

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Women & Men

Noar, Black, and Pierce (2009) conducted a systematic review and meta-analysis of both published and unpublished studies testing “**computer technology-based HIV prevention behavioral interventions** aimed at increasing condom use among a variety of at-risk populations” (p. 107). The 12 randomized controlled trials included in the analysis were published or presented between 2002 and 2008 and involved a total of 4,639 participants. Noar and colleagues found that

the overall mean weighted effect size for condom use . . . indicat[ed] . . . a statistically significant impact of the interventions . . . [and] compares favorably to previously tested interventions delivered by human facilitators. Statistically significant effect sizes were also found for frequency of sexual behavior, number of partners, and incident sexually transmitted diseases [(STDs)]. In addition, interventions were significantly more efficacious when they were directed at men or women (versus mixed sex groups), utilized individualized tailoring, used a Stages of Change model, and had more intervention sessions. (p. 107)

Noar and colleagues conclude that “computer technology-based HIV

prevention interventions have similar efficacy to more traditional human-delivered interventions. Given their low cost to deliver, ability to customize intervention content, and flexible dissemination channels, they hold much promise for the future of HIV prevention” (p. 107).

About Adolescents & Young Adults

Guilamo-Ramos, Jaccard, Dittus, and Collins (2008) surveyed a random sample of 668 mother-adolescent dyads recruited from middle schools located in an inner-city neighborhood of New York “to understand why some mothers speak less often with their children about not having sexual intercourse” (p. 760). The investigators found that

mothers were more likely to have talked with their child if they: (a) thought they had the knowledge to answer questions and the skills to explain themselves clearly; (b) felt it would not cause embarrassment to them or their child; (c) thought that doing so helps the child adopt more mature thinking; (d) felt more relaxed and comfortable about talking about sex; (e) felt that talking with their children implies that they are a responsible parent; and (f) felt better about themselves in general and had higher levels of self-esteem. Finally, the harder mothers thought it would be to have such conversations, the less

likely they were to have done so. (p. 767)

Guilamo-Ramos and colleagues offer several ideas for **increasing parent-adolescent communication about sexual intercourse**, observing that

almost all of the factors associated with communication frequency can be addressed in intervention programs. Parents can be given a knowledge base and skill-set for talking about these topics with their child. . . . By practicing conversations ahead of time and talking through their planned conversations with other parents or support persons, they can reduce their own discomfort and approach discussions calmly and in a more relaxed fashion. Observing videotapes of other parents communicating with adolescents could be of help. Giving parents a general sense of self-confidence also could be useful. . . . Many of the above techniques are used in a scattered fashion in different programs, but they

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have not been condensed into a single intervention effort. . . . [This] research suggests a more integrative approach might be helpful. (pp. 767-768)

Halkitis, Siconolfi, Fumerton, and Barlup (2008) conducted "a qualitative study to develop a greater understanding of 'intentional' unprotected anal intercourse [(UAI)] among drug-using gay and bisexual men, also known colloquially as **barebacking**" (p. 11). The investigators offer the following thematic analysis of life histories elicited from a sample of 12 men between the ages of 21 and 29 years who were randomly selected from a larger sample that was stratified by race/ethnicity:

The men . . . reported that drugs and alcohol diminished their inhibitions and reduced their judgment and reasoning abilities, facilitating sexual experiences, including [UAI], in which they would not normally have participated. . . . Notably, these men acknowledged the risks associated with their substance use, and reported concern for their safety because of the increased likelihood that they will bareback while high.

Many of the men . . . reported mental health issues, including depression, low self-esteem, and feelings of isolation and loneliness, and described barebacking as . . . either representative of, or

a treatment for, these emotional symptoms. . . . Especially salient for these men was the use of barebacking to alleviate painful feelings of isolation and loneliness, particularly as a means of achieving intimacy and emotional connectedness with sexual partners. . . . Barebacking also functioned as an outlet for sensation seeking and risk-taking in some of these men, who saw sex without condoms as a form of sexual adventurism. . . .

The men also detailed the ways they attempted to rationalize their decisions regarding risk-taking. They reported using heuristics [relatively automatic decision-making rules] based on their partner's physical characteristics, including overall bodily appearance and age. . . . Additionally, some of [the] men felt that they could determine their partner's serostatus based on his mannerisms, prior acquaintance with the partner, or simply trusting their own "instinct." Previous research on sexual risk-taking has focused on gay and bisexual men's beliefs about their own physiological or spiritual resistance to HIV infection . . . ; however, these men appeared to project beliefs about noninfectivity onto their partners. Additionally, all of these heuristics replaced any form of serostatus disclosure.

Despite the fact that viral load is extremely high after initial infection, during which time antibodies are not easily detected . . . , several of the men detailed using HIV antibody testing as a way of affirming their ability to continue taking risks. These men experienced cycles of fear of testing HIV-positive, actually testing HIV-negative, and resuming risky behaviors.

All . . . participants deferred to their partners' requests during sexual acts, including deciding whether to bareback or use condoms. Barebacking has commonly been defined as *intentional* unprotected sex . . . yet . . . most . . . self-identifying barebackers do not intentionally plan to bareback. Instead, "it just happens." . . . Only two participants claimed to actively seek unprotected sex, and even they used condoms when preferred by the partner. . . .

[P]articipants were willing to continue intentional risk-taking behavior despite clear knowledge or personal experience of the possible consequences. . . . They often expressed a desire to change their behaviors despite a seeming inability (as demonstrated by continued risk-taking) to implement safer sex practices, such as serostatus disclosure or condom use. (pp. 22-23)

According to Halkitis and colleagues,

what is apparent in the[se] narratives . . . is that misinformation may be a factor in the sexual risk-taking behaviors of young HIV-negative men, but . . . deeper intrapsychic processes, including low levels of self-esteem, elevated levels of depression, as well as other emotions (often heightened by concurrent substance use),

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and the desire to please sexual partners may drive the decision-making of these men, which may eventually lead some to HIV seroconversion.

To this end, intervention strategies need to . . . delve more thoroughly into these realities and empower young men to seek support for the states that drive their risks – both sexual and drug using. . . . The[se] results . . . suggest that prevention and intervention programs that are multifaceted and address the psychological, emotional, and behavioral aspects of barebacking, in addition to educating individuals about the mechanics of disease transmission and safer sex practices, will have an increased potential for effecting change in the lives of individuals who continue to put themselves at risk for HIV through unprotected sex. Programs that screen for and address mental health issues and substance use are imperative, as some men seem to be using barebacking as a way of coping with difficult emotional and psychological issues. Further, programs which help men develop both motivations and skills (e.g., partner negotiation) to stay HIV-negative may help prevent seroconversion in the interim of mental health treatment. Additional focus placed on the individual's self-esteem and awareness . . . , along with tools to help men communicate with sexual partners, may also help men keep unprotected sex from "just happening." (p. 24)

About Men Who Have Sex With Men

Continuing this focus on the role of psychological factors in predicting HIV sexual transmission risk behavior among men who have sex with men (MSM), Hart, James, Purcell, and Farber (2008) note that "**social**

anxiety, or anxiety about being evaluated in interpersonal situations, is **associated with unprotected insertive anal intercourse** among young . . . MSM . . . and with other behavioral risk factors for unprotected intercourse, such as depression, smoking, alcohol use, and drug use. Social anxiety may be especially relevant in understanding HIV risk among HIV-seropositive men, given its stronger association with unprotected insertive than with receptive anal intercourse" (p. 879). To investigate this supposition, Hart and colleagues recruited 206 "HIV-positive men attending regularly scheduled primary care medical appointments at a community HIV clinic. . . . The sample was primarily African American, unemployed, of low educational level, and 95% of the sample had an AIDS diagnosis" (p. 879). The sample included MSM ($n = 84$), men who have sex with women only ($n = 52$), and men who claimed that they were abstinent from sex with partners of either gender in the preceding 6 months ($n = 70$). The investigators found that

high social performance anxiety, which has hitherto been unexplored as a risk factor for HIV sexual transmission risk among HIV-positive individuals, is associated in a clinical sample of HIV-positive MSM with . . . significantly increased odds of engaging in unprotected insertive anal intercourse with non-HIV-positive partners. Specifically, sexual transmission risk appears to be more closely associated with social performance anxiety, or anxiety about being evaluated negatively when performing a behavior, than with anxiety about social interactions. . . . [Furthermore, these findings demonstrate] that social performance anxiety is associated with this high-risk behavior controlling for club drug use, tobacco use, and depression, all of which have been

linked to HIV risk behavior in previous studies. . . . Findings also suggest that social performance anxiety may be a specific risk factor for MSM and not all HIV-positive men.

