may include self-acceptance regardless of past actions (e.g., substance use); identification of effective strategies to address the challenges of mental illness (e.g., medication management adherence, social isolation, unstable living circumstances); and the development of skills to identify and effectively address situations that may heighten HIV risk.
>
> Many ... [study] participants used religious precepts to establish behavioral standards for themselves. The incorporation of spiritual or religious routines into daily living regimens may provide [persons with] SMI ... with structure and predictability in their lives, which are often characterized by disorganization and unpredictability. Gradually, the increased predictability and structure may help to decrease impulsivity, establish boundaries, and reduce HIV risk behaviors.
>
> Participation in spiritual or religious activities with others may also provide a sense of community for [persons with] SMI ... who have been socially isolated, institutionalized, or victimized in exploitative relationships. ... The resulting social support may help individuals to transform their core identity from that of victimized mentally ill persons to that of loved and valued individuals. This metamorphosis may be critical to the development of a sense of self-efficacy in decision[-]making. This enhanced sense of community may be particularly important to Hispanic [women with] SMI who may have lost a sense of community or support as the result of migration. The development of a healthy social support system may provide assistance with tangible needs, thereby reducing the need to engage in survival behaviors that may increase HIV risk, such as trading sex for food, shelter, or safety. (pp. 1176-1177)

Loue and Sajatovic stress that "the spiritual components of an HIV prevention intervention must encompass elements of faith that may be common to a wide range of individuals and be sufficiently broad to suggest and allow diversity of belief, including a conceptualization of spirituality that does not require a belief in a higher power" (p. 1177). Additionally, when working with persons with SMI, "[p]ractitioners must have sufficient familiarity with the relevant religious precepts to allow them to distinguish their patients' religious beliefs and rituals from delusions and compulsions ..." (p. 1177; see sidebar). One way to gather the information needed to discern spiritual content reflective of mental illness is to conduct a spiritual assessment.

Are You Spiritual Assessment Savvy?

According to Richards and Bergin (2005), "[a] religious-spiritual assessment should be embedded in a multilevel, multisystemic assessment strategy" (p. 234). This recommendation extends to work conducted with persons living with HIV/AIDS, because "[v]irtually every study on religion and spirituality conducted among men and women with HIV attests to the significance of ... [these] construct[s] for these individuals" (Pargament et al., 2004, p. 1202). Moreover, "[a] small but growing body of empirical evidence indicates that religiousness and spirituality play an important role in the health and well-being of people living with HIV" (Pargament et al., 2004, p. 1207).

How might one then proceed with such an assessment process? "Given ... the fact that research and clinical experience with religious-spiritual assessment ... [are] still in an early state," Richards and Bergin observe that "therapists must rely heavily on clinical wisdom and hunches when deciding what religious and spiritual information to seek about their clients" (p. 224).

Fortunately, some clinical guidance has been offered by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO, an independent, not-for-profit organization that evaluates and accredits nearly 15,000 health care organizations and programs in the United States, now requires the administration of a spiritual assessment (JCAHO, 2004). Hodge (2004, 2006)

continue to provide emotional and practical support to the individual ... in the interim between HIV infection diagnosis and the time when comprehensive care is established. Beyond regular contact and provision of information, an interventionist would introduce the individual to community resources and accompany her to initial appointments with HIV service providers. (p. 219)

Psychiatric Assessment

Israelski et al. (2007) utilized the Beck Depression Inventory, the Posttraumatic Stress Checklist-Civilian, and the Stanford Acute Stress Reaction Questionnaire to screen for

has outlined a two-stage spiritual assessment process based on JCAHO requirements that may also be of use in non-JCAHO-accredited settings.

Initial or Brief Spiritual Assessment

Hodge defines spiritual assessment as "the process of gathering, analyzing, and synthesizing spiritual and religious information into a specific framework that provides the basis for, and gives direction to, subsequent practice decisions. ... " (Hodge, 2006, p. 318). He suggests that clinicians begin with an "initial" or "brief" spiritual assessment. "The purpose of the initial assessment is twofold. One goal is to identify the effect of client's spirituality on service provision and client care. ... [F]or service provision to be as effective as possible, spiritual beliefs and practices often have to be taken into account. ... Another goal is to identify whether an additional, more comprehensive spiritual assessment is required" (Hodge, 2005a, pp. 314-315).

"At a minimum, the brief assessment should include an exploration of three areas: (1) denomination or faith tradition, (2) significant spiritual beliefs, and (3) important spiritual practices" (Hodge, 2006, p. 318). Hodge's model conforms to JCAHO's spiritual assessment recommendations and consists of four questions:

1. I was wondering if spirituality or religion is important to you?

2. Are there certain spiritual beliefs and practices that you find particularly helpful in dealing with problems?

3. I was also wondering if you attend a church or some other type of spiritual community?

4. Are there any spiritual needs or concerns I can help you with? (Hodge, 2006, p. 319)

Hodge encourages clinicians to phrase their questions in this neutral manner, which validates the experiences of clients who are spiritual, religious, both, or neither. After assessing the client's response to the first question, clinicians may decide to divide the second question

> into two discrete items for more specificity in terms of beliefs and practices (e.g., "Are there certain spiritual beliefs that are particularly helpful in dealing with problems?" "Are there particular spiritual practices that you find especially useful when facing difficult circumstances?"). In other words, if clients' replies suggest that spirituality is a significant factor in their personal ontology, exploring the belief and practice dimensions separately may yield more clinically useful information. Similarly, if previous responses warrant, it may also be helpful to ascertain how often clients engage in spiritual or religious practices and the salience of the practices to clients. (Hodge, 2004, pp. 38-39)

With regard to the question on attendance at a church or other spiritual community, "[i]f the client attends a mosque, for example, then that term would be used in all subsequent conversation" (Hodge, 2006, p. 319).

(Tool Box is continued on Page 8)

Discerning Spiritual Content Reflective of Mental Illness

As Hodge (2004) observes, the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition – text revision (*DSM-IV-TR*; American Psychiatric Association, 2000)

> provides guidelines for distinguishing between content that reflects psychosis and content that is normative in the area of spirituality (e.g., a client who reports that he or she hears God's voice). First, note the client's spiritual identity and associated worldview (e.g., Pentecostal, which is open to metaphysical phenomena). Second, understand to what extent the client's manifestation is normative within the context of the client's spiritual worldview (e.g., within the context of a Pentecostal worldview, hearing God's voice is a normal occurrence and therefore not necessarily a manifestation of psychosis). It is also important to emphasize that even if the metaphysical experience reported by the client appears to be abnormal within the context of their worldview, the experience should be assessed in light of the person's overall functioning ... .
>
> It is not always clear, however, exactly what constitutes normative spiritual experiences within the client's spiritual worldview. In cases in which doubt exists, ... [clinicians] should seek out collaborations with clergy ... . In addition to providing individual services that address clients' needs, and linking clients to social support resources in their spiritual communities, clergy are typically able to provide information about what are considered appropriate expressions of spirituality in a given spiritual tradition.
>
> It is important to emphasize that clergy from the client's specific tradition should be consulted. ... As in other matters, it is often clients themselves who are the best source of information about appropriate candidates for collaboration. (p. 41)

Hodge stresses that, "[a]lthough psychosis can be manifested in spiritual content, ... spirituality is positively associated with mental health ... [and] spirituality is often a key component in recovery from mental illness. ... [Clinicians] can facilitate the recovery process by helping clients operationalize their spiritual strengths. Conducting an assessment, particularly a complete spiritual assessment, is likely to uncover strengths and resources that can be tapped to foster recovery" (p. 41).

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Hodge, D.R. (2004). Spirituality and people with mental illness: Developing spiritual competency in assessment and intervention. *Families in Society, 85*(1), 36-44.

diagnostic symptom criteria within an ethnically diverse and economically disadvantaged sample of 210 men and women living with HIV and receiving services at two public clinics in northern California. The investigators "found that three stress-related psychiatric disorders – **depression**, [**PTSD**], and **acute stress disorder** – appear to be highly prevalent among patients with HIV/AIDS who receive services for primary health-care in a public setting. Well over one-third of the patients studied ... met screening criteria for one of these three diagnoses. Furthermore, many patients (38 per cent) concurrently

(Biopsychosocial Update is continued on Page 10)

(Tool Box -- continued from Page 7)

The final question inquires about clients' spiritual needs. "In addition to asking about religious needs in a general, nonspecific sense, it may be helpful to list some common spiritual needs (e.g., 'Are there any spiritual needs I can help you address such as arranging a visit from the chaplain or your pastor?')" (Hodge, 2004, pp. 38-39).