. . . [T]hese findings suggest that social anxiety in HIV-positive MSM, particularly performance anxiety, is an important psychological factor to address in the development and implementation of HIV risk reduction interventions. If socially anxious MSM are at increased risk of having [UAI], then HIV prevention interventions incorporating social anxiety-related concerns may not only reduce social fear and related psychological impairment . . . but may also decrease the threat of transmitting HIV among MSM. Further work examining the mechanisms by which social anxiety may potentially lead to risky sex would be useful when designing these interventions. (pp. 883-884)

Another intrapersonal perspective on HIV risk reduction comes from the Netherlands where, among a convenience sample of 1,613 MSM who completed an online survey, Adam, Teva, and de Wit (2008) analyzed data from 1,129 men who reported sex with casual partners. "Potential sexual risk-taking in the preceding 12 months was indexed by number of casual partners (<10 vs ≥ 10), [UAI] with casual partners (UAI-C; no vs yes) and sexually transmitted infections [(STIs)] (no vs yes)" (p. 463). Adam and colleagues found that "potential sexual risk-taking with casual partners was highly prevalent in this online sample of MSM; 51.0% had 10 or more casual sex partners, 38.8% had engaged in UAI-C and 22.9% reported having had a[n] STI]. . . . [S]exual sensation seeking was significantly related to more risk-taking according to each outcome variable, while all effects of **sexual self-**

control were significantly protective. As expected, sexual self-control attenuated the effects of high sexual sensation seeking on UAI-C, but not on numbers of partners and infection with a[*n* STI]" (p. 463).

The investigators conclude that "sexual self-control can buffer the influence of high sexual sensation seeking on UAI-C. While some men may spontaneously self-regulate their sexual desires, . . . other men may need more support. Self-regu-

lation of sexual behaviours can be promoted by planning ahead of time, for instance by methods known as implementation intentions, . . . or action and coping plans. . . . These simple self-regulation tools have been found to make a major difference in other domains of health behaviour change" (p. 466).

Continuing the evaluation of data compiled by the Healthy Living Project (HLP) Team (2007; see the [Summer 2007](#) issue of *mental health*

AIDS for details), Morin et al. (2008) "examined the extent to which the enhanced serosorting among MSM in the HLP¹ paralleled intervention-

¹ "The [HLP] experimental intervention . . . consisted of 15 90-minute individual counseling sessions grouped into 3 modules, each consisting of 5 sessions. Module 1 (stress, coping, and adjustment) addressed quality of life, psychologic coping, and achieving positive affect and supportive social relationships. Module 2 (safer behaviors) addressed self-regulatory issues, such as avoiding sexual and drug-related risk of HIV transmission or acquisition of

SAVA Latina: Addressing the Interplay of Substance Abuse, Violence, & AIDS Affecting Hispanic Women (Part 1)

The term "syndemic" was coined by medical anthropologist Merrill Singer to refer to "the set of synergistic or intertwined and mutual[ly] enhancing health and social problems facing the urban poor" (Singer, 1994, p. 933). The first syndemic he identified and analyzed was the SAVA (Substance Abuse, Violence, and AIDS) syndemic (Singer 1996, 2006), and research on this syndemic has continued to the present day.

This is the first of a two-part series. Part 1 reviews the literature linking these interlocking threats to health and safety, including recent work delineating pathways that tie together violence and HIV risk. The focus then shifts to violence and its effects on immigrant Hispanic women (Latinas) living in the United States, cultural factors that contribute to the risk for both violence and HIV in this population, and screening questions (in Spanish) that have demonstrated utility in identifying women who have been abused.

Part 2 (to be presented in the Summer 2009 issue of *mental health AIDS*) will summarize the impact of violence on the health (including mental health) of women in general and Latinas in particular, unmet mental health needs in this population, and the evolving state of intervention research, including culturally specific interventions for clinicians working in the cross-currents of these health and social problems.

SAVA in Review

A rationale for linking violence against women (VAW) and HIV was laid out by Maman, Campbell, Sweat, and Gielen (2000), who reviewed 29 studies from the United States and sub-Saharan Africa on the interface of HIV and violence and offered an agenda for future investigation and cross-disciplinary service delivery.

Maman and colleagues examined three ways through which violence is thought "to increase women's risk for HIV infection: (1) through forced or coercive sexual intercourse with an infected partner, (2) by limiting women's ability to negotiate safe[r] sexual behaviors, and (3) by establishing a pattern of sexual risk taking among individuals assaulted in childhood and adolescence" (p. 466). The investigators also examined the question of "increased risk for violence among women living with HIV infection" (p. 474).

"Although men are also victims of violence, women are disproportionately victimised by intimate partners and, therefore, most affected by this intersection."

— Campbell et al., 2008, p. 221

Two more recent review articles have built on the work of Maman and colleagues:

o Gielen et al. (2007) reviewed 35 studies conducted with women in the United States and published between 1998 and 2006 that addressed "the intersection of HIV and adult intimate partner violence (IPV)" (p. 178). IPV, "sometimes referred to as domestic violence, battery, or spousal abuse," encompasses "physical, sexual, and/or psychological abuse committed by a current or former partner regardless of sexual orientation" (Weidel, Proven-

cio-Vasquez, Watson, & González-Guarda, 2008, p. 248).

o Campbell et al. (2008) reviewed 71 studies from the "domestic and international literature on the intersection of IPV and HIV" (p. 222) in heterosexual relationships involving females aged 12 years and older that were published in English between 1998 and 2007.

In their critical synthesis of the literature, Gielen and colleagues found that "most studies describe rates of IPV among women at risk or living with HIV/AIDS and identify correlates, using multiple types of convenience samples (e.g., women in methadone treatment, women in shelters or clinics), cross-sectional designs, and self-reported risk behaviors" (p. 178), but "measurement, design, and analysis issues make comparisons across studies difficult" (p. 194). Studies do

suggest, nevertheless, that "HIV-positive women appear to experience any IPV at rates comparable to HIV-negative women from the same underlying populations; however, their abuse seems to be more frequent and more severe" (p. 178). Finally, this review

supports the need to include substance abuse as a third, intertwined health problem that must be considered in efforts to understand the relationship between HIV risk and IPV. The relationship between HIV and IPV can be mediated by . . . risky behaviors asso-

related reductions in HIV transmission risk” (p. 545). According to Morin and colleagues, “there was an overall reduction in transmission risk acts among MSM in both intervention and

additional [STDs], and disclosure of HIV status to potential partners. Module 3 (health behaviors) addressed accessing health services, adherence, and active participation in medical care decision making. Intervention sessions followed a standard structure and set of activities but were individually tailored to participants’ specific life contexts, stressors, and goals” (Healthy Living Project Team, 2007, p. 215).

ciated with drug use and the problem use of alcohol. . . . However, because the temporal relationship between substance use, IPV, and sexual risk taking is difficult to establish – particularly through cross-sectional studies – the pathways through which these events and behaviors interact are not yet clearly understood. (p. 194)

According to Campbell and colleagues, the research they reviewed

clearly indicates complex but real relationships between two epidemics threatening the health and safety of women in the US and around the world. . . . The increased risk for HIV/AIDS related to VAW, particularly IPV, works through both male and female behaviour, through physiological consequences of violence and affects both adult women and adolescents. There is now evidence that all three behavioural areas proposed by Maman and colleagues (2000) are mechanisms by which the risk is increased: forced sex with an infected partner; limited or compromised negotiation of safer sex practices; and increased sexual risk-taking behaviours. Another mechanism found to be important is the increase in other STIs [sexually transmitted infections] that accompany abuse and facilitate HIV transmission. There is beginning to be evidence of a connection between abuse-related immunocompromised states, which may have implications for both HIV infection, conversion from HIV to

control arms, with significant intervention effects observed at the 5-, 10-, 15-, and 20-month assessments. . . . These intervention-related decreases in HIV transmission risk acts seemed to be partially due to **sustained serosorting practices**. MSM in the intervention condition reported a significantly greater proportion of sexual partners who were HIV infected at the 5- and 10-month assessments” (p. 544). Morin and colleagues conclude that “**a cognitive-behavioral intervention as part of**

AIDS or AIDS-related infections such as tuberculosis. All of these connections need further investigation of the precise mechanisms of enhanced transmission in order to design effective prevention strategies. (pp. 226-227)

Pointing the Way

Employing a mixed methodology to address a central question raised in these two literature reviews, Fuentes (2008) delineates pathways that link experiences of IPV to increased risk for STIs, including HIV, among a sample of ethnically diverse women. She “elicited data from both life-history interviews of 28 abused women and structured interviews with 215 abused and nonabused women” (p. 1591) and, through the analysis of these data, “confirmed that abused women face heightened risk for STI/HIV compared with their nonabused counterparts. The greater the severity or frequency of abuse in a woman’s life, the greater the sexual risk. This relationship held regardless of ethnicity or sociodemographic factors, such as level of education, age, number of children, or occupation” (p. 1599). According to Fuentes,

this study fills important gaps in the current domestic violence literature by not only verifying increased risk for STIs, including HIV/AIDS, among abused women but also by employing a mixed-method approach in order to delineate the specific pathways by which this risk is generated. Pathways joining abuse and subsequent sexual risk consisted of multiple, interrelated risk factors, such as depression,

prevention case management may be efficacious in reducing risk of HIV transmission in this population. . . . [T]he HLP’s failure to maintain an effect at the 25-month assessment (10 months after the conclusion of the intervention) suggests the need for prevention to be part of ongoing care or case management” (p. 548). According to the investigators,

perhaps the most appropriate adaptation of the intervention would be a specialist-delivered

substance abuse, earlier age of first sex compared with non-abused women, greater numbers of current and lifetime sexual partners relative to nonabused women, engaging in exchange sex, inability to negotiate safe[r] sex, a partner who abuses substances, nonmonogamous partners, lack of emotional or financial support from friends and family, and hasty involvement in and escalation of intensity of relationships with new men. These risks were shown to increase in severity proportionate to the severity and frequency of abuse experienced. Sociodemographically diverse Anglo, Latina, and African American women who had experienced abuse exhibited more similarities than differences regarding sexual risk. (p. 1600)

A Question of Magnitude

Even though “IPV is a major health concern that crosses all races, ethnicities, and social classes,” Weidel and colleagues (2008) point out that “the incidence of IPV is 54% higher in Hispanics than in non-Hispanic Whites . . . [and a]lthough Hispanics represent 13% of the population in the United States, they account for 34% of the incidence of IPV. . . . IPV among Hispanics living in the United States seems to be higher than among Hispanics living in Latin American countries. Compared with non-Hispanic White women, Latina victims of IPV tend to be younger, less educated, and more economically disadvantaged” (p. 248).