Moving to a Comprehensive Spiritual Assessment

"At least four somewhat interrelated factors may bear on the decision to move from a brief to a comprehensive assessment. It should be noted at the outset that these four guidelines are often held in tension with, and inform, one another. In brief, these four principles can be summarized as respect for client self-determination, the practitioner's ability to provide culturally competent services, the degree to which the norms of the client's faith tradition relate to service provision, and salience of spirituality in the client's life" (Hodge, 2006, p. 320).

o **Client self-determination**: Hodge emphasizes that "it is important to obtain clients' consent before proceeding with a spiritual assessment. Although many clients may be willing to answer the relatively few questions involved in a brief assessment, informed consent should be obtained again before proceeding with a comprehensive assessment. Indeed, it is perhaps best to view informed consent as an ongoing process in which practitioners continuously monitor clients' responses to ensure that they remain fully supportive of the continuing dialogue" (Hodge, 2006, p. 320). Hodge does suggest, however, that "[c]lient reluctance to proceed with an assessment ... can be sensitively explored, a process that is especially advisable when the other guidelines point toward the importance of a comprehensive assessment" (Hodge, 2006, p. 323).

o **Clinician cultural competence**: According to Hodge, "if an initial assessment indicates the presence of a culturally different worldview that the practitioner may have difficulty working with in a culturally sensitive manner, then it may be advisable to refrain from conducting a comprehensive assessment. ... Consequently, serious consideration should be given to referring the client to another practitioner who has the necessary skills and knowledge to work with the particular client population in a culturally competent manner" (Hodge, 2006, p. 321).

o **Spiritual norms and their relationship to service provision**: While conducting the initial assessment, clinicians in Hodge's view should remain

> alert to various indicators that might suggest a connection between the client's spirituality and possible diagnoses, interventions, or other aspects of service provision. Making such connections typically requires ... some degree of knowledge regarding common norms extant in various denominations and faith traditions. ... If the initial assessment suggests the existence of certain spiritual beliefs and practices that may relate to later treatment decisions, then further assessment is warranted to clarify the exact nature of the relationship between the value in question and possible treatment decisions. (Hodge, 2006, p. 322)

o **Spiritual salience in client's life**: "Finally," according to Hodge, "a comprehensive assessment might be considered when spirituality plays a central role in the client's life. ... [I]f the initial assessment suggests that spirituality functions as an organizing principle in the client's life, then further assessment may be appropriate" (Hodge, 2006, pp. 322-323).

Five Complementary Comprehensive Spiritual Assessment Tools

Hodge (2005a) reviews and compares five comprehensive spiritual assessment tools that highlight various facets of a client's spiritual life. One tool – the spiritual history – is the only approach that is conducted in an exclusively verbal manner. The other four tools – the spiritual lifemap, spiritual genogram, spiritual ecomap, and spiritual ecogram – are diagrammatic or pictorial in nature. Given space limitations here, readers are encouraged to consult Hodge's original articles (cited below) for detailed accounts of each assessment approach. The following brief descriptions may, however, assist clinicians in selecting the assessment tool most appropriate to the clinical setting as well as the needs and interests of individual clients.

Spiritual histories (Hodge, 2001a) are conducted much like traditional family histories in which clients describe their spiritual journeys. "For verbally oriented people, spiritual histories may provide the best assessment method. ... [T]he relatively unstructured format allows clients to relate their stories in a straightforward manner without having to adapt their narratives to fit a particular diagrammatic format. ... Spiritual histories are also easy to conduct. The assessment model is relatively easy to communicate to clients, and the verbal format is conducive to building a therapeutic alliance with clients" (Hodge, 2005a, p. 316). Of course,

> [n]ot all clients are verbally oriented ... [and] some may prefer the pictorial assessment approaches discussed in later sections. Individuals who are nervous about sharing what is often a highly personal topic may desire a diagrammatic approach that deflects attention away from themselves and onto an inanimate object. Some clients prefer having a specific framework around which to organize their thoughts[; for others,] ... the process of conceptualizing and depicting one's spiritual journey pictorially may help to focus and objectify spiritual assets, which can then be discussed and marshaled to address problems. (Hodge, 2005a, p. 316)

Spiritual lifemaps (Hodge, 2005c) cover the same time span as spiritual histories, but in a pictorial format that may be appealing to clients who are more artistic or less verbally oriented. "Much like road maps, spiritual lifemaps tell us where we have come from, where we are now, and where we are going. ... To fully operationalize the potential of this method, it is important to ask clients to incorporate the various trials they have faced along with the spiritual resources they

have used to overcome those trials. ... Delineating successful strategies that clients have used in the past frequently suggests options for overcoming present struggles" (Hodge, 2005a, pp. 316-317).

"The pictorial lifemap affords practitioners the opportunity to learn more about the client's worldview, while focusing on building therapeutic rapport by providing an atmosphere that is accepting, nonjudgmental, and supportive during assessment. ... Lifemaps ... may [also] be assigned as 'homework,' saving valuable therapeutic time" (Hodge, 2005a, p. 317). For some clients, however, "it may be important to understand the effects of spirituality in greater breadth (that is, among the wider family system) or in greater depth (that is, across generations). In such settings, spiritual genograms may be used" (Hodge, 2005a, p. 317).

Spiritual genograms (Hodge, 2001b) "chart the flow of spirituality over the course of at least three generations and may be particularly appropriate in situations in which the extended family plays a more central role" (Hodge, 2004, p. 39). Genograms serve as "a blueprint of complex intergenerational spiritual interactions ... [and] may appeal to clients who prefer a very structured assessment approach" (Hodge, 2005a, p. 319). At the same time,

> [s]piritual genograms are relatively time consuming to construct, require a fair degree of practitioner involvement to explain and conduct the assessment, and place some limitations on how clients relate their spirituality. In situations where the family system or historical influences are of minor importance, spiritual genograms may be an inappropriate approach. Furthermore, because many clients do not connect past events with current difficulties, some clients may view genogram construction as an ineffective use of time ... . With such clients, it may be more appropriate to use assessment approaches that focus on the 'here and now,' such as spiritual ecomaps. (Hodge, 2005a, p. 319)

Spiritual ecomaps (Hodge, 2000; Hodge & Williams, 2002) "depict the ... [clients'] present, existential relationships with key spiritual variables in their environment and, consequently, may be useful for more present-focused clients who are interested in exploring current spiritual strengths rather than historical influences" (Hodge, 2004, p. 39), the latter common to spiritual histories, lifemaps, and genograms.

> Spiritual ecomaps are relatively easy to grasp conceptually, quick to construct, and perhaps most important, readily focus on clients' current, existential spiritual strengths ... . This assessment approach may be ideal for operationalizing clients' spiritual assets in a timely fashion because the time spent in assessment is focused on tapping into present spiritual resources. As in the case with all diagrammatic methods, spiritual ecomaps provide an object that can serve as the focus point of discussion, which can be an important consideration for those clients who find it less threatening to have a concrete object as the focus of conversation. However, by virtue of their design, ecomaps may be particularly helpful in transferring attention from the client to the concrete, diagrammatic assessment because they focus on environmental systems rather than, for example, clients' life stor[ies] ... . Although other approaches may implicitly emphasize the client, spiritual ecomaps explicitly stress the systems in clients' environments ... .
>
> Spiritual ecomaps suffer from the same limitations as other diagrammatic approaches relative to verbal spiritual histories. A diagrammatic approach may hold little appeal to clients who want to talk. Although relatively quick and simple to construct, ecomaps may not appeal to more creative individuals, but clients can be encouraged to express their creativity by adding symbols and other material to the ecomap. In some situations, the focus on the client's current, existential relationships to spiritual assets may result in a limited assessment that overlooks important historical factors. In some contexts, an approach that examines current and historical resources on the same diagrammatic tool may be useful. (Hodge, 2005a, pp. 320-321)

Spiritual ecograms (Hodge, 2005b) "combine the assessment strengths of spiritual ecomaps and genograms in a single assessment approach ... . Ecograms tap information that exists in present space, much like a traditional spiritual ecomap, and also access information that exists across time, like a traditional spiritual genogram. Ecograms also depict the connections between past and present functioning. Historical influences on current systems can be seen as well as present relationships with historical influences ..." (Hodge, 2005a, p. 321).

> The primary asset of spiritual ecograms is their ability to illustrate current and historical resources as well as the connections between those strengths in a single graphic rendering. This advantage may be welcomed when working with populations in which the family system plays an important role. ... In some instances, however, ... [clinicians] may desire a simpler, more focused, diagrammatic assessment approach. Spiritual ecomaps, for example, are less time consuming to construct and may provide all the information required in a given situation. In other contexts, ... [clinicians] may desire to use the limited amount of page space to amplify the generational dynamics in a spiritual genogram. Lifemaps also may provide a better assessment approach with more artistically inclined clients, and spiritual histories may be better suited for more verbally oriented clients. (Hodge, 2005a, p. 322)

With regard to family spiritual assessment, "[a]lthough all the approaches can be used with families, perhaps spiritual genograms, ecomaps, and ecograms are best suited for family therapy" (Hodge, 2004, p. 39).

(Tool Box is continued on Page 10)

(Biopsychosocial Update -- continued from Page 7)

met criteria for two or more mental health disorders; one in five patients met criteria for all three" (p. 222). "Notably, 43 per cent of the [118] patients who met screening criteria for at least one of the three disorders reported that they were not ... already receiving any psychiatric treatment (i.e.[,] either psychiatric medication or psychotherapy)" (p. 224). Israelski and colleagues conclude that "the primary healthcare of patients with HIV/AIDS could be improved by more regular use of tools to routinely screen and diagnose mental health disorders related to traumatic life events. It is likely that interventions to ameliorate concomitant psychiatric conditions will lead to improved healthcare outcomes for patients with HIV/AIDS and mental health disorders" (p. 223).

With regard to the diagnosis of psychiatric disorders, Beyer, Taylor, Gersing, and Krishnan (2007) drew on data from psychiatric outpatient clinics within a tertiary-care/academic medical center to estimate **the prevalence of HIV infection in a *general* psychiatric population** (as distinguished from the population of persons with severe mental illnesses, which has been studied extensively). Among the 11,284 patients evaluated through psychiatric outpatient clinics between 2001 and 2004, 130 reported that they were living with HIV. "HIV infection was present in 1.2% of the psychiatric outpatients, approximately four times the occurrence of HIV infection in the general adult population of the United States. The major psychiatric diagnostic categories with a high prevalence of HIV infection were substance abuse disorders (5%), personality disorders (3.1%), bipolar disorders (2.6%), and [PTSD] (2.1%)" (p. 31). Beyer and colleagues con-

(Tool Box -- continued from Page 9)

Exercise Caution When Using Quantitative Instrumentation

At the present time, there exists "an impressive array of measures of religious and spiritual experience for the numerous domains of the religious and spiritual experience" (Hill, 2005, p. 55). In fact, "Hill and Hood (1999) reviewed 125 measures of religion and spirituality from 17 different categories (e.g., beliefs, attitudes, religious orientation, faith development, fundamentalism, attitudes toward death, congregational involvement, and satisfaction)" (Hill & Pargament, 2003, p. 66). Additional quantitative measures of such constructs as perceived closeness to God, religious orientation and motivation, religious support, and religious and spiritual struggle are outlined by Hill and Pargament (2003). Scales that have demonstrated reasonably strong psychometric properties are also highlighted by Hill (2005).

Yet, it must be emphasized that "religious and spiritual measures designed for clinical populations ... are rare" (Hill, 2005, p. 44). "Because most religious and spiritual measures have not been adequately validated in clinical situations," Richards and Bergin (2005) stress that "therapists should use them only after carefully examining them and personally verifying their suitability for their clients. Even then, therapists should interpret these measures tentatively. Normative data are so limited for most of these measures that sharing normative comparisons with clients should be avoided. At most, these measures should be used only to give therapists some tentative insights into their clients and perhaps as a tool to help clients engage in exploration and self-discovery" (p. 241).

References

Hill, P.C. (2005). Measurement in the psychology of religion and spirituality: Current status and evaluation. In R.F. Paloutzian & C.L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 43-61). New York: Guilford Press.

Hill, P.C., & Hood, R.W., Jr. (Eds.). (1999). *Measures of religiosity.* Birmingham, AL: Religious Education Press.

Hill, P.C., & Pargament, K.I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58*(1), 64-74.

Hodge, D.R. (2000). Spiritual ecomaps: A new diagrammatic tool for assessing marital and family spirituality. *Journal of Marital & Family Therapy, 26*(2), 217-228.

Hodge, D.R. (2001a). Spiritual assessment: A review of major qualitative methods and a new framework for assessing spirituality. *Social Work, 46*(3), 203-214.

Hodge, D.R. (2001b). Spiritual genograms: A generational approach to assessing spirituality. *Families in Society, 82*(1), 35-48.

Hodge, D.R. (2004). Spirituality and people with mental illness: Developing spiritual competency in assessment and intervention. *Families in Society, 85*(1), 36-44.

Hodge, D.R. (2005a). Developing a spiritual assessment toolbox: A discussion of the strengths and limitations of five different assessment methods. *Health & Social Work, 30*(4), 314-323.

Hodge, D.R. (2005b). Spiritual ecograms: A new assessment instrument for identifying clients' strengths in space and across time. *Families in Society, 86*(2), 287-296.

Hodge, D.R. (2005c). Spiritual lifemaps: A client-centered pictorial instrument for spiritual assessment, planning, and intervention. *Social Work, 50*(1), 77-87.

Hodge, D.R. (2006). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. *Social Work, 51*(4), 317-326.

Hodge, D.R., & Williams, T.R. (2002). Assessing African American spirituality with spiritual ecomaps. *Families in Society, 83*(5-6), 585-595.

Joint Commission on Accreditation of Healthcare Organizations. (2004, January 1). *Does the Joint Commission specify what needs to be included in a spiritual assessment?* Retrieved January 7, 2007, from http://www.jointcommission.org/AccreditationPrograms/LongTermCare/Standards/FAQs/Provision+of+Care/Assessment/Spiritual_Assessment.htm?HTTP___JCSEARCH.JCAHO.ORG_CGI_BIN_MSM FIND.EXE?RESMASK=MssResEN.mskhttp%3A//jcsearch.jcaho.org/cgi-bin/MsmFind.exe%3Fhttp%3A//jcsearch.jcaho.org/cgi-bin/MsmFind.exe%3FRESMASK%3DMssResEN.msk

Loue, S., & Sajatovic, M. (2006). Spirituality, coping, and HIV risk and prevention in a sample of severely mentally ill Puerto Rican women. *Journal of Urban Health, 83*(6), 1168-1182.

Pargament, K.I., McCarthy, S., Shah, P., Ano, G., Tarakeshwar, N., Wachholtz, A., Sirrine, N., Vasconcelles, E., Murray-Swank, N., Locher, A., & Duggan, J. (2004). Religion and HIV: A review of the literature and clinical implications. *Southern Medical Journal, 97*(12), 1201-1209.

Richards, P.S., & Bergin, A.E. (2005). Religious and spiritual assessment. In P.S. Richards & A.E. Bergin (Eds.), *A spiritual strategy for counseling and psychotherapy, 2nd ed.* (pp. 219-249). Washington, DC: American Psychological Association.

– Compiled by Abraham Feingold, Psy.D.

clude that patients with substance-related disorders "remain at the highest risk for HIV infection, but patients with other psychiatric diagnoses are also vulnerable, especially those with personality disorders, bipolar disorder, and PTSD. The presence of a dual diagnosis (particularly in patients with these psychiatric diagnoses) substantially increases that risk of HIV infection. Clinicians should be aware that HIV infection is prevalent in ... psychiatric outpatients and should consider this in their evaluations and treatment plans" (p. 36).

Lam, Naar-King, and Wright (2007) sought "to describe **mental health symptoms** in a sample of [66] **HIV-positive youth** (ages 16-25 [years]) and to evaluate potential predictors of symptoms as a foundation for intervention" (p. 24, 26). Eighty-seven percent of the youths in this study were African American.