In her review of the literature on IPV
(Tool Box is continued on Page 6)

(Tool Box -- continued from Page 5)

among Latinos, Klevens (2007) cautions that “many of the studies . . . were based on convenience samples or random samples of selected locations, and thus the findings may not be representative of [all] Latinos in the United States.” Nevertheless, when taken together, Klevens’s review suggests that, when controlling for confounders such as age, income, family history, impulsivity, and alcohol use,

IPV affects Latinos about as much as non-Latinos and is similar in its manifestations and consequences. Many of the risk factors associated with its occurrence are the same as those observed among non-Latinos, except that beliefs approving IPV and alcohol-drinking patterns may not have much explanatory value for the occurrence of IPV among Latinos. Role strain, especially as a result of immigration and acculturation, might be unique to Latinos, and its significance, and the importance of male dominance among Latinas experiencing IPV, deserve more research. (p. 118)

IPV & HIV: The Latino Connection

According to Moreno (2007), “Latina women account for 11% of the female population . . . , yet they represent 18% of the cumulative cases of AIDS. . . . The AIDS case rate for Latinas (12.4 per 100,000) is much higher than for White women (2.0 per 100,000)” (p. 340). Moreno draws on additional research to support her contention that “Latina women at risk for IPV are demographically comparable to women

at risk for HIV transmission . . . and seem to share similar cultural factors” (p. 341):

Cultural factors that have been implicated in IPV include demarked gender roles, power differentials, gender norms, and cultural scripts such as *machismo* and *marianismo*. . . . These factors influence . . . willingness and ability to seek care, stay in treatment, and leave abusive relationships, in addition to structural factors, such as limited knowledge of the U.S. health care system, immigration status, social marginalization, and financial hardships. . . . The literature identifies similar risk factors for acquiring HIV, including structural barriers, such as poverty, unemployment, limited job skills, low educational attainment . . . , and substance abuse . . . ; and cultural factors, such as stigma against condom use, lack of information

beliefs; perceptions; acculturation; immigration status; limited English skills; and religion. (pp. 340-341)

Moreno also used a mixed methodology (three focus groups with 32 Latinas living with HIV who had experienced some form of abuse; key informant interviews with five focus group participants; and two community meetings with 30 women, 20 of whom had also participated in the focus groups) to explore the context in which IPV and HIV infection co-occur. Many Latinas in Moreno’s study reported childhood abuse (physical, sexual, psychological, economic) that continued into adulthood and for which these women never sought assistance. Participants also “reconceptualized the definition of IPV to include situational abuse, such as threats of deportation and being infected with HIV. Undocumented women in this study were forced to stay in abusive

“Because of the relationship between these two women’s health problems, efforts to understand and intervene on one without considering the other may be incomplete or ineffective.”

— Gielen et al., 2007, p. 179

about how HIV is transmitted . . . ; traditional gender roles, such as machismo, which encourages male domination and dictates certain sexual behavior, such as having multiple sexual partners and being more knowledgeable about sex . . . , and marianismo, which requires submissiveness and obedience of women, and dictates that women should be ignorant about sex and passive in sexual interactions . . . ; power differentials;

relationships, remain isolated, have little or no access to resources, and lived in fear of being deported. Although life here is difficult, these Latinas felt that they had to remain in the United States, because there are few free or adequate HIV services in their native countries, and they would face even greater stigma because of HIV/AIDS” (p. 349).

Moreover, according to Weidel and colleagues (2008), “the disparity

model in HIV clinical care settings where sessions could be provided in the context of regular medical visits. Intervention sessions could follow the model of the HLP by focusing initially on managing stress and executing effective coping responses, and subsequent sessions should address HIV transmission risk and other important health behaviors. After the active intervention phase, occasional booster sessions may be necessary to assist participants in achieving sus-

tained behavior change. (pp. 549-550)

**About Persons
Who Use Substances**

Mausbach, Semple, Strathdee, and Patterson (2009) “tested a modified version of the TPB [Theory of Planned Behavior] for predicating both safer sex intentions and actual engagement in safer sex in a sample of [228] HIV-negative heterosexual methamphetamine [(meth)] users. According to this model, the three constructs of attitudes toward

condoms, social norms regarding condom use, and perceived control beliefs for safer sex behaviors should significantly predict one’s intention to engage in safer sex” (p. 21). The investigators found that “more positive attitudes toward condoms, greater expectations from their peers to engage in safer sex behaviors, and greater control over negotiating safer sex and using condoms all significantly predicted intention to use condoms during sex” (p. 21). Moreover, the results of this study “expand this model by identifying three

within a partnership between traditional Hispanic and more egalitarian American gender roles may be a significant contributing factor for IPV. Hispanic men may resort to violence as a means of establishing power and authority within a relationship. . . . This may explain why a more acculturated woman coupled with a less acculturated man increases the likelihood of IPV . . . and why Hispanic women who earn more than their male partner are at greater risk of abuse" (p. 249).

Returning to Moreno's sample of Latinas living with HIV, many

discussed their sexual behavior and IPV in the context of culture. They talked about their early training in marianismo, which emphasized remaining docile, ignorant about sex, and eager to please men at all costs, as well as enduring infidelity for the sake of the family and children; and the way marianismo and machismo become the social norm and increase their risk and susceptibility for STIs and HIV. In the context of HIV, marianismo can act as a protective factor, because it aims for sexual exclusivity and proscribes promiscuity. Nevertheless, it can also be considered an influencing risk factor for HIV, because these cultural scripts make it inappropriate for women to discuss sex with their partners, ask about sexual histories, learn about protection, and negotiate condom use.

Machismo can also be considered

a protective factor against HIV, because it emphasizes responsibility, but it can be a risk factor too, because it encourages multiple sexual partners to demonstrate virility, which places women at risk due to their partners' behavior. Most women in the study were infected by heterosexual transmission, and many said that their infector knew his serostatus but did not inform them of it.

Alternatively, the same factors of marianismo and machismo hamper women's ability to leave abusive relationships because of sociocultural expectations, shame and fear, economic problems, few job skills, and shattered self-esteem. At the same time, fatalism (external locus of control) emerged as a theme in the Latino culture that disempowers both women and men from taking action and changing their risky behaviors and abusive situations. (pp. 349-350)

Speeding Relief en Español

Bonomi, Anderson, Cannon, Slesnick, and Rodriguez (2009), among many others, "recommend screening Latina women for abuse in healthcare settings, particularly those presenting with mental health concerns" (p. 47). How might such screening be carried out rapidly, particularly if Spanish is the client's preferred language?

Wrangle, Fisher, and Paranjape (2008) selected seven validated, dichotomous response-option ("yes" or "no") IPV screening questions from English-language instruments and had them pro-

fessionally translated into Spanish. The investigators tested the seven screening questions on 105 Spanish-speaking immigrant Latina women between the ages of 18 and 64 years who were seeking primary care in an urban teaching hospital. The women also responded to a comparison standard: the Index of Spouse Abuse (ISA), which was adapted for lifetime IPV and also professionally translated into Spanish. In this way, Wrangle and colleagues

demonstrated that two simple questions when used in combination can function as a highly sensitive screening tool to identify IPV in Latinas. The two questions that were more sensitive when translated into Spanish were "Have you ever been in a relationship where you have felt controlled by your partner?" [*¿Alguna vez ha estado en una relación en donde se ha sentido controlada por su pareja?*] and "Have you ever been in a relationship where you have felt lonely?" [*¿Alguna vez ha estado en una relación en donde se ha sentido como si estuviera sola?*]. (p. 265)

"Consistent with . . . [other] studies[,] . . . the most sensitive questions concern psychological forms of abuse. As almost all women who suffered from emotional abuse in . . . [this] study also experienced physical abuse, it is possible that the questions that ask about emotional abuse are less direct and, therefore, are more likely to yield a positive response from abused

(Tool Box is continued on Page 8)

additional factors that predict intention to engage in safer sex in this population. Specifically, greater desire to stop unsafe sex was associated with greater intention to practice safer sex, whereas higher levels of [meth] use and greater intentions to engage in sex were associated with reduced intention to practice safer sex behaviors" (p. 21).

Summing up, the investigators found that "48% of the total variance in safer sex intentions was predicted by . . . [this] model, with less nega-

tive attitudes toward safer sex, greater normative beliefs, greater control beliefs, less [meth] use, less intent to have sex, and greater desire to stop unsafe sex emerging as significant predictors of greater safer sex intentions" (p. 17). Moreover, "consistent with the TPB, safer sex intentions significantly predicted behavioral outcomes (i.e., future safer sex behavior). That is, individuals who reported more intention to engage in safer sex actually used condoms a greater percentage of the time they had sex" (p. 21).