> As measured by the Brief Symptom Inventory (BSI), 50% of the youth scored above the cutoff for clinically significant mental health symptoms ... . Lower social support, higher viral load, HIV-status disclosure to acquaintances, and being gay/lesbian/bisexual (GLB) were all significantly correlated with more mental health symptoms, but disclosure to family and close friends and contact with service providers were not. Furthermore, regression analysis showed that social support, viral load, and disclosure to acquaintances predicted 32% of the variance in mental health symptoms. Being GLB was no longer significant, most likely because of shared variance with low social support. (p. 20)

Although these findings represent "a first step in characterizing the mental health symptoms of a clinical sample of HIV-positive youth" (p. 27), Lam and colleagues suggest that

> [m]ental health services and interventions to boost social support are critical in the care of HIV-positive youth and may even serve to improve health status. Alternatively improving the health status of youth, potentially via improved adherence to medication, may also serve to reduce mental health symptoms. There appear to be both cost and benefits to disclosing HIV-status, and youth may benefit from counseling around this issue. Finally, stigma around HIV and around sexual orientation may play a large role in mental health symptoms and social support of HIV-positive African American youth. Interventions to reduce stigma ... at the individual level (peer counseling) may be beneficial. (pp. 27-28)

Wiener, Battles, Ryder, and Pao (2006) documented the **use of psychotropic medications among** 64 **children and adolescents receiving continuous HIV care** at a single institution. On the basis of chart review, the investigators report that 45% of this sample had received at least one psychotropic medication and 13% had received two or more psychotropic medications concurrently at some point over a 4-year period. "The most common medication category prescribed was antidepressants (30%), followed by stimulant-type medications (25%)" (p. 747). Wiener and colleagues stress that

> [t]his study highlights the need for careful psychiatric assessment at regular intervals in children and adolescents with HIV/AIDS who develop behavioral or psychiatric symptoms. It also underscores the importance of documenting clinical diagnoses and significant target symptoms of treatment in the medical chart to communicate critical information between practitioners of different disciplines. Many psychotropic medications are prescribed for a variety of conditions, and it is important for practitioners to document their rationale, e.g., whether a tricyclic antidepressant is used for pain, sleep, or depression or some combination. (p. 751)

Neuropsychological Assessment

Over a 2-year period (on average), Cysique et al. (2007) monitored 227 gay or bisexual men living with HIV who did not meet criteria for the diagnosis of a current major depressive episode (MDE) at baseline.

> Participants received repeated NP [neuropsychological] assessments, as well as structured psychiatric interviews[,] to ascertain presence or absence of both lifetime MDD [major depressive disorder] and current MDE. Ninety-eight participants had a lifetime history of MDD, and 23 participants met criteria for incident MDE at one of their follow-up evaluations. Groups with and without lifetime MDD and/or incident MDE had comparable demographics, HIV disease status and treatment histories at baseline, and numbers of intervening assessments between baseline and the final follow-up. Lifetime MDD was associated with greater complaints of cognitive difficulties in everyday life, and such complaints were increased at the times of incident MDE. However, detailed group comparisons revealed no NP performance differences in association with either **lifetime or incident major depression**. Finally, NP data from consistently nondepressed participants were used to develop "norms for change[,]" and these findings failed to show any increased rates of NP worsening among individuals with incident MDE. (p. 1)

According to Cysique and colleagues, these longitudinal findings

are generally consistent with previously reported cross-sectional evidence that (1) MDD is not responsible for the substantially increased rates of NP impairment that are seen in HIV-infected populations and (2) MDD is not usually a significant confound[ing factor] in interpreting NP results of individual patients with HIV infection. ... Although MDD does not appear to significantly impair NP performance of HIV-infected persons, the current longitudinal findings support prior cross-sectional evidence that depressed mood often is associated with increased rates of cognitive complaints. This finding is important because self-reports of difficulties with cognition in everyday functioning may be used to help diagnose HIV-associated neurocognitive disorders[.] ... [These] findings strongly suggest that self-reports of impaired functioning should not be accepted uncritically in HIV-infected persons with significantly depressed mood. Although such reports by depressed patients may have some validity ..., they should be confirmed by independent informants and/or objective tests of instrumental activities of daily living ..., as well as by formal NP testing. (p. 8)[3]

Over a 2-year period, van Gorp et al. (2007) monitored 118 adults living with HIV to identify **barriers and facilitators to the process of returning to work**. During that time, 52% of study participants were able to obtain employment. Among the many measures utilized in this study, the investigators found that the California Verbal Learning Test (CVLT)

stood out as a robust predictor of finding employment. In fact, this study found that the likelihood of finding employment *doubled* from the lowest to the highest score on the CVLT obtained at baseline, with those attaining the highest score on the CVLT having a greater than 70% chance of finding work. Thus effortful learning and memory ability seems a key variable in predicting success in returning to work – even over IQ, health measures and other variables including entitlements, perhaps because the CVLT involves many components[,] including it being an effortful task, utilizing clustering as an effective strategy, and utilizing working memory as well. The unique combination of cognitive processes embodied in the CVLT seems to tap a construct that seems uniquely tied to success in returning to work, at least in this cohort. Motor speed was also a significant, but less consistent, predictor of those who found work during the study period. These variables, therefore, are obviously key to examine in any formal assessment of HIV+ persons.

Barriers to work include (not surprisingly) being older, having an AIDS diagnosis ..., and duration of unemployment. [Alt]hough clinicians cannot do much to alter the first two variables, they can perhaps encourage those who stop work in the context of illness to seek to return as soon as it is feasible to reduce as much as possible this duration of unemployment. The longer the individual is out of work, the lower the odds he or she will successfully find employment later.

In addition, ... providers may be too quick to recommend going on disability when their patients express concerns about working. They need to be aware that workplace re-entry after a period of unemployment is not easily accomplished. Seeking workplace accommodations for health reasons while maintaining some level of employment may be one option with fewer long-term costs.

People who do return to work report less depression following their employment. Although some depressive symptoms do not seem to pose a significant barrier to returning to work (at least in the absence of significant clinical depression), success in finding work does appear to significantly improve mood. Not surprisingly, HIV+ individuals who do return to work report improved mood and quality of life. (p. 87)

Overall, van Gorp and colleagues conclude that "[t]argeted efforts to lessen duration of unemployment, and other approaches (e.g., cognitive rehabilitation) to improve learning and motor function may optimize chances of successful re-entry to the workforce for those seeking to return to work in the context of HIV infection" (p. 88).

Parent-Child Assessment

Brackis-Cott, Mellins, Dolezal, and Spiegel (2007) conducted interviews with a convenience sample of 220 mother/child dyads living in lower-income, inner-city, primarily ethnic-minority neighborhoods, to assess symptoms of **anxiety and depression**. About half of the mothers were living with HIV, while all of the children (who were between the ages of 10 and 14 years) were uninfected.

Overall, mothers with HIV exhibited more depressive symptomatology than uninfected mothers. There were no significant differences, however, in depressive symptomatology between children of mothers who were HIV-positive and children of mothers

[3] For more information on this topic, see the **Tool Box** in the Summer 2003 issue of *mental health* **AIDS** entitled "Remain Objective Regarding Subjective, HIV-Related Cognitive Complaints."

who were HIV-negative. Among families directly affected by HIV, mothers who disclosed their status to their children endorsed greater depressive symptomatology than those who did not disclose and children who had been disclosed to were more likely to score in the clinically depressed range on the Child Depression Inventory than those who did not know. Latina mothers and their children were at increased risk for both depression and anxiety symptoms, particularly in families where the mother was not born in the United States. (p. 67)

Brackis-Cott and colleagues drew on these data in making a number of intervention recommendations:

> Not surprisingly, mothers with HIV-infection exhibited relatively more depressive symptomatology than did mothers without HIV infection. ... [E]valuation for depression and other mental health problems should [therefore] become a routine part of ... care for HIV-infected women ... . Furthermore, for HIV-infected mothers, the stress of living with a chronic, stigmatized, often fatal disease is compounded by issues of disclosure and tremendous parenting responsibilities, including having a plan for their children's future care if the mother becomes too ill or dies. Mental health interventions to address ... permanency planning for children, as well as [a range of] clinical issues[,] are thus necessary.
>
> Secondly, ... [the] finding that Latina women scored higher on depression and anxiety scales ... [suggests that c]linicians working with Latina women need to be bilingual and familiar with the dominant culture of the population they are treating. In addition to culturally sensitive psychotherapy, clinicians can encourage these women to access social support within their community and help them to preserve cultural values from their country of origin, as these may be protective against depression and anxiety symptomatology.
>
> Last, service providers of HIV-affected families are increasingly recommending parental disclosure of HIV status to children... . However, as indicated in ... [this] study as well as others, knowledge of maternal HIV status may be associated with increased symptoms of depression and anxiety. When or if disclosure is advocated, proper supports should be in place for both mothers and children. Disclosure of a family member's HIV status to a child is often misunderstood as a discrete event that can be accomplished in a single communication. Rather, disclosure is an ongoing process, and new information should be provided with any change in parental health status ... . Parents and other adult caregivers of the HIV-affected child should be counseled about the importance of developmentally appropriate communication regarding the parent's health, the child's need for the information, and his or her readiness to receive it ... . Adults should be counseled to provide children with realistic reassurance about the parent's health, and about their own future care and security. (pp. 84-85)

In another study assessing mothers living with HIV and their children, Murphy, Austin, and Greenwell (2006) examined both the **degree and impact of HIV-related stigma** among a convenience sample of 118 mothers living with HIV, as well as their early- and middle-adolescent children (averaging 13 years of age) who were not infected. Murphy and colleagues report that "[m]others who perceived greater HIV-related stigma also reported higher levels of depression, health-related anxiety, number of illness symptoms, and poorer functioning on medical outcomes (including physical health, bodily pain, fatigue, social functioning, and mental health). They also reported more alcohol use. The only scales for which mothers perceiving greater stigma did not differ from mothers perceiving lower levels of stigma were social support and family functioning" (p. 36). The investigators suggest that "[s]upport groups and interventions for HIV-infected women need to focus on normalizing HIV as a chronic disease, and on cognitive-behavioral strategies to deal with perceived stigma, stigma-related thoughts, and guilt towards stigma by association for their children" (p. 38). With regard to the adolescents studied, "[n]o significant differences were found in children's depression by perceived level of stigma; however, adolescents who perceived high levels of stigma because of their mothers' HIV status were more likely to participate in delinquent behavior, compared with those reporting low HIV-related stigma" (p. 20). "Adolescents perceiving higher levels of stigma were significantly more likely to exhibit **externalizing behaviors**, including bullying and physical violence" (p. 37). The investigators draw on earlier research and, in agreement with Brackis-Cott and colleagues, suggest that "[p]roviding ongoing support and information to the children of HIV-infected mothers may attenuate the stigma associated with HIV infection and thus decrease externalizing behavior problems" (p. 37).[4]

---

[4] "Among adolescents who have not been told of their mothers' HIV infection, support may be just as crucial for them as for adolescents who have been informed of their mothers' serostatus. For such adolescents in ... [this] sample, as for those to whom disclosure has been made, participation in delinquent acts occurred less frequently among those who had greater attachment to either their mother or their peers. However, unlike those who were

Sampling a younger cohort of children, New, Lee, and Elliott (2007) screened for **emotional and behavioral health among** 57 **children** (between the ages of 6 and 12 years) **living with HIV, as well as their** 54 **primary caregivers**. Among the 16 children who met screening criteria for behavioral or emotional health problems, 6 (38%) met criteria for a psychiatric diagnosis based on standardized interviews. Of the 15 caregivers who met screening criteria, all 13 who completed a computerized psychiatric interview met criteria for a psychiatric diagnosis. Importantly, while mental health needs were identified among these families living with HIV, a decided majority of these families did *not* exhibit psychiatric disorders. To New and colleagues, "[t]hese findings are surprising and contrary to what was expected and might suggest that children with HIV and their caregivers are remarkably resilient in the face of a multitude of challenges to their own and to their child's physical and mental health" (p. 128). Yet, "while the overall findings might suggest that there are lower than expected rates of emotional distress among this population, the fact that a proportion of these families do experience significant distress cannot be ignored. HIV is truly a family illness. Screening, ongoing support, and family-friendly, culturally sensitive mental health services should be an integral part of whole childcare for families living with HIV" (p. 129).

told of their mother's HIV infection, adolescents to whom disclosure had not been made were more likely to participate in delinquent acts when they were older and when they had a boyfriend or girlfriend, and having a boyfriend or girlfriend occurred more frequently among those who scored lower on attachment to their mothers. It may be that older adolescents who had not been informed of their mothers' HIV serostatus were more likely than their younger counterparts to be aware that something was amiss with their mothers, and this awareness may have triggered externalizing behavior among those who were less engaged with their mothers but more engaged with, and perhaps dependent upon, their peers. In contrast, among adolescents who knew their mothers' HIV status, participation in delinquent acts appeared to be more of a reaction to their mothers' poor physical or mental health and to be less related to what was going on in the adolescent's life outside the family" (p. 38).

HIV Treatment News

Medical Care

Himelhoch, Powe, Breakey, and Gebo (2007) conducted

> a cross-sectional study of a random, national sample of HIV experts drawn from the membership of the American Academy of HIV Medicine. Participants were mailed a self-administered questionnaire with a case vignette of a new onset AIDS patient and were specifically asked whether or not they would **recommend HAART** [highly active antiretroviral therapy] **treatment**. Vignettes were randomly assigned to include **a diagnosis of schizophrenia** or not. ... [The investigators] located 649 clinicians (93%); 347 responded (53.4%). Responders and nonresponders did not differ in demographics or work characteristics. (p. 110)

Himelhoch and colleagues report that "[r]ecommendation of [ARV] treatment did not differ between those who received a case vignette with schizophrenia versus those who did not ... . Compared to those who received a case vignette without schizophrenia, those who received vignettes with schizophrenia were more likely to avoid prescribing efavirenz, a medication with known neuropsychiatric side effects, ... more likely to agree to be helped by a [mental health] specialist ..., and more likely to recommend directly observed therapy ..." (p. 110). The investigators conclude that "HIV clinicians recognize the importance of recommending HAART treatment to individuals with schizophrenia and AIDS and [to] avoid using [ARV] medication with known neuropsychiatric side effects" (p.110), but stress that "[f]urther work is needed to assure these vignette findings actually translate into clinical practice" (p. 118).

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Stress Management

Sikkema et al. (2007) conducted a randomized controlled trial of **a group intervention for coping with HIV/AIDS and childhood sexual abuse** (CSA). A total of 202 men and women living with HIV – diverse with regard to ethnicity and sexual orientation, as well as gender – who had also been sexually abused as children, were "randomly assigned to one of three conditions: the HIV and trauma coping group experimental intervention, an HIV time-matched support group comparison condition, or a waitlist control condition. ... In both group conditions, co-therapists delivered the interventions in a local community health center over a course of 15 weekly 90-min sessions" (p. 52).

In the HIV and trauma coping group intervention,

> [p]articipants identified stressors that they perceived to be related to their sexual abuse experiences and those related to their HIV diagnosis. Parallels between these two traumatic experiences in terms of stress response and coping strategies were emphasized and processed during group discussion. For instance, participants expressed that, when diagnosed with HIV, they felt just as powerless as they had felt when sexually abused as children. Results of coping efforts were then reappraised and new coping strategies tried if results were not satisfactory. (p. 52)

Study participants assigned to the waitlist control condition were later randomly assigned to either the coping intervention or support group com-

parison condition. "Traumatic stress symptoms were assessed at baseline and post-intervention, with analysis conducted for the three-condition comparison followed by analysis of the two-condition comparison between the coping and support group interventions" (p. 49). Sikkema and colleagues report that

> [t]he HIV and trauma coping group intervention significantly reduced symptoms of traumatic stress when compared to both ... [the] support group comparison and waitlist control condition within the respective three- and two-condition phases of the study. ... [I]n the two-condition comparison, both intervention[s] ... reduced intrusive symptoms, likely at least partially attributable to desensitization achieved through actively addressing traumatic experiences in the groups. However, only the coping intervention, and not the support group intervention, demonstrated significant change in intrusive symptoms when compared to the waitlist control condition in the three-condition comparison. Additionally, the coping intervention, which focused on active approaches to confronting and coping with stress, provided the most benefit in addressing avoidance symptoms, particularly in the two-condition comparison. ...
>
> Further, in a test of clinical significance, individuals in the HIV and trauma coping group intervention condition were more likely to show recovery or reliable improvement in traumatic stress symptoms. These results not only confirm the effectiveness of the coping intervention ..., but also document the meaningfulness of the change in symptoms experienced. Clinically significant change was evidenced by 50% of participants receiving the coping intervention ... . (p. 57)

The investigators conclude that "a group intervention tailored for coping with CSA and HIV/AIDS is beneficial in reducing traumatic stress among both men and women with HIV disease. This type of treatment approach provides an integration of interventions currently available to address CSA and HIV mental health issues, and thus extends the limited number of effective interventions available for those with HIV/AIDS that are facing multiple stressors, including sexual trauma" (p. 58).