Regarding the "development of interventions for increasing safer sex practices in [meth]-using individuals" (p. 21), Mausbach and colleagues suggest, on the basis of their findings, that "it would be interesting to test whether or not reducing [meth] use increases intentions to practice safer sex, which in turn decreases risky sexual behaviors. That is, interventions designed to reduce risky sexual behavior may wish to incorporate cognitive-behavioral and contingency management components for reducing [meth] use" (pp. 21-22).

The investigators also found that

desire to stop risky sex behaviors was associated with intentions to use condoms during sex . . . suggest[ing] . . . that motivational interviewing (MI) . . . may be useful for reducing risky sex behaviors in this population. In particular MI seeks to produce “change talk,” or a desire to change, which in turn strengthens one’s commitment to actual change. . . . [The] use of MI to elicit “change talk” for risky sexual behavior in [meth]-using

individuals may be an important component of risk-reduction intervention. MI may be used prior to an existing intervention for reducing sexual risk behaviors or can be integrated into these interventions as a means of augmenting their effects. Again, . . . [the] study was correlational, and these suggestions should be tested scientifically to determine their merit. (p. 22)

About Persons With Severe Mental Illnesses

Collins et al. (2008) examined the

relationship between perceived stigma and HIV risk behaviors among a convenience sample of 92 urban, multiethnic women with severe mental illnesses. The investigators identified five domains of perceived stigma – “personal experience with mental illness stigma, relationship devaluation and discrimination, ethnic devaluation and discrimination, perceived attractiveness, and experiences of discrimination” (p. 500) – and found that “personal experiences of mental illness stigma and experiences of discrimination were related to substance use with sex and having a casual/exchange partner, respectively. Relationship stigma was related to more sexual risk behaviors overall. Conversely, perceived ethnic stigma was associated with less likelihood of selecting a casual/exchange partner. The data underscore the importance of examining multiple sources of stigma among **women with multiple stigmatized labels** and supporting responses to stigma that lead to reduced risk” (p. 505).

Collins and colleagues contend that,

for effective HIV prevention interventions to occur . . . , providers need to understand how specific ethnic and cultural communities perceive mental illness and what the illness means for women’s perceptions of their own desirability and options for relationships. Immigration status, poverty, and other stigmatized identities should factor into these discussions. . . . [These] findings also suggest that clinical interventions around stigma and HIV prevention should target the sexual lives of younger women, who are more likely to engage in risky sexual behaviors. Finally, barriers that reduce the likelihood that sexuality will be routinely and respectfully addressed in the clinical setting must be identified and eliminated. (p. 505)

(Tool Box -- continued from Page 7)
women” (p. 266). The investigators point out that this two-question instrument

screens for lifetime IPV, instead of IPV only in a current relationship. Although the importance of being able to detect ongoing IPV cannot be overemphasized, the ability to identify women who have experienced IPV over their lifetime is also critically important, because IPV is associated with short-term and long-term ill health effects, even after the violence stops. . . . Women who screen positive for IPV would need to be asked follow-up questions to assess the presence of ongoing IPV and to assess risk factors for escalation of IPV in the event ongoing IPV is identified. (p. 266)

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HIV Assessment News

HIV Counseling & Testing

Carey, Coury-Doniger, Senn, Vanable, and Urban (2008) evaluated two 15-20 minute interventions designed to **promote rapid HIV testing** among STD clinic clients who declined HIV testing at registration. In all, 60 study participants, primarily African American men, were randomly assigned either to view an educational DVD or to participate in one-to-one, stage-based behavioral counseling (SBC) with a nurse. In the SBC condition,

nurse counselors used open-ended questions and a nonjudgmental approach to elicit information regarding a patient's life circumstances (e.g., attitudes toward testing). Based on a series of semistructured questions, patients were staged as (a) precontemplative (i.e., sees no need for an HIV test), (b) contemplative (i.e., sees a need, but has barriers to taking the test), or (c) ready-for-action (i.e., is ready to take an HIV test today). Next, a counseling strategy suited to the patient's stage-of-change was delivered. For example, with a precontemplative patient, a counselor might discuss interrelationships among STDs; with a contemplative patient, in contrast, a counselor might identify barriers to getting an HIV test today. Counselors were well-trained, received regular supervision, and followed a manual.

In the informational intervention, a nurse met briefly with the patient to assess his or her recent risk behavior and stage-of-change for taking an HIV test. The patient then watched an informational DVD that included information about HIV transmission and prevention, the meaning of a positive and negative test result, information about the window period, an explanation of confiden-

tial versus anonymous testing, HIV testing procedures, and the benefits of HIV testing. (pp. 834-835)

"The primary outcome was whether patients agreed to be tested for HIV. The secondary outcomes included attitudes, knowledge, and stage-of-change regarding HIV testing. Patients receiving both interventions improved their attitudes and knowledge about testing. . . . Patients receiving SBC agreed to testing more often (45%) than did patients who viewed the DVD (19%)" (p. 833). According to the investigators, "one explanation for the observed differential outcome is that SBC may have be[en] more effective because the behavioral counseling was uniquely *tailored* to each patient's individual circumstances (e.g., patients' attitudes toward their partners and relationships); in contrast, the DVD was *targeted* to the clinic population but not tailored to the individual patient. . . . In addition, although both interventions allowed patients the opportunity to ask questions of their provider, SBC may have facilitated more interpersonal interaction than the DVD" (p. 837).

Carey and colleagues note that "patients enrolled in this study had repeatedly declined HIV testing, even when told that they would need to have blood drawn for mandatory syphilis testing. Thus, the interventions . . . evaluated were efficacious even among patients who had repeatedly declined testing" and "because the interventions . . . were efficacious with these reluctant patients, it is likely that they will be even more efficacious with less reluctant patients" (p. 837). Because "use of a brief, behavioral counseling intervention guided by theory led to a significant increase in testing relative to a carefully prepared, educational DVD among patients who are otherwise unlikely to be tested," the investigators conclude that "use of behavioral

counseling is recommended when patients initially decline testing" (p. 837).

Neuropsychological Assessment

As Ryan, Byrd, Mindt, Rausch, and Morgello (2008) affirm, "estimation of premorbid intellectual functioning is an essential part of interpreting neuropsychological [(NP)] performance following brain injury and disease. . . . Using reading level as a premorbid indicator is predicated on reading's high correlation with IQ in the general population, its greater resistance to dementia than vocabulary tests, and its supposed reliance on previous knowledge rather than current cognitive functioning" (pp. 1018-1019). Ryan and colleagues go on to observe that "the Wide Range Achievement Test – Reading Recognition subtest (WRAT) . . . is routinely used for assessing premorbid intelligence because it is well normed and easy to administer" (p. 1019). In contrast, "the **General Ability Measure for Adults** (GAMA) assesses intellectual functioning using abstract designs, thereby limiting reliance on verbal comprehension. . . . It was specifically designed for individuals with limited educational experiences and/or verbal skills. Given these features of the GAMA, it may be an appropriate measure of intellectual functioning for a racially and ethnically diverse urban cohort who have likely experienced a poor quality of education" (p. 1020).

The investigators administered the WRAT-3 Reading subtest (WRS), the GAMA, and NP tests to a racially and ethnically diverse sample of 95 adults living with HIV/AIDS who had varying levels of literacy. Participants who scored at less than an eighth-grade reading level on the WRS but at or above the eighth-grade reading level on the GAMA were found to have significantly better overall NP functioning when compared to those who scored at less than an eighth-grade reading level on both instru-

ments. Ryan and colleagues conclude that, when conducting an NP evaluation, "the GAMA . . . should be considered . . . when reading scores . . . [indicate less than an eighth-grade reading level]." As this study demonstrates, identifying an accurate premorbid estimation method for individuals whose **low literacy is secondary to a poor quality of education** would be a significant contribution to [NP] research" (p. 1029).

HIV Treatment News

Medical Care

Does a **once-daily dosing schedule** actually result in improved adherence to antiretroviral therapy (ART)? "To synthesize existing data across studies," Parienti, Bangsberg, Verdon, and Gardner (2009) "conducted a meta-analysis that compared adherence and virologic suppression rates in patients receiving once-daily versus twice-daily regimens in randomized, controlled trials" (p. 484). Findings from 11 studies involving 3,029 participants and published or presented between 2004 and 2008 were included in this meta-analysis. Parienti and colleagues found that

once-daily dosing improved adherence, particularly at treatment initiation and if all of the medications were administered once per day. Furthermore, these effects were compatible with better virologic outcome in selected subgroups. However, . . . the objective impact of once-daily versus twice-daily dosing on adherence rates is modest. Because adherence to medication regimens is a complex behavior with multiple factors at play, efforts to improve adherence should not be restricted to prescription of once-daily medications. . . . Other factors, including tolerability, potency, and potential risk of resistance, given the patient's individual adherence

pattern, are important considerations in selecting the optimal regimen for each patient. (p. 487)

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Adherence to Treatment

Woods et al. (2009) explored **prospective memory** (ProM), the "execution of a future intention in the face of ongoing distractions (i.e., 'remembering to remember'" (p. 43), among 79 individuals, predominantly men, with generally mild HIV disease. ProM has been implicated in nonadherence to combination antiretroviral therapies (cART), in that "HIV-infected individuals with impaired ProM might not notice important time-based cues to take their medications during the course of day-to-day activities, thereby delaying (or missing) scheduled doses, which decreases the likelihood of maintaining adequate virologic control and favorable disease outcomes" (p. 48). Woods and colleagues found that

HIV-infected individuals with deficits in . . . ProM . . . are at elevated risk of cART nonadherence as measured [over a 1-month period] by electronic pill monitoring. At a group level, Nonadherent individuals demonstrated significantly poorer ProM functioning as compared to Adherent . . . [individuals], particularly on an index of time-based ProM. These findings . . . were primarily driven by an elevated rate of LoT [loss of time] errors in the Nonadherent participants, meaning that although Nonadherent individuals remembered to perform the prescribed intention, they did so at an incorrect time (i.e., >15% away from the target execution time). . . . In fact, individuals who committed one or more LoT errors were almost six times more likely to be classified as Nonadherent at 1-month follow-up. . . .

Notably, ProM LoT errors were a unique and independent predictor of nonadherence when considered alongside well-established predictors of adherence. Consistent with prior research, impairment in retrospective learning and memory . . . , psychiatric comorbidity . . . , HIV disease severity . . . , and psychosocial factors . . . were also associated with nonadherence. Nevertheless, ProM LoT errors remained a significant predictor of nonadherence, even when these other factors were included in the statistical model. The independence of ProM as a predictor of nonadherence suggests that this construct may play a unique role in successful medication management. (pp. 47-48)

According to the investigators,

such findings suggest that interventions that target ProM may be effective in improving adherence. For example, cognitive techniques such as goal management training . . . , which uses structured exercises designed to teach individuals to engage in an "executive review" of their plans and intentions for the day (e.g., "What am I doing right now?", "What else do I have to do today and when?") may be effective in improving ProM. . . . Other intervention approaches might focus on reducing the need for strategic monitoring, perhaps by reducing cognitive load (i.e., reducing the number and complexity of intentions held "online" . . .) and/or minimizing ongoing distraction. . . . Relatedly, a noninvasive and relatively inexpensive . . . intervention option might involve a programmable electronic device (e.g., a watch) that prominently notifies the patient when it is time to take a medication with a detailed text message that includes the medication name, dosage,

and particular conditions under which it should be taken. . . . Prospective, theory-driven controlled trials of the effectiveness of these various strategies (perhaps as well as combined, individualized therapeutic approaches) as treatments for HIV-associated ProM impairment and nonadherence are needed. (p. 49)

Plankey et al. (2009) sought to ascertain the “association of **self-perceived fat gain or fat loss in central and peripheral body sites** with adherence to highly active antiretroviral therapy (HAART)” (p. 53) among a large and ethnically diverse cohort of 1,671 women living with HIV. In this study, report by a participant of “any increase or decrease in the chest, abdomen, or upper back in the prior 6 months defined central fat gain and central fat loss, respectively. Report of any increase or decrease in the face, arms, legs or buttocks in the prior 6 months defined peripheral fat gain or peripheral fat loss” (p. 53). This study defined adherence as “report of taking HAART \geq 95% of the time during the prior 6 months” (p. 53). The investigators found that “younger age, being African-American (vs. White non-Hispanic), a history of IDU [injecting drug use], higher HIV RNA [viral load] at the previous visit, and alcohol consumption were significant predictors of HAART non-adherence. . . . After multivariate adjustment, self-perception of central fat gain was associated with a 1.5-fold increased odds of HAART non-adherence compared to no change. Self-perception of fat gain in the abdomen was the strongest predictor of HAART non-adherence when the individual body sites were studied” (p. 53).

Plankey and colleagues conclude that “women who perceive central fat gain particularly in the abdomen are at risk for decreased adherence to HAART despite recent evidence to suggest that HIV and specific

antiretroviral drugs are more commonly associated with fat loss than fat gain” (p. 53). The investigators suggest that “clinicians should . . . be ready to explore issues of HAART adherence in those women who report the perception of gaining central fat irrespective of objective measurements” (p. 59).

Amico et al. (2009) “assessed the determinants of adherence behavior postulated by the **Information-Motivation-Behavioral Skills model of ART adherence**” (p. 66) among a convenience sample of 149 men and women, predominantly African American, living with HIV and engaged in medical care in Mississippi. In this study, “the model’s core constructs and the relationship between them were examined. Specifically, adherence-related information, motivation (personal and social), and behavioral skills were evaluated in terms of their association with self-reported dose adherence over a preceding 3-day period” (p. 72). Amico and colleagues

found support for each of the propositions of the IMB model of ART adherence. . . . Within the current sample, adherence-related information about one’s regimen was related to adherence behavioral skills and was not significantly directly associated with 3-day self-reports of dose adherence. Thus, it appears that being well-informed did not necessarily imply high levels of adherence, but did relate to one’s fund of behavioral skills, which was directly related to levels of ART adherence. Similarly, social motivation, or the extent to which one believed that important others supported them in taking their medications, and personal motivation, or one’s negative beliefs about ART medications and lifestyle consequences of adherence, were also related to behavioral skills. The behavioral skills

construct, in turn, was directly related to self-reported adherence. In full, the model results suggest that better adherence is associated with more accurate information about one’s regimen, stronger social motivation for taking medications, fewer barriers to personal motivation, and stronger adherence behavioral skills. (p. 73)

The investigators point out that this study

separated the personal and social components of motivation to adhere to therapy. In doing so, . . . [the investigators] found that these constructs are related to adherence information and adherence behavioral skills, and that these components are relatively independent of each other. These findings suggest that each type of motivation helps influence adherence to ART and that each should receive attention in adherence promotion interventions. On both empirical and rational bases, it appears that one can have positive or negative beliefs about adherence and HIV medications that are independent of the perceptions of support for adherence from significant others. Similarly, lacking social support may limit social motivation, but individuals may nonetheless develop strong positive beliefs about adherence and HIV medications. (p. 73)

On the basis of these findings, Amico and colleagues conclude that “adherence interventions may be most effective if intervention components target (1) adherence-related information, (2) the minimization of negative beliefs about HIV medications and perceived negative lifestyle consequences of ART adherence, (3) the development of adherence-related social support, and (4) the development of practical skills in adhering to medication across various

situations and contexts as well as the confidence to implement them” (p. 73).

Dilorio et al. (2009) “developed and tested a model of ART adherence using **personal and social variables** identified in the ART adherence literature and elaborated within the framework of social cognitive theory [(SCT)]” (p. 11).² This model “included personal (self-efficacy, outcome expectancy, stigma, depression, and spirituality), social (social support, difficult life circumstances), and provider (patient satisfaction and decision-making) variables” (p. 10). Study participants were recruited from an HIV/AIDS clinic in Atlanta, GA; the 236 participants were primarily male and African American. “In the final model, self-efficacy and depression demonstrated direct associations with adherence . . . whereas stigma, patient satisfaction, and social support were indirectly related to adherence through their association with either self-efficacy or depression” (p. 10). Although “additional research is necessary to determine whether or not this exploratory model is supported” (p. 20), Dilorio and colleagues surmise from these findings that

adherence interventions that support self-efficacy and address depressive symptoms may function to improve or maintain desirable levels of medication taking. Attempts to disrupt the vicious cycle of low self-efficacy, depression, and nonadherence can begin with interventions directed at

² “SCT proposes that personal factors, environmental (social) factors, and behavioral factors all interact to determine behavior. . . . The central construct of the SCT is perceived self-efficacy, . . . [or] ‘a judgment of one’s ability to organize and execute given types of performances.’ Self-efficacious people are more successful in performing specific behaviors because they are more likely than others to persevere even under difficult situations until their goals are achieved” (Dilorio et al., 2009, p. 11).

modifying depression or alternatively by enhancing self-efficacy and developing strategies to address real barriers to medication taking. While . . . [these] results and those of others suggest that social support may play more of an indirect rather than direct role in promoting adherence, social support along with patient satisfaction and stigma play key roles in adherence behavior and should be considered in intervention approaches. Interventions that attempt to improve social support, improve patient satisfaction, and reduce stigma can serve to improve the core factors that are associated with medication adherence. (p. 20)

With regard to addressing depressive symptoms, Safren et al. (2009) conducted a two-arm, randomized, controlled, cross-over trial to compare **cognitive-behavioral therapy for HIV medication adherence and depression** (CBT-AD)³ to “en-

³ “CBT-AD begins with a single-session intervention on HIV medication adherence . . . [that] involves 11 informational, problem-solving, and cognitive-behavioral steps (e.g., education about adherence, scheduling, cue control strategies including the use of a watch alarm, adaptive thoughts about adherence, cues, provider communication). In each step, participants and the clinician define the problem, generate alternative solutions, make decisions about the solutions, and develop a plan for implementing them. Participants also receive adherence tools such as assistance with a schedule and a cue-dosing watch that can sound two alarms per day.

The remaining 11 sessions continued to address strategies for and barriers to medication adherence, with a review of electronic pill-cap (MEMS) data on adherence at the beginning of each session, and discussion of progress or difficulties with adherence. At each session, patients also completed the Beck Depression Inventory . . . and proceeded with the completion of specific modules of treatment. Although the treatment manual provided guidance for the number of sessions for each module, flexibility in the number of sessions devoted to any module was allowed to address the complexity and variability of issues facing

hanced treatment as usual only (ETAU). ETAU, which both groups received, included a single-session intervention for adherence and a letter to the patient’s provider documenting her or his continued depression. The intervention group also received 10 to 12 sessions of CBT-AD” (p. 1), and antiretroviral adherence was measured by Medication Event Monitoring Systems (MEMS). An ethnically diverse sample of 45 men and women participated in this trial; individuals with active substance abuse or dependence were screened out. Eleven of the 22 participants assigned to ETAU elected to cross over to CBT-AD after the acute outcome assessment. The investigators report that,

at the acute outcome assessment (3-months), those who received CBT-AD evidenced significantly greater improvements in medication adherence and depression relative to the comparison group. Those who were originally assigned to the comparison group who chose to cross over to CBT-AD showed similar improvements in both depression

patients with HIV and depression. Module 1 first provided psycho-education about HIV and depression, and then transitioned to [MI] exercises (e.g., pros and cons of changing to improve one’s depression and adherence) designed to set the stage for behavioral change interventions to follow. Module 2 provided behavioral activation interventions across one session and was designed to increase regularly occurring activities that involve pleasure and mastery. Module 3 provided cognitive restructuring interventions across three sessions . . . , with attention specifically to negative automatic thoughts that relate to HIV medication adherence. Module 4 provided problem solving interventions across three sessions. . . . [P]atients [were helped to] engage in a process that results in the selection of an action plan . . . and [to] break this plan into manageable steps. Module 5 provided progressive muscle relaxation training/and diaphragmatic breathing skills across one session. A [detailed] description of . . . [this] approach is available ([see] Safren, Gonzalez, & Soroudi, 2007a; 2007b)” (Safren et al., 2009, p. 3).

and adherence outcomes. Treatment gains for those in the intervention group were generally maintained at 6- and 12-month follow-up assessments. By the end of the follow-up period, those originally assigned [to] CBT-AD demonstrated improvements in plasma HIV RNA concentrations, though these differences did not emerge before the cross-over, and hence there were not between-group . . . differences. (p. 1)

Safren and colleagues conclude that “CBT-AD is a potentially efficacious approach for individuals with HIV struggling with depression and adherence. Replication and extension in larger efficacy trials are needed” (p. 1). The investigators further observe that this approach is “unique because it integrates adherence training, a health promotion behavior, into each and every session of the [CBT] intervention and also targets the treatment of a clinical diagnosis of depression. . . . Targeting both the treatment of a comorbid psychiatric condition and increasing self-care behaviors may make it possible to help individuals with HIV and high levels of impairment maximize both medical and quality of life outcomes” (p. 8).

Stress Management

Ironson et al. (2008) set out to determine if **perceived stress**, along with levels of the stress-related hormones **norepinephrine** and cortisol, would predict CD4 cell count and viral load responses to starting a new protease inhibitor (PI) among a diverse sample of 55 men and women living with HIV. Measurements were taken before starting the new PI and an average of 3 months after starting the new PI to ascertain CD4 and viral load response to the PI. Ironson and colleagues found that “higher perceived stress significantly predicted lower effectiveness of the new PI in increasing CD4 and decreasing [viral load] controlling for age, duration of new

PI, baseline CD4/[viral load], . . . STDs . . . , and gender/ethnic risk groups. Higher norepinephrine, but not cortisol, predicted worse [viral load] response to PIs and, in fact, mediated the relationship between perceived stress and change in [viral load]” (p. 221). In short, “perceived stress and high norepinephrine levels . . . [we]re prospectively associated with a poorer response to starting a new PI. . . . [For this reason, assessing stress and norepinephrine levels in patients starting on antiretroviral medications might be clinically useful” (p. 221) and “patients high in stress could be advised to practice a stress management technique for relaxation” (p. 225). Ironson and colleagues point out that

both pharmacologic and psychological approaches are available for stress management. Stress management, including relaxation techniques, stress awareness, cognitive reframing, coping, anger management, assertiveness training, and social support . . . , has had a variety of beneficial psychological and biological effects in HIV [care]. . . . In particular, there is evidence to suggest that a variety of stress management techniques, including cognitive behavioral approaches incorporating relaxation practices . . . , as well as massage . . . , are related to lower [norepinephrine] levels. Furthermore, frequency of relaxation techniques in HIV has been related both to immune outcomes . . . and lower mortality . . . , although the latter was with a small sample. (p. 225)

The depletion of CD4+ T lymphocytes (CD4 cells, also known as T-cells) is a hallmark of HIV disease progression. Creswell, Myers, Cole, and Irwin (2009) compared a standardized and manualized 8-week **mindfulness-based stress reduction (MBSR) meditation program** to a 1-day control stress reduction edu-

cation seminar⁴ to determine whether the 8-week program buffered a decline in CD4 cells among an ethnically diverse community sample of 48 adults living with HIV who were randomized to one of these two conditions. CD4 cell counts were taken at baseline and again within 2 weeks of the last session of the 8-week program. Creswell and colleagues found that “participants in the 1-day control seminar showed declines in CD4+ T lymphocyte counts whereas counts among participants in the 8-week MBSR program were unchanged from baseline to post-intervention. . . . This effect was independent of antiretroviral . . . medication use. Additional analyses indicated that treatment adherence to the mindfulness meditation program, as measured by class attendance, mediated the effects of mindfulness meditation training on buffering CD4+ T lymphocyte declines” (p. 184). In other words, the more classes participants in the MBSR program at-

⁴ “It is thought that the MBSR program helps participants bring a more open and receptive awareness to their present moment experiences in daily life, facilitating a greater recognition and regulation of stress” (p. 184). This program encompasses “eight weekly 120-min group sessions, a day-long retreat in the seventh week, and daily home mindfulness meditation practice. The group session consisted of instructor-guided mindfulness body awareness activities, mindfulness meditations, mindful stretching, and group discussions. A . . . day-long retreat in week 6-7 of the MBSR program focused on integrating and elaborating on the exercises the participants learned during the 8-week course. Finally, participants were instructed to practice 30 min of audio-guided mindfulness exercises each day at home during the 8-week program. The one-day stress education MBSR program was a condensed version of the 8-week MBSR program. Participants in this condition attended a day-long . . . seminar where they received information, instruction, and practice in the same mindfulness practices taught in the 8-week program, including group discussions. Instructors did not discuss or encourage participants to start home or daily-life mindfulness practices in the one-day MBSR condition. The one-day MBSR program was administered between weeks 4-6 during the 8-week program” (Creswell et al., 2009, pp. 185-186).

tended, the higher were their CD4 cell counts when measured post-intervention, and the protective effects of this intervention were equivalent in those who were taking antiretrovirals and those who were not. Creswell and colleagues conclude that, despite limitations inherent in this small study, the findings “provide a first indication that a low-cost group-based mindfulness meditation training program can buffer CD4+ T lymphocyte declines in a diverse community sample of HIV-1 infected adults. Well-controlled studies with larger samples are needed . . . but the present findings provided a promising first indication that mindfulness meditation may have benefit as a complementary adjunct [to antiretroviral] treatment for HIV-1” (p. 188).

As described by Bormann, Aschbacher, Wetherell, Roesch, and Redwine (2009),

mantram repetition is an ancient traditional practice of [silently] repeating a spiritual word or phrase . . . continuously throughout the day. . . . In a randomized clinical trial previously conducted [described in the [Fall 2006](#) issue of *mental health AIDS*], HIV-infected adults who completed a 5-week mantram intervention program reported significant increases in spiritual faith/assurance and decreases in trait-anger compared to an attention-matched control condition. . . . Perceived stress and depression were measured, but no group differences were found. . . . Practicing mantram repetition frequently throughout the day and integrating it into one’s lifestyle appeared to enhance spiritual faith by increasing awareness of, or a sense of connectedness with, the sacred. . . . For certain patients, mantram repetition may be easier to implement, as compared to types of meditation or

relaxation techniques that require a quiet environment, closed eyes, particular postures, or lengthy sitting periods. HIV research has demonstrated that people who report experiencing a positive relationship to God or a higher power tend to have better health status and greater longevity, whereas people who feel judged or punished by God tend to have worse health status. . . . If the spiritual components of an intervention are the key efficacious elements, then one would expect to see a direct relationship between measures of spiritual faith and relevant health outcomes, including biomarkers of immune function. (p. 162)

To assess this assumption, the investigators randomized 71 adults living with HIV to either a **spiritually based mantram intervention** or to an attention-matched control condition, and measured faith/assurance and average daily salivary cortisol levels at preintervention, postintervention, and again after 5 weeks. “Stress-related . . . cortisol secretion can stimulate HIV viral replication . . . and affect various immunologic measures pertinent to HIV pathogenesis and disease progression. . . . Therefore, reducing stress hormones with the mantram intervention may have health benefits in HIV-positive individuals” (p. 168).

Bormann and colleagues found that “faith levels increased among mantram participants from pre- to postintervention. Greater faith at preintervention was significantly associated with lower average cortisol at postintervention in the mantram group but not in the controls. The associations between faith at postintervention and cortisol levels at 5-week follow-up were significant among both groups but weaker than the pre- to postintervention association identified in the mantram group” (p. 161).

The investigators concluded that “a spiritually based group intervention using mantram repetition may serve the dual function of increasing a sense of faith and reducing physiological biomarkers of stress over time, which may have additional health benefits” (p. 168). Bormann and colleagues suggest, however, that “larger-scale studies with morbidity and mortality outcome measures need to be performed to determine if mantram repetition intervention effects are replicable and clinically relevant” (p. 169).

Coping, Social Support, & Quality of Life

Pérez et al. (2009) “prospectively examined the effects of **spiritual striving**, social support, and **acceptance coping** on changes in depressive symptoms” (p. 88) among a culturally diverse convenience sample of 180 adults living with HIV. The investigators observe that “both Eastern and Western religious traditions promote the practice of acceptance in the face of suffering. . . . As a form of coping, acceptance includes the following: ‘the person must be able to recognize the experience of discomfort or displeasure, connect it to some aspect of the situation, and act effectively while still experiencing discomfort’” (p. 89). The investigators defined “spiritual striving” as “the process of consciously trying to grow spiritually and pursuing a meaningful and fulfilling daily life” (p. 89).

With measurements taken at baseline, 3-, and 6-months, Pérez and colleagues found that

higher levels of spiritual striving predicted lower levels of depressive symptoms, and acceptance as a coping style partially mediated this relationship. . . . [The investigators] also found that acceptance coping increased as spiritual striving increased. . . . The mediation suggests an important link between spiritual

Tool Box
Resources

Books & Articles

Alessi, E.J. (2008). Changing directions in HIV prevention: The move toward a psychosocial model. *Journal of Gay & Lesbian Social Services, 20*(4), 273-287.

"This article examines the psychosocial model of HIV prevention and the various psychosocial factors that may contribute to high-risk sexual behavior and concludes with examples of prevention research that have already incorporated the model" (p. 273).

Côté, J., Godin, G., Ramirez Garcia, P., Gagnon, M., & Rouleau, G. (2008). Program development for enhancing adherence to antiretroviral therapy among persons living with HIV. *AIDS Patient Care & STDs, 22*(12), 965-975. "In this paper the development of a self-management program to optimize long-term adherence to antiretroviral therapy for people living with HIV/AIDS is presented. The program is based on intervention mapping: that is, a framework that facilitates the use of theory and empirical evidence in intervention development. . . . To address individuals' resources and skills in conjunction with the experience of taking the medication, we developed two different modalities to deliver the intervention: direct support and virtual support. Direct support consists of four 45-minute individualized, face-to-face sessions with a health professional. The Web application involved at least four interactive sessions with a computer" (p. 965).

Eaton, L.A., & Kalichman, S.C. (2009). Changes in transmission risk behaviors across stages of HIV disease

among people living with HIV. *Journal of the Association of Nurses in AIDS Care, 20*(1), 39-49.

"In this article, the authors review studies that have examined the association between HIV transmission risk behaviors and HIV disease stage. The aim of this review is to characterize the changes in risk behaviors that occur over the course of HIV infection in order to better guide positive prevention efforts" (p. 40).

Kagee, A. (2008). Application of the DSM-IV criteria to the experience of living with AIDS: Some concerns. *Journal of Health Psychology, 13*(8), 1008-1011.

"A diagnosis with HIV is often considered traumatic. According to the DSM-IV-TR's criteria for PTSD [posttraumatic stress disorder], a traumatic event precipitates a set of reactions in an individual that includes avoidant behaviour, intrusive thoughts, and physiologic hyperarousal. However, persons diagnosed with HIV are typically concerned with events that will occur in the future such as physical decline and death, access to treatment, the welfare of dependants, and stigma and discrimination. Their concerns are thus future-oriented rather than anchored to a past traumatic event, which is the requirement of PTSD. This article argues that an HIV diagnosis may be inappropriately regarded as traumatic" (p. 1008).

Kalichman, S.C., Simbayi, L.C., Cloete, A., Mthembu, P.P., Mkhonta, R.N., & Ginindza, T. (2009). Measuring AIDS stigmas in people living with HIV/AIDS: The Internalized AIDS-Related Stigma Scale. *AIDS Care, 21*(1), 87-93.

"Here we present a psychometric study of the Internalized AIDS-Related Stigma Scale (IA-RSS). We adapted six items

for the community-held AIDS-Related Stigma Scale to reflect internal representations of AIDS-related stigma. We tested the psychometric properties of the IA-RSS in three countries: South Africa, Swaziland, and the USA" (p. 88) and found that the IA-RSS was "internally consistent . . . and time stable. . . . We also found evidence in support of the scale's convergent, discriminant, and criterion-related validity. The [IA-RSS] appears reliable and valid and may be useful for research and evaluation with HIV-positive populations across southern African and North American cultures" (p. 87).

Natale, A.P., & Moxley, D.P. (2009). Service engagement with high-risk men who have sex with men: Challenges and implications for social work practice. *Social Work in Health Care, 48*(1), 38-56.

"This article reviews . . . challenges in treatment engagement of men who have sex with men . . . [.] identifies HIV and substance use risk factors influencing out of care dynamics[,] . . . examines . . . research identifying contextual and cultural factors central to achieving cultural competence[, and] . . . identifies service qualities and characteristics social workers can incorporate into practice and programs to increase the likelihood of successful engagement and treatment adherence" (p. 38).

Robinson, W.A., Petty, M.S., Patton, C., & Kang, H. (2008). Aging with HIV: Historical and intra-community differences in experience of aging with HIV. *Journal of Gay & Lesbian Social Services, 20*(1-2), 111-128.

"This article presents findings from a study of a long-running HIV support
(Tool Box is continued on Page 16)

striving and acceptance as a coping style in reducing depressive symptoms. One possible interpretation could be that the peace of mind or mindfulness often associated with a spiritual/religious practice decreases depressive symptoms by increasing the use of acceptance in situations out of the control of the individual. (p. 94)

According to Pérez and colleagues, these findings

have important clinical implications for professionals who work with depressed HIV-positive patients. Specifically, assessing spiritual beliefs and supporting spiritual striving may be an effective adjunct to standard interventions for the treatment of depres-

sion for a substantial proportion of adults living with HIV/AIDS. For example, psychoeducational interventions that incorporate practices such as meditation or prayer for people who are receptive to spiritual practices may improve mood by reducing depressive symptoms.

Given the finding that acceptance

(Tool Box -- continued from Page 15)

group. It locates the members, all gay men living with HIV, in a specific historical and political context to explore how feelings of loss and the struggle to sustain community affect long-term survivors and other older HIV+ gay men. We identify specific challenges presented by aging for men who contracted HIV early in the epidemic, contrasting them with those faced by men infected with the virus later in life. While both groups appear to struggle with a vision of what life could have been, had AIDS not forced loss and change, they also celebrate the community their shared plight has enabled" (p. 112).

Rubenstein, D., & Sorrentino, D. (2008). Psychotherapy with HIV/AIDS patients: Assessment and treatment plan development. *American Journal of Psychotherapy*, 62(4), 365-375.

"Successful psychotherapy with patients who test positive for HIV . . . involves a sensitive, careful, and thorough biopsychosocial assessment with specific, detailed attention to the impact that a diagnosis of HIV/AIDS has on overall level of patient functioning" (p. 365). "Careful assessment in the areas of mental health/substance abuse, peer relationships and social support, family relationships, intimate relationships, work, and health are important in developing an appropriate and effective treatment plan" (p. 374).

Sales, J.M., Spitalnick, J., Milhausen, R.R., Wingood, G.M., DiClemente, R.J., Salazar, L.F., & Crosby, R.A. (2009). Validation of the worry about sexual outcomes scale for use in STI/HIV prevention interventions for adolescent females. *Health Education Research*, 24(1), 140-152.

"The 10-item worry about sexual outcomes (WASO) scale [examined among a sample of African American adolescent females] . . . is a reliable and valid measure of . . . adolescents' worry about [sexually transmitted infections], HIV and pregnancy. The WASO represents a brief self-administered instrument that can be easily integrated into sexual risk reduction assessments and interventions" (p. 140).

Simoni, J., Amico, K.R., Pearson, C., & Malow, R. (2008). Strategies for promoting adherence to antiretroviral therapy: A review of the literature. *Current Infectious Disease Reports*, 10(6), 515-521.

"This article summarizes the literature on behavioral interventions to promote ART adherence and highlights some of the most recent and innovative research on patient education and case management, modified directly observed therapy, contingency management, interventions emphasizing social support, and novel technologies to promote awareness. Research in the area of adherence in pediatric HIV infection and in resource-constrained international settings also is considered. . . . We conclude with suggestions for incorporating research findings into clinical practice" (p. 515).

Vance, D.E., Struzick, T.C., & Masten, J. (2008). Hardiness, successful aging, and HIV: Implications for social work. *Journal of Gerontological Social Work*, 51(3-4), 260-283.

"This article provides a review of hardiness in aging and HIV, and emphasizes its importance in facilitating successful aging with this disease. Conceptual and methodological concerns in studying hardiness and successful aging are addressed. Potential interventions and clinical implications for social work are posited for augmenting qualities of hardiness in people aging with HIV" (p. 260).

On the Web

The Centers for Disease Control and Prevention (CDC) released the *2008 Compendium of Evidence-Based HIV Prevention Interventions* (<http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm>). The *2008 Compendium* includes 57 behavioral interventions, with 8 added since the *Compendium* was last updated. According to the CDC Web site, "these interventions represent the strongest HIV behavioral interventions in the literature to date that have been rigorously evaluated and have demonstrated efficacy in reducing HIV or STD incidence or HIV-related risk behaviors or promoting safer behaviors."

— Compiled by
Abraham Feingold, Psy.D.

mediates the relationship between spiritual striving and depressive symptoms, it may be particularly helpful to encourage spiritual practices and beliefs that are likely to promote a positive form of acceptance in coping with HIV/AIDS. It is important to note that previous research indicates that a form of acceptance known as "realistic acceptance" is predictive of shorter survival in gay men with AIDS. . . . This highlights the need to . . . [draw] a distinction between practices and beliefs that promote positive acceptance compared to those that lead to debilitating resignation. Despite the apparent similarity in the terms "acceptance coping" and "realistic acceptance," this distinction in meaning may be linked to very different health implications. (p. 94)

According to Rao et al. (2009), "**art therapy** is a clinical intervention based on the belief that the creative process involved in the making of art is healing. . . . Studies have suggested that art therapy can lead to increased awareness of self, as well as improved ability to cope with symptoms, stress, and traumatic experiences" (p. 64). Rao and colleagues tested

the feasibility and effectiveness of art therapy for relief of symptoms experienced by people living with HIV/AIDS. In this randomized clinical trial of art therapy, the primary objective was to assess change in physical and psychological symptoms. Participants were recruited from a large urban hospital's inpatient population and outpatient HIV clinic. . . . [An ethnically and racially diverse sample of 79 men and women living with HIV] provided socio-demographic information, participated in either a one-hour art therapy session or viewed a

videotape about art therapy, and completed pre- and posttest measures of psychological and physical symptoms. (p. 64)

The investigators adjusted for “pre-test score, age, gender, and race/ethnicity” (p. 64) in their analysis and found that “physical symptom mean scores were better for those who participated in the art therapy compared to those who viewed the videotape, and this difference between conditions was statistically significant. . . . Thus, the study demonstrated the potential benefits of one session of art therapy in relation to symptoms associated with HIV/AIDS” (p. 64).

O’Connell-Edwards, Jones, Forehand, and Larkin (2008) “examined **optimism and depressive symptoms** as moderators of the association between immune functioning (CD4 count) and physical health symptoms among [99] low-income, [urban] African American mothers with HIV/AIDS. Findings revealed a significant main effect of depressive symptoms, but not CD4 count, on physical health symptoms” (p. 327). In other words, “more compromised immune functioning (lower CD4 count) was associated with more physical symptoms under conditions of higher levels of depressive symptoms, but not lower levels of depressive symptoms. This finding was observed using both a self-report measure and a clinician-rating of women’s depressive symptoms” (p. 322). “In contrast, there was no main effect for optimism and optimism did not interact with CD4 count to account for variability in physical symptoms” (p. 327). O’Connell-Edwards and colleagues conclude that “appropriate assessment and treatment of depressive symptoms, including behavioral or pharmacological interventions, provide an opportunity to modify the impact of immune functioning on

physical health symptoms. These interventions will presumably result in improving both physical and mental health functioning and improving quality of life among a group disproportionately affected by HIV/AIDS” (p. 329).

Mosack et al. (2009) “examined associations between psychosocial variables (coping self-efficacy, social support, and cognitive depression) and subjective health status among a large national sample ($N=3,670$) of . . . [HIV-positive] **persons with different sexual identities**” (p. 133). After controlling for ethnicity, the investigators found that

heterosexual men reported fewer symptoms than did either bisexual or gay men and heterosexual women reported fewer symptoms than did bisexual women. Heterosexual and bisexual women reported greater symptom intrusiveness than did heterosexual or gay men. Coping self-efficacy and cognitive depression independently explained symptom reports and symptom intrusiveness for heterosexual, gay, and bisexual men. Coping self-efficacy and cognitive depression explained symptom intrusiveness among heterosexual women. Cognitive depression significantly contributed to the number of symptom reports for heterosexual and bisexual women and to symptom intrusiveness for lesbian and bisexual women. (p. 133)

It would appear that “individuals . . . experience HIV differently on the basis of sociocultural realities associated with sexual identity” and that “symptom intrusiveness may be a more sensitive measure of subjective health status for these groups” (p. 133). “The results,” however, “suggest that the most salient point of intervention with regard to illness

adjustment or health-related quality of life is the alleviation of cognitive depression, regardless of sexual identity status. Therefore, identifying and treating psychological distress is likely to decrease physiological morbidity among a substantial proportion of HIV-positive persons” (p. 138). In addition,

lower coping self-efficacy . . . independently predicted more symptom reports and greater symptom intrusiveness for all 3 groups of men. These results suggest that a strength-based approach may assist HIV-positive men, in particular, to achieve a sense of competence in adjusting to their illness. Cognitive-behavioral interventions can promote the identification of personal strengths and facilitate the development of skills to cope with particularly difficult or stressful life events. Individuals can then learn how to reframe life stressors as manageable challenges and develop strategies to effectively deal with them, which reduces psychological stress by improving not only their overall mental health, but also their symptom experiences. (p. 138)

Moskowitz, Hult, Bussolari, and Acree (2009) determined, “through meta-analysis, which **types of coping are related to psychological well-being, HIV-relevant health behaviors, and physical health** among people with HIV, and whether contextual (pre-post HAART; time since diagnosis), measurement (HIV-related event vs. general prompts for coping measurement), and individual (gender) variables moderate the association of coping and well-being” (p. 125). The investigators analyzed findings from 63 studies published from 1990 through 2005 involving 15,490 participants and found that

Direct Action [i.e., problem focused, including instrumental or task-oriented coping] and Positive Reappraisal were consistently associated with better outcomes in people coping with HIV across affective, health behavior, and physical health categories. In contrast, disengagement forms of coping, such as Behavioral Disengagement and Use of Alcohol or Drugs to Cope, were consistently associated with poorer outcomes. The findings also indicate that in some cases, coping effectiveness was dependent on contextual factors, including time since diagnosis and the advent of HAART. (p. 121)

Expanding on these contextual factors, Moskowitz and colleagues report that, even though “Direct Action was associated with more positive affect, less negative affect, better health behaviors, and better physical health,” (p. 134), there were

two significant moderators of the effects of Direct Action, indicating that it is not uniformly effective under all circumstances. First, Direct Action appears to have a stronger beneficial effect on physical health in the first years after diagnosis compared with later on. Upon diagnosis with HIV, people are faced with a number of challenges that are best addressed with Direct Action. . . . However, as the individual enters the chronic phase of . . . HIV, the types of stressors encountered may be less amenable to change as a result of Direct Action coping. . . .

A second moderator . . . was the year the data were collected relative to the widespread use of HAART. Prior to the introduction of HAART, Direct Action was associated with significantly better physical health; however,

after the introduction of HAART, Direct Action was not associated with physical health (better or poorer). Given the exceptional effectiveness of HAART in improving physical health and extending lives, in the context of HAART use, it may be that there is very little additional variance in physical health to account for with psychosocial variables, such as coping. . . .

In contrast, Direct Action was more effective *after* the introduction of HAART with respect to reducing negative affect. . . . The introduction of HAART transformed HIV from an imminently terminal to a chronic disease that could be managed. . . . This post-HAART shift to more optimistic appraisals of HIV could explain the change in the association between Direct Action and negative affect. . . . Although the association of Direct Action and positive affect did not differ significantly between pre- and post-HAART studies, the direction of the correlations supports the hypothesis that Direct Action was more strongly associated with positive affect after the introduction of HAART. (pp. 134-135)

As for Positive Reappraisal, this form of coping was “associated with increased positive affect, decreased negative affect, and better physical health. . . . The beneficial effects of Positive Reappraisal were not moderated by the contextual, measurement, or individual variables explored here” (p. 135).

With regard to forms of coping with HIV that do not work,

Behavioral Disengagement, Alcohol/Drug Disengagement, Distancing, and Social Isolation each appeared to be maladaptive in a number of the outcome categories.

Behavioral Disengagement . . . captures giving up or ceasing efforts to cope with the problem. . . . Alcohol/Drug Disengagement captures use of substances to avoid the problem. . . . Distancing includes behaviors such as acting as if the event has not occurred . . . or refusing to take the event seriously. In the case of some small daily stressors or hassles, Distancing may be an adaptive strategy. However, in the case of HIV, Distancing is not helpful with respect to negative affect, health behaviors, or physical health.

Although only a few studies . . . look[ed] at Social Isolation as a coping strategy . . . , in the present analysis, . . . Social Isolation in the context of HIV is particularly maladaptive in terms of positive . . . and negative affect. . . . Seeking Social Support may seem to be the flip-side of Social Isolation and would perhaps be expected to be associated with better outcomes. There is, however, only limited support here for widespread positive effects of Seeking Social Support. Although Seeking Social Support was associated with significantly less negative affect, it was not significantly associated with positive affect, health behaviors, or physical health. (p. 135)

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Safren, S.A., O'Cleirigh, C., Tan, J.Y., Raminani, S.R., Reilly, L.C., Otto, M.W., & Mayer, K.H. (2009). A randomized controlled trial of cognitive behavioral therapy for adherence and depression (CBT-AD) in HIV-infected individuals. *Health Psychology, 28*(1), 1-10.

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Tool Box

A Note on Content

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

J.H., & the HIV Neurobehavioral Research Center Group. (2009). Timing is everything: Antiretroviral nonadherence is associated with impairment in time-based prospec-

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

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

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

tive memory. *Journal of the International Neuropsychological Society, 15*(1), 42-52.

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