Care for Caregivers

Engler et al. (2006)

> examined **the role of coping in the experience of caregiver burden** among a heterogeneous sample of [176] caregivers for [persons living with HIV]. The results indicated that three types of coping – blame-withdrawal, active-approach, and distancing – were significantly positively correlated with caregiver burden. Furthermore, active-approach and distancing coping moderated the relationship between caregiver stress and caregiver burden even after controlling for demographic variables and caregiver depression; blame-withdrawal coping approached significance. (p. 990)

Engler and colleagues conclude from these findings that

> caregivers' coping mitigated the effects of stress on burden; as coping efforts increased, the impact of stress on burden decreased. Still, some caregivers were likely to experience burden even at low levels of stress or caregiver demand. That is, despite perceiving few HIV symptoms in the [person living with HIV], a subset of caregivers reported high levels of caregiver burden. This is an important finding given that the majority of the caregivers reported relatively low levels of stress from the [person living with HIV]'s symptoms in the era of HAART in which patient symptoms and immunosuppression are better controlled. ... These results ... seem to suggest that caregivers may benefit from any attempt to cope with stress. Healthcare providers may facilitate this process when working with people living with HIV and their informal caregivers. (p. 990)

Coping, Social Support, & Quality of Life

Dutch investigators (van der Veek, Kraaij, Van Koppen, Garnefski, & Joekes, 2007) explored relationships among cognitive coping, **frustration in the attainment of higher-order goals** (e.g., "being as healthy as possible"; "experiencing as little bodily discomfort or pain as possible"; "being ill as little as possible") and psychological distress in a sample of 43 adults living with HIV who were members of HIV societies in the Netherlands. The investigators found that study "[p]articipants who reported more higher-order goal hindrance ... also reported more depressive symptoms and a reduced quality of life" (p. 228). van der Veek and colleagues conclude that clinicians "may usefully pay attention to disturbance[s] in [the] attainment of higher-order goals, which ... result from the illness itself, the medical regimen or related side-effects. Patients might also benefit from support in the process of abandoning unattainable goals and (re)formulating new, realistic goals" (p. 228).

Remien et al. (2006) interviewed an ethnically diverse, predominantly low-income sample of 978 **women living with HIV** in four U.S. cities (New York, Los Angeles, San Francisco, and Milwaukee) and found that study participants self-identified **high levels of depressive symptomatology**. In fact,

> [f]orty-one percent of women re-

ported moderate to severe levels of depression. ... The findings ... suggest that women living with HIV, especially those who are socially and economically marginalized, continue to experience significant distress, even when they receive ongoing medical care and have access to HAART. While there was no relationship between depression and HAART utilization or standard clinical markers of disease status (i.e., CD4+ count or detectable/undetectable viral load), depressive symptomatology was related to the experience of physical symptoms of disease and the degree of perceived intrusiveness of these symptoms. This suggests that the women in this study were

Tool Box

Resources

Books & Articles:

Abell, N., Ryan, S., & Kamata, A. (2006). Assessing capacity for self-care among HIV-positive heads of household: Bilingual validation of the Parental Self-Care Scale. *Social Work Research, 30*(4), 233-243.

According to Abell and colleagues, both the English- and Spanish-language versions of the Parental Self-Care Scale have "the potential to assess HIV-positive parents' perceptions of their own capacities to maintain a complicated health regimen while remaining responsible for the well-being of their families" (p. 241).

Bletzer, K.V. (2007). Identity and resilience among persons with HIV: A rural African American experience. *Qualitative Health Research, 17*(2), 162-175.

"In this article, the author ... [describes] the life trajectories of two persons who used and sold drugs ... and examines the process of life reorganization they put into motion after testing positive for HIV" (p. 162).

Bradley-Springer, L.A., & Cook, P.F. (2006). Prevention with HIV-infected men: Recommendations for practice and research. *Journal of the Association of Nurses in AIDS Care, 17*(6), 14-27.

"This report explores epidemiologic and psychosocial issues related to prevention in men with HIV and compares how those variables relate to prevention efforts. The report ends with a discussion of a method to approach HIV risk reduction in clinical care settings" (p. 14).

Lyles, C.M., Kay, L.S., Crepaz, N., Herbst, J.H., Passin, W.F., Kim, A.S., Rama, S.M., Thadiparthi, S., DeLuca, J.B., & Mullins, M.M. (2007). Best-evidence interventions: Findings from a systematic review of HIV behavioral interventions for US populations at high risk, 2000-2004. *American Journal of Public Health, 97*(1), 133-143.

The Centers for Disease Control and Prevention's HIV/AIDS Prevention Research Synthesis Team "identified 18 behavioral interventions, reported from 2000 through 2004, with the best evidence of efficacy in reducing HIV risk. ... Providers of HIV prevention [services] can use the findings ... to select evidence-based intervention(s) best suited for their community's needs" (p. 139).

Lyon, M.E., & D'Angelo, L.J. (Eds.). (2006). *Teenagers, HIV, and AIDS: Insights from youths living with the virus.* Westport, CT: Praeger Publishers/ Greenwood Publishing Group.

"In this volume, experts who work with HIV/AIDS-infected teenagers examine the psychological and social fallout compounding the frightening medical issues faced by adolescents who've received the diagnosis. Readers share the challenge with teens as they face the stigma of HIV/AIDS and the tough decisions about who to tell of their infection and when to do it. We learn the hard truth about health care, self care, and new treatment options for affected teens. And we read about the heartbreaking end-of-life care issues for dying adolescents. Perhaps most importantly, the authors offer resources that teens and their families can turn to for information and support. They also explain what family, friends, teachers, and other professionals can do to help infected teens maximize their mental health and their quality of life."

Machtinger, E.L., & Bangsberg, D.R. (2007). Seven steps to better adherence: A practical approach to promoting adherence to antiretroviral therapy. *AIDS Reader, 17*(1), 43-C3.

"While adherence to antiretroviral therapy is regarded as the most important determinant of clinical outcomes in HIV-positive persons, most clinicians receive little guidance on practical steps to support and improve adherence. A structured, evidence-based, 7-step approach to supporting and improving antiretroviral adherence is described here. These steps can serve as a starting point or review for care providers working to support HIV-positive patients to successfully adhere to antiretroviral therapy" (p. 43).

Malow, R.M., Dévieux, J.G., & Lucenko, B. (2006). History of childhood sexual abuse as a risk factor for HIV risk behavior. *Journal of Trauma Practice, 5*(3), 13-32.

"This article presents a review of literature and concepts linking child sexual abuse [CSA] history and HIV risk behavior. Correlates of both CSA and HIV risk are reviewed and a proposed model of association is presented. ... Clinical implications include the need to assess: (1) abuse history among high-risk populations and (2) HIV risk behavior among CSA and other trauma survivors" (p. 13).

Pudil, J. (2006). I'm gone when you're gone: How a group can survive when its leader takes a leave of absence. *Social Work with Groups, 29*(2-3), 217-233.

"This article presents a process to allow the primary worker to take a leave of absence while the group continues with an interim worker. The author's personal experience of a leave of absence from a HIV+ adolescent support group will be used to illustrate this transfer process. In providing ample time and a thoughtful process of transfer, this leave of absence was successful in maintaining group attendance and participation" (p. 217).

Sales, J.M., Milhausen, R.R., & DiClemente, R.J. (2006). A decade in review: Building on the experiences of past adolescent STI/HIV interventions to optimise future prevention efforts. *Sexually Transmitted Infections, 82*(6), 431-436.

"The major purpose of this article is to systematically review and synthesise

more distressed by the experience of feeling sick than by the biological markers of disease progression that clinicians deem to be most relevant. Increased viral load and decreased CD4+ count are not necessarily accompanied by feelings of illness. The overall high levels of depressive symptoms in this sample suggest that clinicians working with HIV-positive women should consistently inquire about physical symptoms of illness, their level of "bother" and associated feelings of distress, in the course of routine evaluation, regardless of health status as measured by routine laboratory markers. (p. 281)

The investigators also found that

empirical findings from selected adolescent STI [sexually transmitted infection]/HIV interventions conducted in the United States between 1994 and 2004. Specifically, the most current adolescent STI risk reduction interventions conducted in diverse venues, such as in the community, schools, clinics, and specialised adolescent centres (that is, detention homes and drug programmes) were examined for reported efficacy, and were assessed for programmatic and methodological strengths and weaknesses. Next, a subset of programmatic characteristics was identified that were associated with the efficacy of STI risk reduction programmes both within a particular venue, as well as across all venues. Finally, ... [the authors] discuss the research and practice implications of these findings for optimising future evidence[-]based STI risk reduction programmes for adolescents in the United States" (p. 431).

Shambley-Ebron, D.Z., & Boyle, J.S. (2006). In our grandmother's footsteps: Perceptions of being strong in African American women with HIV/AIDS. *Advances in Nursing Science, 29*(3), 195-206.
"An ethnographic study of African American mothers living with HIV/AIDS revealed that they believed in a tradition and heritage of strength that fostered their survival during difficult life experiences such as living and mothering with HIV/AIDS. They enacted this strength in culturally significant ways. This article discusses the importance of recognizing and supporting cultural strengths of African American women to help manage illness, while remaining cognizant of the context of oppression, discrimination, and stigma that distort cultural traditions and instead penalize women when they are ill" (p. 195).

van Kesteren, N.M.C., Kok, G., Hospers, H.J., Schippers, J., & de Wildt, W. (2006). Systematic development of a self-help and motivational enhancement intervention to promote sexual health in HIV-positive men who have sex with men. *AIDS Patient Care & STDs, 20*(12), 858-875.
"This paper presents the process by which a theory- and evidence-based intervention was developed to promote sexual health in HIV-positive MSM. Intervention Mapping, a tool for planning and developing health promotion interventions, was used as a guide in developing the intervention. ... Intervention Mapping not only explicates the processes involved in intervention development, it also guides the application of both theory and empirical evidence to all phases of intervention development. Intervention Mapping has been shown to contribute to well-considered choices and transparency both in the process of intervention development and in anticipation of its implementation" (pp. 871-872).

Williams, A.B., & Friedland, G.H. (Eds.). (2006). HIV medication adherence. *Journal of Acquired Immune Deficiency Syndromes, 43*(Suppl. 1), S1-S155.
"The articles in this special supplement ... comprise discussions of the theoretic underpinnings of adherence research and of the challenges of collaboration across disciplines ..., a state-of-the-art review of the outcomes of adherence intervention trials ..., results from 2 adherence intervention clinical trials ..., explorations of important methodologic aspects of adherence intervention research such as the role of qualitative methods ..., the challenge of developing a theory-driven intervention ..., measurement strategies ..., data management issues with electronic monitoring devices ..., an innovative approach to assess intervention effectiveness ..., a promising cost-effectiveness model for adherence interventions ..., and the earliest reports of exciting work being conducted abroad in the resource-limited parts of the world in which the epidemic continues to expand ... . Finally, ... one of the early leaders in antiretroviral adherence research ... comments on where we are today and offers her thoughts for the future" (p. S2).

Wojna, V., & Nath, A. (2006). Challenges to the diagnosis and management of HIV dementia. *AIDS Reader, 16*(11), 615-616, 621-624, 626, 629-632.
Clinicians face "several new challenges in the diagnosis and treatment of a patient with HIV infection who presents with cognitive impairment. In this article, ... [Wojna and Nath] provide a systematic approach to addressing each of these issues and guidelines for management of these patients. ... [They] also discuss the latest experimental approaches and the clinical trials being conducted for the better management of this population" (p. 615).

Wright, K., Naar-King, S., Lam, P., Templin, T., & Frey, M. (2007). Stigma scale revised: Reliability and validity of a brief measure of stigma for HIV+ youth. *Journal of Adolescent Health, 40*(1), 96-98.
"This study assessed the reliability and validity of an abbreviated measure of HIV stigma in a sample of minority HIV+ youth with diverse gender and sexual orientation. Results demonstrated good reliability and validity for the total 10-item stigma scale as well as for the subscales" (p. 98).

On the Web:
"AIDS.gov serves as an information gateway to guide users to Federal domestic HIV/AIDS information and resources." The goal of this site "is to ease access to information on Federal HIV/AIDS prevention, testing, treatment, and research programs, policies, and resources. AIDS.gov contains links to guide ... [viewers] to information on those topics."

– Compiled by Abraham Feingold, Psy.D.

> stress mediate[d] ... the effects of symptoms and illness intrusiveness, and that coping mediate[d] ... the effects of social ... [support] on depression, strongly suggest[ing] ... that interventions that enhance coping skills are important to help women better utilize their social resources and manage stress, and thereby, reduce the negative impact of poor physical health on mental health. Thus, although health status (i.e., physical symptoms) and stress can lead to depressive symptoms, it should not be accepted as a given that depression is an inevitable outcome of poor health in the context of HIV illness or that a greater frequency of HIV-related physical symptoms should necessarily lead to the experience of depressed symptomatology for women living with HIV. ... [These] results also underscore the importance of understanding factors associated with better coping and ways to enhance self-efficacy for coping among HIV-positive women. It seems that the level of confidence in one's ability to effectively handle stress influences the extent to which supportive resources are utilized, and ... can directly influence depression. (p. 282)

In closing, Remien and colleagues point out that these findings highlight "the need for the routine integration of mental health services into HIV primary care settings ... [and] the widespread need for psychological support and ongoing mental health services for women living with HIV. ... In addition to current standard mental health interventions, peer support (either one-on-one or in group) and counselor and volunteer led HIV support groups, common in many community[-]based organizations across the country, can be more formally linked to standard medical treatment and referral practices" (pp. 282-283).

On the topic of social support, Emlet (2006) conducted interviews to examine **social networks** and **social isolation** in two matched samples: 44 older adults (ages 50 and older) living with HIV/AIDS and 44 younger adults (ages 20-39) living with HIV/AIDS in the Pacific Northwest. The investigator found that "[b]oth groups' social networks had similar patterns; however, older adults were more likely to live alone. More than 38 percent of older adults and 54 percent of older adults of color were at risk of social isolation compared with 25 percent of those 20 to 39 years of age. Older men and older adults of color had significantly lower scores on the social network scale than others. Having a confidant and receiving instrumental support were significantly correlated with reduced HIV stigma" (p. 299). These findings, according to Emlet,

> suggest that age, coupled with race, ethnicity, or gender, can further affect the potential for social isolation. Therefore, ... [clinicians] can and should respectfully ask older clients if they have questions or concerns about HIV or AIDS, thereby normalizing the issue and giving the client permission to speak about it[.] ... [In work] with HIV-infected clients, particularly older individuals, systematic methods should be used for assessing sources of social support. The most abbreviated version of the LSNS [Lubben Social Network Scale] (six items) ... is an example of a short, clinically oriented scale that can be easily administered as part of the standardized assessment and takes less than five minutes to complete. HIV-related stigma in all populations infected or affected by HIV should be carefully considered, and any potential negative impact of stigma addressed. At a very practical level, ... [clinicians] need to be knowledgeable about services funded through mechanisms such as the Older Americans Act and the Ryan White CARE Act to provide referrals to formal services. Formal services may augment or take the place of lacking informal networks. (pp. 306-307)

Lastly, Mphande-Finn and Sommers-Flanagan (2007) analyzed interview data provided by 7 white **women living with HIV/AIDS in rural communities** in the northwestern United States. "Based on these interviews, eight themes emerged. These included (a) daily powerful emotions, (b) emotional and physical abandonment, (c) romantic betrayal, (d) medical treatment issues, (e) loss and grief, (f) appreciating a good support system, (g) renewed purpose for living, and (h) personal growth and transformation" (p. 3). The investigators translate these findings into a number of treatment recommendations:

> The identification and articulation of powerful emotions ... may occur on a daily basis. Community-based interventions, particularly for women, may be enhanced if services are constructed so as to allow regular emotional exploration and expression ... .
>
> The women spoke about the abandonment they experienced following their ... diagnoses. This suggests that it may be helpful for women to prepare for abandonment related to the HIV/AIDS diagnoses and to have more social-emotional support systems in place before and during their disease experience. They also might benefit from analyzing and expanding their own support-seeking behavioral repertoire ... .
>
> Rural women are most likely to contract HIV/AIDS from heterosexual intercourse ... . In this small rural sample, the women were universally infected by long-

term romantic partners. When women contract HIV from partners, they may benefit from directly working through the deep feelings of betrayal that are likely to emerge ... .

The women were clear about the burden of their medical/health issues, experience of grief and loss, and appreciation of support from individuals and health care systems. ... Some women ... may [therefore] benefit from structured support groups in the medical care system focusing, in part, on grief, loss, betrayal, and other deep feelings ... .

Perhaps the most interesting findings in this study were the themes of renewed purpose for living and personal growth and transformation. This suggests that for some rural women with HIV/AIDS, the news is not all bad. ... It is reasonable to conclude that some women who contract HIV/AIDS may feel an urge to contribute to society. It may be appropriate for health care and mental health professionals to cultivate this impulse in ... women [living with HIV/AIDS].

Rural settings include unique obstacles to ... prevention and treatment ... . Acquiring treatment may be difficult, and rural ... patients often travel hours to obtain medical care because getting tested for HIV, discussing sexual practices with health care providers, and practicing safe[r] sex are difficult to do privately near their homes... . If these obstacles are overcome, rural women might move more quickly toward renewed purpose and personal growth. There may be a link between rural women who receive social-medical-psychological support and regaining hope, trust, and a desire to contribute to community ... . (pp. 9-10)

References

Beyer, J.L., Taylor, L., Gersing, K.R., & Krishnan, K.R. (2007). Prevalence of HIV infection in a general psychiatric outpatient population. *Psychosomatics, 48*(1), 31-37.

Brackis-Cott, E., Mellins, C.A., Dolezal, C., & Spiegel, D. (2007). The mental health risk of mothers and children: The role of maternal HIV infection. *Journal of Early Adolescence, 27*(1), 67-89.

Cole, J., Logan, T.K., & Shannon, L. (2007). Risky sexual behavior among women with protective orders against violent male partners. *AIDS & Behavior, 11*(1), 103-112.

Cysique, L.A., Deutsch, R., Atkinson, J.H., Young, C., Marcotte, T.D., Dawson, L., Grant, I., Heaton, R.K., & the HNRC Group. (2007). Incident major depression does not affect neuropsychological functioning in HIV-infected men. *Journal of the International Neuropsychological Society, 13*(1), 1-11.

Emlet, C.A. (2006). An examination of the social networks and social isolation in older and younger adults living with HIV/AIDS. *Health & Social Work, 31*(4), 299-308.

Engler, P., Anderson, B., Herman, D., Bishop, D., Miller, I., Pirraglia, P., Hayaki, J., & Stein, M. (2006). Coping and burden among informal HIV caregivers. *Psychosomatic Medicine, 68*(6), 985-992.

Fitzgerald, T., Lundgren, L., & Chassler, D. (2007). Factors associated with HIV/AIDS high-risk behaviours among female injection drug users. *AIDS Care, 19*(1), 67-74.

Herbst, J.H., Kay, L.S., Passin, W.F., Lyles, C.M., Crepaz, N., & Marín, B.V. (2007). A systematic review and meta-analysis of behavioral interventions to reduce HIV risk behaviors of Hispanics in the United States and Puerto Rico. *AIDS & Behavior, 11*(1), 25-47.

Himelhoch, S., Powe, N.R., Breakey, W., & Gebo, K.A. (2007). Schizophrenia, AIDS and the decision to prescribe HAART: Results of a national survey of HIV clinicians. *Journal of Prevention & Intervention in the Community, 33*(1-2), 109-120.

Israelski, D.M., Prentiss, D.E., Lubega, S., Balmas, G., Garcia, P., Muhammad, M., Cummings, S., & Koopman, C. (2007). Psychiatric co-morbidity in vulnerable populations receiving primary care for HIV/AIDS. *AIDS Care, 19*(2), 220-225.

Klein, H., Elifson, K.W., & Sterk, C.E. (2007). Childhood neglect and adulthood involvement in HIV-related risk behaviors. *Child Abuse & Neglect, 31*(1), 39-53.

Lam, P.K., Naar-King, S., & Wright, K. (2007). Social support and disclosure as predictors of mental health in HIV-positive youth. *AIDS Patient Care & STDs, 21*(1), 20-29.

LaSala, M.C. (2007). Parental influence, gay youths, and safer sex. *Health & Social Work, 32*(1), 49-55.

Lightfoot, M., Tevendale, H., Comulada, W.S., & Rotheram-Borus, M.J. (2007). Who benefited from an efficacious intervention for youth living with HIV: A moderator analysis. *AIDS & Behavior, 11*(1), 61-70.

Mausbach, B.T., Semple, S.J., Strathdee, S.A., Zians, J., & Patterson, T.L. (2007). Efficacy of a behavioral intervention for increasing safer sex behaviors in HIV-positive MSM methamphetamine users: Results from the EDGE study. *Drug & Alcohol Dependence, 87*(2-3), 249-257.

Mphande-Finn, J.T., & Sommers-Flanagan, J. (2007). The experience of HIV/AIDS among rural women in the northwestern United States: A qualitative analysis. *Journal of Community Psychology, 35*(1), 3-12.

Murphy, D.A., Austin, E.L., & Greenwell, L. (2006). Correlates of HIV-related stigma among HIV-positive mothers and their uninfected adolescent children. *Women & Health, 44*(3), 19-42.

New, M.J., Lee, S.S., & Elliott, B.M. (2007). Psychological adjustment in children and families living with HIV. *Journal of Pediatric Psychology, 32*(2), 123-131.

Remien, R.H., Exner, T., Kertzner, R.M., Ehrhardt, A.A., Rotheram-Borus, M.J., Johnson, M.O., Weinhardt, L.S., Kittel, L.E., Goldstein, R.B., Pinto, R.M., Morin, S.F., Chesney, M.A., Lightfoot, M., Gore-Felton, C., Dodge, B., Kelly, J.A., & the NIMH Healthy Living Project Trial Group. (2006). Depressive symptomatology among HIV-positive women in the era of HAART: A stress and coping model. *American Journal of Community Psychology, 38*(3-4), 275-285.

Rotheram-Borus, M.J., Swendeman, D., Comulada, W.S., Weiss, R.E., Lee, M., & Lightfoot, M. (2004). Prevention for substance-using HIV-positive young people: Telephone and in-person delivery. *Journal of*

Acquired Immune Deficiency Syndromes, 37(Suppl. 2), S68-S77.

Semple, S.J., Grant, I., & Patterson, T.L. (2006). Perceived behavior of others and AIDS risk behavior among heterosexually-identified methamphetamine users. *Journal of Psychoactive Drugs, 38*(4, SARC Suppl. 3), 405-413.

Semple, S.J., Zians, J., Grant, I., & Patterson, T.L. (2006). Methamphetamine use, impulsivity, and sexual risk behavior among HIV-positive men who have sex with men. *Journal of Addictive Diseases, 25*(4), 105-114.

Sikkema, K.J., Hansen, N.B., Kochman, A., Tarakeshwar, N., Neufeld, S., Meade, C.S., & Fox, A.M. (2007). Outcomes from a group intervention for coping with HIV/AIDS and childhood sexual abuse: Reductions in traumatic stress. *AIDS & Behavior, 11*(1), 49-60.

Smith, D.K., Leve, L.D., & Chamberlain, P. (2006). Adolescent girls' offending and health-risking sexual behavior: The predictive role of trauma. *Child Maltreatment, 11*(4), 346-353.

Stevens, P.E., & Hildebrandt, E. (2006). Life changing words: Women's responses to being diagnosed with HIV infection. *Advances in Nursing Science, 29*(3), 207-221.

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:

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

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

van der Veek, S.M.C., Kraaij, V., Van Koppen, W., Garnefski, N., & Joekes, K. (2007). Goal disturbance, cognitive coping and psychological distress in HIV-infected persons. *Journal of Health Psychology, 12*(2), 225-230.

van Gorp, W.G., Rabkin, J.G., Ferrando, S.J., Mintz, J., Ryan, E., Borkowski, T., & McElhiney, M. (2007). Neuropsychiatric predictors of return to work in HIV/AIDS. *Journal of the International Neuropsychological Society, 13*(1), 80-89.

Wiener, L., Battles, H., Ryder, C., & Pao, M. (2006). Psychotropic medication use in human immunodeficiency virus-infected youth receiving treatment at a single institution. *Journal of Child & Adolescent Psychopharmacology, 16*(6), 747-753.

– Compiled by
Abraham Feingold, Psy.D.

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

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov