mental health **AIDS**

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Biopsychosocial Update

HIV Prevention News

About Women

Crepaz et al. (2009) undertook "a comprehensive literature review covering studies published from January 1988 to June 2007" and conducted a meta-analysis to evaluate "the efficacy of HIV behavioral interventions for **African American females** in the United States, and . . . identif[y] . . . factors associated with intervention efficacy" (p. 2069). Among 37 relevant studies, the investigators found that "behavioral interventions had a significant impact on reductions in HIV-risk sex behaviors . . . and sexually transmitted infections (STIs . . .). Greater intervention efficacy was observed in studies that specifically targeted African American females[,] used gender- or culture-specific materials, used female deliverers, addressed empowerment issues, provided skills training in condom use and negotiation of safer sex, and used role-playing to teach negotiation skills" (p. 2069).

"Although it is important to address psychological processes, behavioral skills, and communication within a relationship," Crepaz and colleagues astutely observe that "individual behavioral change does not occur in a vacuum. Thus, it is also essential to attend to socioecological factors that affect HIV risk, including sexual networks, concurrent partnership, . . . intimate partner violence, ratio of men to women in African American communities, . . . and economic oppression" (p. 2074), and that "more research is needed to examine the potential contribution of prevention strategies that attend to [these] community-level and structural-level factors affecting HIV infection and transmission in this population" (p. 2069).

About Women & Men

Durantini and Albarracín (2009) conducted a meta-analysis "to test theoretical hypotheses about the **predictors of enrollment and completion of condom-use-promotion interventions** among men and women" (p. 631). "The 76 studies were produced between 1987 and 2005, and yielded 83 experimental conditions and 20 control conditions. Most of the conditions belonged to reports published in journals (k = 70), although some were unpublished theses (k = 6)" (p. 634). The investigators found that

> experimental interventions providing instrumental and financial resources . . . [i.e., "payments, transportation, child care, reminders, HIV test (when it was only offered, but was not a required part of the program), other health care, and other incentives" (p. 633)] increased initiation and retention more among predominantly male samples, whereas experimental interventions using group formats increased initiation and retention more among predominantly female samples. These patterns remained while controlling for past condom use, other HIV-risk behaviors, and demographics associated with gender composition. (p. 631)

Durantini and Albarracín conclude that "people seek out HIV-prevention interventions to fulfill gender-specific needs, and these differences must be taken into account in the design of HIV-prevention interventions" (p. 631). Additional findings

> emerged from more exploratory moderator analyses. First, the intervention setting had a differential effect across genders: school and community intervention settings were linked to better retention in predominantly female samples but worse retention in predominantly male samples. In contrast, work and hospital settings were associated with better retention in predominantly male samples but worse retention in predominantly female samples. Second, recruitment by personal contact attracted women but made no difference for

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men. Third, both predominantly female and male samples showed more completion in short interventions (i.e., with fewer sessions), but this effect was stronger in the predominantly male samples. Fourth, with regards to session length, predominantly female samples showed more completion of longer sessions, but predominantly male samples showed more completion of shorter sessions. Last, when the intervention included attitudinal arguments, control arguments, condom-use skills training, and negotiation-skills training, predominantly female samples showed more completion but predominantly male samples showed less completion. Contrarily, when the intervention included HIV testing and condom provision, predominantly male samples showed more completion but predominantly female samples showed less completion. (p. 637)

On the basis of these findings, Durantini and Albarracín make several recommendations:

> First, the implementation of various forms of financial and instrumental assistance seems key to attract men . . . [and social service providers] must increase efforts to offer . . . [these forms of assistance to] men. . . . Second, with regard to the format, individual interventions and short sessions may be advantageous for men . . . [and] the use of group interventions may be a deterrent for men, particularly those who adhere to traditional masculine roles. Finally, the content of the intervention itself is essential to ensure intervention completion by men, particularly the provision of HIV testing and condoms as part of the intervention.
>
> With respect to women, long group sessions seem ideal to obtain enrollment and completion of HIV-prevention interventions. Women also benefit from a small number of sessions, and these formats may be combined with strategies able to raise emotional involvement and gratification: attitudinal and control arguments as well as training in negotiation skills and condom use. Delivery in community settings and schools should also maximize intervention completion in female populations. Hospitals and work places are ideal settings for men. In contrast, the use of financial and instrumental incentives for women deserves further work. In particular, it is presently unclear why predominantly female samples show lesser acceptance of and retention in interventions that offer instrumental/financial resources. (pp. 637-639)

About Adolescents & Young Adults

Two recent papers emerged from Project STYLE (Strengthening Today's Youth Life Experience), which utilized a family-focused approach to HIV prevention among **adolescents** who were **engaged in outpatient psychiatric services** in Providence, Rhode Island; Atlanta; and Chicago:

o Hadley et al. (2009) examined "the relationship between **parent-teen sexual communication**, **discussion of condoms**, and **condom use**" (p. 997) among 485 sexually active teens who, along with their parents, "completed questionnaires assessing adolescent sexual risk behavior, sexual communication, and discussion of sexual topics" (p. 997). Based on the adolescents' responses to a computerized diagnostic interview, "the most frequent diagnoses were Oppositional Defiant Disorder (38%), Conduct Disorder (31%), Generalized Anxiety Disorder (20%), Major Depression (18%), Posttraumatic Stress Disorder (14%), Mania (14%), and Hypomania (11%)" (p. 999). Among these teens, Hadley and colleagues found that

> adolescents who report discussing condoms with their parents were significantly more likely to use condoms consistently and this association existed even when controlling for demographic factors and the presence of a psychiatric diagnosis. . . . Discussions by parents of condoms may reinforce the adolescent's intentions to use condoms in order to prevent pregnancy or [STIs]. It is significant that parent and adolescent perceptions of open sexual communication were not related to consistency of condom use. Thus, the general openness of their communication about sexual behaviors was unrelated to the adolescent's

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safe[r] behavior. This finding optimistically suggests that regardless of the sexual communication patterns within the family, techniques that increase the occurrence of parent and adolescent discussions concerning condoms will prove useful in preventing HIV and STIs among adolescents. (p. 1002)

o On this curious finding regarding open sexual communication within the family, Nappi et al. (2009) demonstrate "the importance of examining interactive effects of multiple family processes in relation to sexual risk taking" (p. 1019) in their study of "the influence of family sexual communication and **parental monitoring** among adolescents in psychiatric care. Because links between family sexual communication and adolescent sexual risk remain unclear among youth receiving mental health services," Nappi and colleagues "sought to determine if this relationship is dependent upon the degree to which parents monitor the behavior of these teens" (p. 1013). There were 718 parent-adolescent dyads included in this analysis, which revealed that "parental monitoring moderated the family communication quality-sexual risk behavior relationship among **African American families**. African American parents who perceived themselves as capable of open family sexual communication and frequent monitoring had adolescents who reported decreased sexual risk behavior. The moderator model was not supported among Caucasian and Hispanic families and findings did not depend upon gender" (p. 1012).[1] The investigators observe that

> for African American youth in psychiatric care, greater parental involvement and supervision may be a necessary condition for the protective effect of high quality (i.e., more open and comfortable) family sexual communication on adolescent sexual risk taking. Adolescents of parents that perceive themselves as consistent monitors *and* capable of open and comfortable discourse about sex may be more likely to implement safe[r] sex practices.
>
> Findings are consistent with studies of typically developing youth that highlight the critical role of parental monitoring and limit setting in shaping sexual activity. (pp. 1017-1018)

Because "parental monitoring may protect African American adolescents in psychiatric care from inconsistent condom use" (p. 1018), Nappi and colleagues suggest that "family-based programs designed to reduce risky sexual behavior among African American youth in psychiatric care may be more effective if they involve teaching parents how to both monitor and communicate effectively about sexual topics" (p. 1019).

About Men Who Have Sex With Men

Reisner et al. (2009) "examined the associations of demographics, behavioral HIV risk factors, and psychosocial variables with **depressive symptoms** by severity" (p. 798) among 197 **black men who have sex with men** (MSM) residing in Massachusetts. The investigators report that one third of this sample of black MSM screened positive for clinically significant depressive symptoms, and that these results suggest that depression represents a pervasive psychosocial issue among Black MSM, as it does among MSM in general. . . . More than half of depressed men in the sample (58% or 38/65) had moderate depressive symptoms and . . . increased sexual risk behavior was associated with moderate depressive symptoms. Specifically, men reporting serodiscordant unprotected anal sex with a casual male partner had a nine-fold greater risk and those diagnosed with an STD [sexually transmitted disease] had a six-fold greater risk for having moderate depressive symptoms. Results suggest that moderately depressed Black MSM in particular may be at increased risk for HIV and other STDs. HIV prevention interventions for Black MSM may benefit from incorporating screening and/or treatment for depression, thus allowing MSM who are depressed to respond more effectively to behavioral change approaches to HIV prevention. (p. 805)

Salomon et al. (2009) analyzed baseline data collected from the 4,295 MSM who enrolled in the national, multisite EXPLORE Study[2] and "examined **depressive symptoms, utilization of mental health care, substance use and HIV risk taking behaviors in** [the 814] YMSM [**young men who have sex with men**] aged 16-25 years compared with their older counterparts" (p. 811). Salomon and colleagues "found that YMSM have greater propensity towards depressive symptoms, less utilization of mental health services and higher rates of substance use than their older counterparts. This analysis also pointed to YMSM hav-

[1] Nappi and colleagues (2009) observe that they "may have lacked power to detect a significant parental monitoring x sexual communication interaction among Hispanic and Caucasian families. The overall sample was predominantly African American (*N* = 415) and power to detect effects was greatest among this subsample. We tested the moderator model among far . . . [fewer] Hispanic (*N* = 72) and Caucasian (*N* = 193) families. The power to detect effects with the number of participants in these groups should have been sufficient for a medium . . ., but not a small . . . effect size" (p. 1018).

[2] "The EXPLORE study was the first randomized trial designed to test the efficacy of a behavioral intervention specifically for MSM in preventing the acquisition of HIV using HIV incidence as the primary outcome measure" (Salomon et al., 2009, p. 812).

ing higher rates of unprotected receptive and insertive anal sex with partners of presumed HIV-negative status and higher rates of receptive anal sex with partners whose HIV status was unknown when compared with older MSM in th[is] . . . cohort" (p. 815). According to the investigators, "the high rates of depressive symptoms, low utilization of mental health services, high rates of substance use and high rates of sexual risk taking behaviors among the YMSM in this cohort may, combined, place YMSM at greater risk of contracting HIV" (pp. 815-816) and that "higher rates of depressive symptoms combined with lower rates of utilization of individual and group counseling and psychopharmacology point to significant gaps in many YMSM's use of mental health care" (p. 817). Additionally, "in the EXPLORE cohort, YMSM were more likely than their older counterparts to have reported heavy alcohol use as well as use of marijuana, hallucinogens, cocaine and amphetamines" (p. 817). Salomon and colleagues contend that "these findings suggest the need for more appropriate and accessible mental health care and substance use services for YMSM. Additionally, HIV prevention work with this population should provide comprehensive education about HIV testing and risk reduction counseling that focuses on communication about serostatus and safety in sexual situations" (p. 811).

When HIV testing results in a seropositive diagnosis, "statistical associations between substance use and seroconversion among gay and bisexual men . . . often ignore men's own interpretations of their seroconversion," according to Aguinaldo, Myers, Ryder, Haubrich, and Calzavara (2009), who used "in-depth interviews with [30] **gay and bisexual men who reported using drugs or alcohol at the time of their seroconversion**" to "identify how these men explain the events that led to HIV transmission" (p. 1395). Notably, "whereas a small minority of respondents reported substance use to explain their seroconversion, the majority reported three competing explanations. These participants claimed that they lacked sufficient knowledge about the behavioral risks that led to their seroconversion [i.e., "the men believed the behaviors in which they engaged were safe from HIV infection" (p. 1402)]; that their decision to engage in unsafe sex was because of negative personal affect; and that they 'trusted the wrong person'" (p. 1395) and took risks "they otherwise would not. A fourth explanation was given that claimed seroconversion resulted from sexual victimization" (p. 1402). Aguinaldo and colleagues observe that these

> findings do not differ substantially from the HIV-prevention literature on gay and bisexual men more generally. In fact, the explanations offered by substance-using men coincide with those found in other qualitative health research that has explored gay men's accounts of seroconversion. . . . What this suggests is that those who use substances for recreational purposes and who are gay or bisexual would likely benefit from HIV-prevention campaigns that are designed for gay or bisexual men rather than substance-using men. This is not to suggest that substance use treatment should be dismissed outright as a form of HIV prevention. However, to base HIV-prevention campaigns for substance-using gay and bisexual men solely on drug and alcohol abstinence will ignore the experiences that some . . . [study] participants understand to be the cause of their HIV infection. (p. 1402)

On the basis of these findings, the investigators conclude that "HIV-prevention efforts might better reiterate the modes of transmission and their shifting degrees of risk contingent on a host of factors; reduce negative affect among gay men; identify and appreciate the social and sexual meanings and representa-

Tool Box

Books & Articles

Berg, R.C. (2009). Barebacking: A review of the literature. *Archives of Sexual Behavior, 38*(5), 754-764.
"This article synthesizes the peer-reviewed literature about barebacking, an HIV risk behavior that is generally understood as intentional unprotected anal intercourse between men where HIV transmission is a possibility" (p. 754).

Coleman, C.L., Jemmott, L., Jemmott, J.B., Strumpf, N., & Ratcliffe, S. (2009). Development of an HIV risk reduction intervention for older seropositive African American men. *AIDS Patient Care & STDs, 23*(8), 647-655.
"The purpose of this study was to assess the feasibility and acceptability of an HIV risk[-]reduction intervention to increase consistent condom use in a sample of older HIV-positive African American men who have sex with men (MSM). . . . The development of the intervention was implemented in four phases: focus groups, pilot testing of the questionnaire, modifying the intervention, and executing the intervention. . . . The findings suggest that an HIV risk-reduction condition may increase consistent condom use among HIV-positive African American MSM 50 years and older" (p. 647).

De Santis, J.P. (2009). HIV infection risk factors among male-to-female transgender persons: A review of the literature. *Journal of the Association of Nurses in AIDS Care, 20*(5), 362-372.
"Male-to-female (MTF) transgender women experience a host of psychosocial issues such as discrimination, stigmatization, and marginalization. These challenges often limit economic opportunities, affect mental health, and may place members of this population at an increased risk for HIV infection. This report presents

tions of high-risk sexual behaviors; and challenge the assumptions on which sexual decisions are based. . . . HIV-prevention campaigns must speak to the needs and concerns expressed by those to whom these campaigns are directed" (p. 1403).

Similarly, Kelly, Bimbi, Izienicki, and Parsons (2009) "recruited a diverse sample of HIV-positive men (n = 66) at gay community events" in New York City and "one third of these men self-identified as **barebackers**" (p. 792), or men who have intentional unprotected anal sex with other men. Kelly and colleagues found that "barebackers were more likely to report drug use and sex under the influence of drugs (i.e., PnP [party-n-play]). Beyond this, those who identified as barebackers also tended

a review of the literature that focuses on risk factors for HIV infection specific to the MTF population. Factors including needle sharing and substance abuse, high-risk sexual behaviors, commercial sex work, health care access, lack of knowledge regarding HIV transmission, violence, stigma and discrimination, and mental health issues have been identified in the literature as risk factors for the acquisition of HIV infection by members of this population. Implications for care provided to MTF transgender persons are presented, and suggestions for future research are identified" (p. 362).

Goodkin, K. (2009). Psychiatric aspects of HIV spectrum disease. *Focus, 7*(3), 303-310.
"The psychiatrist can play an important role in identifying HIV high risk behaviors, in presenting the option for HIV antibody testing, and in providing follow-up with counseling. The high risk for HIV infection among the severely mentally ill also directly involves the psychiatrist today in HIV/AIDS care. Anxiety, depressive spectrum, neurocognitive, and psychotic disorders present with symptom profiles and in settings that are specific to HIV infection and require the need for individually tailored psychiatric care. Guidelines for the psychiatrist treating HIV infected patients are available. It is incumbent upon the practicing psychiatrist to maintain familiarity with these guidelines and offer the capacity to treat the psychiatric disorders that occur in this patient population" (p. 303).

Goodkin, K., Shapshak, P., & Verma, A. (Eds.). (2008). *The spectrum of neuro-AIDS disorders: Pathophysiology, diagnosis, and treatment.* Washington, DC: ASM Press.
From the publisher: "This book presents the wide variety of HIV-associated disorders and comorbidities with a look at the pre-HAART [highly active antiretroviral therapy] literature as well as the latest findings from the . . . HAART era. . . . In addition, this volume stands out for its chapters on specific patient populations such as women, children, minorities, and older persons, as well as special chapters addressing medico-legal and end-of-life concerns. The book concludes with a look at global issues and the future of neuro-AIDS in the HAART era."

Lightfoot, M.A., & Milburn, N.G. (2009). HIV prevention and African American youth: Examination of individual-level behaviour is not the only answer. *Culture, Health & Sexuality, 11*(7), 731-742.
"African American youth experience higher rates of HIV and other STIs [sexually transmitted infections], even when their sexual behaviour is normative. These findings suggest the need to expand beyond the examination of individual-level factors and to consider contextual issues such as economic, geographic and cultural influences. This paper reviews the relationship between contextual factors and HIV risk and prevalence and the implication for prevention for African American youth" (p. 731).

Lovejoy, T.I., & Suhr, J.A. (2009). The relationship between neuropsychological functioning and HAART adherence in HIV-positive adults: A systematic review. *Journal of Behavioral Medicine, 32*(5), 389-405.
"In this paper, we review 11 empirical studies . . . that utilized psychometrically valid neuropsychological measures to examine the relationship between cognitive functioning and HAART adherence. In general, impaired neuropsychological functioning – particularly within the domains of executive functioning and problem solving, learning and memory, attention and working memory, and global cognitive functioning – was associated with lower medication adherence across studies. However, inconsistent operationalizations of . . . [terms], as well as the paucity of longitudinal data to support temporal relationships, may attenuate these conclusions. We conclude with a set of research recommendations that may help to improve the rigor of future studies and clarify questions left unanswered due to methodological limitations of existing studies" (p. 389).

Olivier, C. (2009). Enhancing confidentiality within small groups: The experiences of AIDS service organizations. *Social Work with Groups, 32*(4), 274-287.
"This article reports on practices for enhancing confidentiality among group members. The research involved surveying group workers on practices used to promote confidentiality and providing [persons living with HIV/AIDS] opportunity to share their perspectives" (p. 274).

Rice, E., Lester, P., Flook, L., Green, S., Valladares, E.S., & Rotheram-Borus, M.J. (2009). Lessons learned from "integrating" intensive family-based interventions into medical care settings for mothers living with HIV/AIDS and their adolescent children. *AIDS & Behavior, 13*(5), 1005-1011.
Rice and colleagues delivered "an intensive family-based HIV prevention intervention for mothers living with HIV (MLH) and their adolescent children, 'integrated' into clinical care settings and also community-based settings. This paper is an investigation into the preferences of the MLH and their adolescents for different delivery sites and the retention to the intervention at those different sites" (p. 1006).

Sandelowski, M., Voils, C.I., Chang, Y., & Lee, E.-J. (2009). A systematic review comparing antiretroviral adherence descriptive and intervention studies conducted in the USA. *AIDS Care, 21*(8), 953-966.
"We examined the extent to which

(Tool Box is continued on Page 6)

to report greater stigma, gay-related stress, self-blame-related coping, and substance abuse coping" (p. 792). On the basis of these findings, the investigators urge clinicians to

> move beyond an oversimplified interconnection of drug use and sexual risk. . . . [T]hese data suggest . . . [that] closer attention should be paid to the issues of stress and coping rather than primarily emphasizing the interconnection of drug use and sex behaviors when designing new preventative and risk reduction efforts. Drug use and barebacking may collectively represent a broader constellation of risk related to underlying stress and maladaptive coping mechanisms. . . . Stress and stigma . . . should [therefore] be addressed in intervention efforts. For example, Motivational Interviewing may be useful to address ambivalence in barebacking and enable some men to recognize the role that stress and coping are playing in their behaviors. In addition, the data suggest that self-blaming men should be targeted for interventions. Such individuals may cope with a wide range of problems by blaming themselves and consequently such maladaptive coping must be addressed on an individual basis. (pp. 795-796)

HIV Assessment News

HIV Counseling & Testing

According to Delaney and O'Brien (2009), "many people undergoing HIV testing experience substantial psychological distress. The **psychological distress associated with testing** may be influenced by **monitoring**. Monitoring refers to a strategy wherein a person tends to seek out information concerning threatening events. Furthermore, the **ability to achieve cognitive structure** (AACS) may influence the relationship between monitoring and psychological distress" (p. 909). More specifically, "one's ability to incorporate and assimilate information (i.e.[,] AACS) interacts with monitoring. Thus, high monitors who also have a high AACS would experience reduced distress with information provision. Alternatively, high monitors with a low AACS would not experience reduced distress with information provision" (p. 910).

Delaney and O'Brien "examined the association among monitoring and AACS on psychological distress during HIV testing" (p. 909) and found that

> people undergoing HIV testing experience significant psychological distress . . . [that] does not significantly abate during the interval between testing and receiving results. . . . [O]nly . . . AACS . . . emerged as a significant, important . . . and unique predictor [of psychological distress]. . . . [I]t appears that independent of monitoring style, a person's ability to organise health information, judge the relevance of that information, and then use the information to reduce uncertainty is associated with reduced distress in a high-stakes environment where the test outcome has an immense impact on a person's perception of self, health and the future. (p. 915)

Although "caution should be used when generalising these results to all individuals who are undergoing HIV

(*Tool Box -- continued from Page 5)*

studies aimed at testing interventions to improve antiretroviral adherence have targeted the facilitators of and barriers known to affect adherence. . . . We discerned congruence between the prominence of substance abuse as a factor identified in the descriptive studies as a barrier to adherence and its prominence as the problem most addressed in those reports of intervention studies that specified the problems targeted for intervention. We also discerned congruence between the prominence of family and provider support as factors identified in the descriptive studies as facilitators of adherence and the presence of social support as an intervention component and outcome variable. Less discernible in the reports of intervention studies was specific attention to other factors prominent in the descriptive studies, which may be due to the complex nature of the problem, individualistic and rationalist slant of interventions, or simply the ways interventions were presented. Our review raises issues about . . . intervention tailoring, targeting, and fidelity" (p. 953).

Stallworth, J.M., Herbst, J.H., Alvarez, M.E., Romaguera, R.A., Amaro, H., & Dean, H.D. (Eds.). (2009). Special supplement: Hispanics/Latinos and HIV/AIDS: Epidemiologic, behavioral and ecological influences of risk and best practices for prevention. *AIDS Education & Prevention, 21*(Suppl. B.), 1-185.

"The purpose of this supplement is to provide a diverse audience – including academic researchers, health departments, health educators, community-based organizations, governmental agencies and officials, and other members of the HIV prevention workforce – with a comprehensive resource to better understand the HIV/AIDS epidemic among Hispanics/Latinos in the United States" (p. 4).

Swendeman, D., Ingram, B.L., & Rotheram-Borus, M.J. (2009). Common elements in self-management of HIV and other chronic illnesses: An integrative framework. *AIDS Care, 21*(10), 1321-1334.

"Similar to other chronic diseases, HIV requires lifetime changes in physical health, psychological functioning, social relations, and adoption of disease-specific regimens. The shift from acute to chronic illness requires a self-management model in which patients assume an active and informed role in healthcare decision making to change behaviors and social relations to optimize health and proactively address predictable challenges of chronic diseases generally

testing" (p. 916), Delaney and O'Brien point out that

> the provision of information . . . is often thought of as an important component of HIV testing, and . . . may be most beneficial for people with higher AACS. These people may have increased capacity for taking in the information, analysing its relevance and applying it to their own life circumstances. Alternatively, people with lower AACS may not be as able to benefit from general information provision. Specifically, providing general information about HIV transmission may intensify distress because they may not be able to sort through and identify information that is relevant to their own history. Thus, they may experience an increased sense of vulnerability and distress which, in turn, may increase their risk for escape and avoidance. Thus, they may benefit more from information that is more limited and more clearly tied to their own risk behaviours. (p. 916)

For individuals with positive test results, referral to HIV primary care services is a crucial component of post-test counseling. Reed et al. (2009) interviewed a diverse sample of 3,942 men and women living with HIV in 18 U.S. states to determine "dates of HIV diagnosis and entry into HIV care," with "**delayed care entry** . . . defined as care entry greater than 3 months after HIV diagnosis" (p. 765). Among these respondents, "28% had delayed care entry. Diagnostic testing-related characteristics associated with delayed care entry included anonymous and first-time HIV testing" (p. 765). "First-time testing and anonymous testing were independently associated with a 33% and 24% increased odds of delayed care entry, respectively. . . . [P]roviders should consider the possibility that a newly diagnosed person may delay care entry whenever their diagnostic test is an anonymous test or is their first-ever HIV test, and reinforce timely care linkage for persons at risk of delay" (p. 768).

Psychiatric Assessment & Intervention

Over a 2-year period, Chernoff et al. (2009) monitored and compared **mental health intervention patterns** in three groups – 319 **youths perinatally infected with HIV**, and a control group that included 174 **perinatally HIV-exposed but uninfected youths** and 82 **HIV-uninfected youths living in households containing one or more persons living with HIV**, all between the ages of 6 and 17 years – from a variety of research sites across the U.S. The investigators found that

> HIV-positive youth and youth in the control group had a similar prevalence of psychiatric symptoms (61%) and impairment (14% to 15%). One hundred four (18%) participants received psychotropic medications (stimulants [14%], antidepressants [6%], and neuroleptic agents [4%]), and 127 (22%) received behavioral treatment. More HIV-positive youth than youth in the control group received psychotropic medication (23% vs. 12%) and behavioral treatment (27% vs. 17%). After adjusting for symptom class and confounders, HIV-positive children had twice the odds of children in the control group of having received stimulants and > 4 times the odds of having received antidepressants. Caregiver-reported symptoms or impairment were associated with higher odds of intervention than reports by children alone. (p. 627)

Chernoff and colleagues conclude that children and adolescents living with HIV "are more likely to receive mental health interventions than control-group children" and urge clinicians and caregivers to "consider available mental health treatment options for *all* children living in families affected by HIV" (italics added; p. 627).

This message is reinforced by findings from a study by Mellins, Brackis-Cott, et al. (2009), who "examined 1) the **prevalence of**

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and HIV specifically. This article reviews literature on chronic disease self-management[1] to identify factors common across chronic diseases, highlight HIV-specific challenges, and review recent developments in self-management interventions for people living with HIV . . . and other chronic diseases. An integrated framework of common elements or tasks in chronic disease self-management is presented that outlines 14 elements in three broad categories: physical health; psychological functioning; and social relationships. Common elements for physical health include: a framework for understanding illness and wellness; health promoting behaviors; treatment adherence; self-monitoring of physical status; accessing appropriate treatment and services; and preventing transmission. Elements related to psychological functioning include: self-efficacy and empowerment; cognitive skills; reducing negative emotional states; and managing identity shifts. Social relationship elements include: collaborative relationships with healthcare providers; social support; disclosure and stigma management; and positive social and family relationships. . . . Recognizing that self-management of HIV has more in common with all chronic diseases than differences suggests that the design and delivery of HIV support services can be incorporated into combined or integrated prevention and wellness services" (p. 1321).

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

[1] For more information on self-management approaches to HIV disease, see the **Tool Box** in the Fall 2007 issue of *mental health* **AIDS** entitled "Enlisting Service Consumers as Active Participants in HIV-Related Assessment & Care."

Tool Box

Lending an Existential Ear to the Elemental Issues in HIV-Related Therapy

"A diagnosis of HIV can reveal our common existential concerns:
it confronts us with the universal aspects of human existence, like a mirror to life.
Life sets us many challenges from which we may learn and grow.
HIV encompasses everything, it is very much about living and
how to ascribe meaning to that living, and as such
does not present anything unique to the human condition. In that sense,
HIV can be seen as no more or less of a catastrophe
than life itself; it is but another phenomenon of life."

—— Horne, 2009, p. 67

Although this approach has received "only limited systematic consideration in the HIV-related psychotherapy literature," Farber (2009) elaborates on the ways in which "existential psychotherapy offers a conceptual framework that is especially well suited to the work of psychotherapy with individuals living with HIV disease" (p. 336). According to Farber, such individuals

> frequently confront complex illness-related physical, psychological, and psychosocial challenges. Psychotherapists often must be prepared to help their patients manage multiple simultaneous concerns including the adverse physical impact of the illness, limitations in material and financial resources, social isolation, and experiences with social marginalization and stigma. This clinical complexity can pose significant challenges for the psychotherapist in considering how best to proceed with the work of psychotherapy. Existential psychotherapy combines a rich conceptual framework with a technically flexible practice approach that can be enormously helpful in addressing, at multiple levels, the intricacies of HIV-related psychotherapy. It offers a useful theoretically guided approach that can inform the use of a range of techniques, and is widely applicable to a broad spectrum of clinical problems. (p. 347)

Rich Conceptual Framework

Existential psychotherapy is grounded in "a theoretical framework that concerns itself with articulating the fundamental dimensions, meanings, and dilemmas of human existence. Among the key theoretical assumptions of the approach is that each human being is unique, exists within a natural/physical, relational/cultural, and personal/bodily context, is free to choose within the limits of existence, and is dynamic in the sense that self is continually unfolding in accordance with individual choices" (Farber, 2009, p. 337).

Farber cites the work of Yalom (1980) in observing that

> conflicts surrounding the existential themes of death, freedom/groundlessness, isolation, and meaninglessness ha[ve] . . . particular applicability to the work of HIV-related psychotherapy. . . . [C]ertain life events (including confrontation with a chronic and life-threatening illness such as HIV disease) can force these existential concerns into the foreground of psychological life, thereby generating deep anxiety that reflects a profound sense of threat to individual existence. Psychological adaptations (or defenses) are organized to manage this existential anxiety. To the extent that these adaptations falter or function inflexibly, the range of emotional experiencing is increasingly constricted, thereby impeding psychological growth. Denial of one's existential reality can compromise one's capacity to explore potentialities, make choices that promote personal fulfillment, discover workable solutions to life challenges, and live fully in the present. . . . Accordingly, a key focus of therapy is on helping one live as fully as possible by overcoming resis-

psychiatric and substance use disorders in perinatally HIV-infected (HIV+) **adolescents and** 2) the association between HIV infection and these mental health outcomes by comparing HIV+ youths to **HIV exposed but uninfected youths** (HIV-) **from similar communities**" (p. 1131). A convenience sample of "340 caregiver/youth dyads; 206 HIV+ and 134 HIV- youths" (p. 1132) were recruited from "four medical centers . . . [providing] family-focused primary and tertiary care to HIV-affected families" in New York City, and "caregivers and children were interviewed separately, but simultaneously" (p. 1132).

The perinatally HIV-exposed but uninfected youths ("seroreverters") were similar in age and demographic characteristics to the youths who were living with HIV. As the investigators point out, "seroreverters are an ideal comparison group because, with the exception of child HIV status, sociodemographic and family characteristics, including perinatal exposure to HIV, are for the most part very similar, providing an opportunity to explore the unique contribution of HIV infection to mental health outcomes" (p. 1132). Mellins, Brackis-Cott, and colleagues found that

> according to caregiver or youth report, a high percentage of HIV+ and HIV- youths met criteria for a non-substance use psychiatric disorder, with significantly higher rates among the HIV+ youths (61% vs. 49% . . .). The most prevalent diagnoses in both groups were anxiety disorders (46% for total sample) which included social phobia, separation anxiety, agoraphobia, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and specific phobias. One quarter of the sample met criteria for a behavioral disorder (ADHD [attention deficit hyperactivity disorder], conduct disorders, and oppositional defiant disorders), with ADHD being most prevalent.

tances to encountering one's existential conflicts. (pp. 338-339)

Farber expands on ways in which existential conflicts emerge in HIV-related psychotherapy as follows:

o **Death** – A fundamental existential dilemma in living arises from the conflict between one's wish to perpetuate one's personal existence and the reality that one is a finite being. . . . In HIV-related psychotherapy, . . . heightened mortality awareness carries the potential to inspire the patient to commit to living as fully as possible in the present. This process involves reflections on life trajectory, individual priorities, and personal goals balanced with the working through of the profound and disconcerting sense of danger to the self arising from literal threats to physical existence associated with HIV disease. The existential dynamics of death also may be expressed metaphorically in patient resistances to change in psychotherapy in that committing to trying out new ways of being can entail risk of losing what is known to one and how one knows oneself. (p. 339)

o **Freedom/Groundlessness** – The dilemma of freedom . . . involves a conflict between the search for a universal blueprint for living and the disquieting fact of existential groundlessness. . . . Existential ideas regarding freedom and authenticity orient the psychotherapist in HIV-related psychotherapy to the importance of . . . highlighting personal choices and options in responding to the challenges of living with HIV disease. . . . This emphasis . . . must be balanced . . . with attention to helping the patient come to terms with HIV-associated realities that limit possibility and choice. . . . Existentially informed HIV-related psychotherapy not only encourages responsibility acceptance through ownership of personal life choices

"An HIV+ diagnosis offers an opportunity to reassess one's way of living and to bring about change by questioning one's view of life."
—— Horne, 2009, p. 65

but also focuses on the working through of existential guilt regarding past choices, including regret about unintended adverse consequences of specific decisions and/or lost possibilities because of specific paths not chosen. . . . The process of grappling with the emotional impact of lost potentialities may be especially salient for patients in the late phases of AIDS progression where physical disease manifestations . . . increasingly limit choice and possibility. . . . To the extent that the patient can work through regret over past choices and apprehension about exercising choices in the present there is opportunity to reflect on how best to proceed with living and strive toward fulfilling potentials yet to unfold while remaining mindful of the real limits imposed by HIV disease. (pp. 340-341)

o **Isolation** – The dilemma of existential isolation derives from a conflict between the reality of fundamental aloneness and the human quest for social connection and belonging to a larger whole. . . . Persons living with HIV disease must confront existential isolation in that they alone bear the burden of directly experiencing the physical and emotional effects of the illness. . . . Given that social connectedness may help individuals to deal with existential isolation, an important priority of HIV-related psychotherapy is to focus on the relational resources available to the individual. . . . [E]xistentially informed HIV-related psychotherapy focuses on heightening awareness of the ways in which the dynamics of existential isolation influence the relational patterns of the patient. . . . Whether the focus is on one's social network or the psychotherapy relationship (or both), this process of working through involves nurturing

(Tool Box is continued on Page 10)

HIV+ youths had significantly higher rates of ADHD. . . . Only 7% of youths met criteria for a mood disorder and 4% for a substance abuse disorder. (p. 1131)

The investigators conclude that "both groups of perinatally HIV-exposed youths . . . had high rates of any psychiatric disorder, with higher rates among the HIV+ youths" (p. 1135) and that "it will be important to fully understand the etiology of these mental health disorders and consider their importance . . . as . . . [researchers] continue to evaluate . . . methods to optimize care for children and youths with HIV infection" (p. 1137).

In another study involving this cohort of perinatally HIV-infected (PHIV+) youth, Mellins, Elkington, et al. (2009) examined "relations between **youth mental health problems** and **sexual and substance use risk behavior**, the impact of **caregiver mental health** and **family functioning** on youth mental health and risk behavior outcomes, and the role of youth HIV status in this process" (p. 810). The investigators recruited and interviewed "193 PHIV+ and 127 perinatally HIV exposed but uninfected (PHIV-) 9- to 16-year-old boys and girls and their primary caregivers. Participants were primarily African American and Latino" (p. 810). Mellins and colleagues found "no differences in rates of sexual risk behavior or substance use between PHIV+ and PHIV- youths. However, adolescent mental health was significantly associated with sexual risk behavior and substance use. Caregiver mental health was associated with youth mental health and indirectly with sexual risk behavior and drug use through its impact on youth mental health. Family functioning did not significantly predict youth outcomes" (p. 810). The investigators conclude that "over and above other key environmental factors and family functioning, youth and caregiver mental health problems are related to sex and drug use risk be-

(Biopsychosocial Update is continued on Page 12)

(Tool Box -- continued from Page 9)

one's capacity to be alone in the encounter with existential isolation. (pp. 341-342)

o **Meaninglessness** – The dilemma of meaninglessness derives from the conflict between one's striving to organize experience meaningfully and the comprehension that one exists in a world with no inherent or absolute meaning. . . . The absence of universal meaning generates existential anxiety, and the creation of meaning assuages this anxiety by allowing one to develop an explanatory structure for one's life and elaborate personal values to guide one's actions and conduct. . . . An existentially informed meaning-focused approach in HIV-related psychotherapy illuminates [the struggle to make meaning of and adapt to] . . . various HIV-associated challenges across the spectrum of disease progression. Possible dynamics surrounding the existential givens of death, freedom, and/or isolation that may underlie meaning-related concerns also are explored. . . . For instance, individuals living with HIV disease may encounter crises of meaning that ensue from questions surrounding the personal implications of mortality (e.g., "Does my transience mean that my life and deeds ultimately are insignificant?"), freedom/groundlessness (e.g., "Why is there no set roadmap I can follow that can tell me how to deal with and explain my physical and emotional suffering with the illness?"), and isolation (e.g., "Why must I suffer alone with this disease?"). In facilitating exploration of these and other questions, the psychotherapist can help the patient to elaborate a meaningful organization of the personal experience of living with HIV disease. . . . [A] meaning-focused approach in HIV-related psychotherapy incorporates strategies to help the patient identify personal priorities and aspirations, pursue activities that provide a sense of purpose, and disentangle psychological obstacles to engaging life as fully as possible within what is realistic given HIV-associated limits on functioning. . . . Helping patients living with end stage HIV disease identify meaning in the struggle to come to terms with the suffering wrought by both the debilitating physical impact of the illness and HIV-associated psychosocial complications . . . can serve a vital palliative function. (pp. 342-343)

"By confronting clients with their finitude, an HIV+ diagnosis can lead them to re-evaluate the values, beliefs and assumptions by which they live their lives; it can provide a call to be more authentic, to open up to new possibilities and realize a sense of wholeness. Therein lies the vitality of death. It is a choice we have to make: we can choose to explore or ignore our relations to our personal existence; to accept or refuse to engage with existential questions."

—— Horne, 2009, p. 69

True to Life

In recent years, several studies have tapped into a range of existential concerns that confront people who are living with HIV/AIDS:

o Mayers, Naples, and Nilsen (2005) interviewed a racially and ethnically diverse sample of nine low-income mothers living with HIV and found that these women "struggled with a range of existential issues that included guilt, responsibility and choice; helplessness and control; death anxiety, loneliness and isolation; and meaning and authenticity. With respect to psychological coping strategies," Mayers and colleagues found that "despite the added burdens of poverty and a stigmatizing disease, these women were able to turn their health crisis into a growth-producing and meaning-giving experience. More specifically, their children came to serve as a crucial meaning-giving force in their lives, a force that motivated them to forge ahead and meet with courage the existential challenges they faced" (p. 93).

o Buseh and Stevens (2006) conducted 10 open-ended interviews over a 2-year period with 29 African American women living with HIV to develop greater understanding about how these women experienced and responded to HIV-related stigma. Buseh and Stevens report that these women "experienced HIV stigma internally as existential despair, socially as shunning and callousness, and institutionally as disregard. Their stories point to multiple constraints imposed by HIV stigma including damaged self-esteem, loss of hope, rejection by loved ones, social restriction, and limitations on the beneficence and competence they should have been able to expect from the institutions that served them" (p. 14). Yet, Buseh and Stevens found that these women "resisted stigma. Over time, by enlisting support, facing the illness, disclosing only at strategic times, redefining stigma as ignorance, and becoming advocates, they were able to challenge and oppose the shame and discredit that HIV infection had brought into their lives" (p. 2).

o Westling, Garcia, and Mann (2007) asked 41 low-income, predominantly racial and ethnic minority women living with HIV to participate in a writing task twice weekly over a period of 1 month and "found that individuals who were able to discover meaning in their lives reported better adherence to their HIV medications than individuals who were not able to discover meaning in their lives. . . . The size of these effects is small to moderate, but . . . finding meaning was associated with adhering to medications 'most' of the time, while failing to find meaning was associated with adhering only 'some' of the time" (p. 633). Westling and colleagues conclude that the "discovery of meaning may result in positive health outcomes by leading individuals to engage in healthier behaviors" (p. 627).

o Valle and Levy (2008) looked into "the cognitive interpretations African American injection drug users make of an HIV-positive test result and the attitudinal and behavioural patterns that accompany those interpretations" (p. 130) among 80 street-recruited injectors who tested seropositive. "Individuals who interpreted testing HIV-positive as a 'wake up call' displayed the attitudinal and behavioural pat-

terns of 'being blessed', 'living clean' and 'advocacy'. Those that interpreted the test result as a 'death knell' displayed 'self-destructive', 'pleasure-seeking' and 'vengeance' [behavior]. Those that interpreted the positive test result as 'just one more problem' displayed 'resignation' and 'minimization'" (p. 130). As Valle and Levy see it, "a positive HIV status can produce lifestyle changes that either facilitate or militate against a person's health and quality of life" (p. 130) and "HIV-prevention interventions that target African American injectors living with HIV would benefit from structuring their services to consider the interpretation the injector makes of his or her status" (p. 136).

o In a cross-sectional study, Dalmida, Holstad, DiIorio, and Laderman (2009) examined "spiritual well-being (SWB), mental health, and immune status" (p. 121) among 129 low- to moderate-income, predominantly African American women living with HIV who were prescribed antiretrovirals. SWB was measured in two dimensions: religious well-being, or "the degree to which a person perceives her SWB expressed in relation to God," and existential well-being, or "the degree to which a person is adjusted to self, community, surroundings, and life overall and can identify meaning and purpose in . . . [her] life" (p. 125). "Findings indicated that spirituality is related to health and healing, and is associated with . . . [lower] depressive symptom . . . [scores] and better immune status. Findings also suggested that spirituality and the ability to find meaning and purpose in life might provide some of the support necessary to help women with HIV deal with the challenges of HIV and life, in general" (p. 138).

Technically Flexible Approach

As for the employment of existential process and technique in HIV-related psychotherapy, Farber (2009) points out that

> existential psychotherapy has been characterized more as a conceptual and theoretical framework for guiding psychotherapeutic work than as a defined system of psychotherapy techniques. . . . As such, it provides a way of conceptualizing the life concerns and dilemmas of a patient living with HIV disease that can inform any number of techniques, including those drawn from a cognitive-behavioral, interpersonal, or psychodynamic approach. At the same time, what the existential approach contributes to HIV-related psychotherapy beyond that offered by these other important and more commonly utilized approaches is its framework for understanding the life experiences and circumstances that comprise the patient's existence and its emphasis on psychotherapy techniques that promote experiential awareness of the patient's existential situation. (p. 336)

"My work heightens my awareness of the intrinsic fragility, uncertainty and limitations of my existence. I am profoundly yet differently affected by my work. Being continually confronted with psychologically demanding HIV client situations, I have found that I need to pay attention to the way my emotions can easily fluctuate from empathy, compassion and admiration for the client to anxiety, helplessness and inadequacy."

—— Horne, 2009, p. 67

To this end,

> the specific process and techniques utilized in a given instance of existential psychotherapy are tailored to the unique situation and experience of the patient. . . . [T]his highly individualized approach involves attending to the unique existential situation of the patient as well as conflicts surrounding core existential concerns that arise as the patient responds to the challenges of living with HIV/AIDS. . . . [E]xistentially informed HIV-related psychotherapy focuses on the healing aspects of the psychotherapy relationship, flexibility in the application of technique, and psychotherapeutic strategies that promote experiential awareness and illuminate choices in living with HIV disease. (p. 343)

Farber expands on these foci in the following fashion:

> o **The Psychotherapy Relationship** – Within an existential . . . framework the psychotherapy relationship is central to change in that it provides a context for patients to experience increasing degrees of relational depth, enhance skills for deepening relationships with others, and heighten self-awareness of how others experience them. . . . A key dimension of the psychotherapist's relational stance . . . is presence, which refers to the psychotherapist's immersion in being with and fully attending to the process of comprehending the patient's experience. . . . Presence in the psychotherapeutic encounter can itself be enormously validating and meaningful for patients in HIV-related psychotherapy, many of whom frequently have experiences of feeling invisible, discounted, and without a voice in their daily lives. Presence . . . help[s] . . . patients feel met and heard in the psychotherapeutic encounter as well as willing to explore themselves (including tolerating painful experiences) and their experiences in the psychotherapy relationship. . . . Existential psychotherapists also highlight the importance of genuineness, openness, and respect in the psychotherapy relationship. . . . The psychotherapist responds openly to patient questions, discusses ideas about the process and goals of therapy, shares perceptions and experiences of the patient, and selectively relates personal experiences when such disclosures clearly serve the psychotherapeutic interests and needs of the patient. . . . An attitude of openness and genuineness on the part of the psychotherapist is key to enhancing the patient's experience of trust, acceptance, and emotional safety. It also helps to demystify the psychotherapy process, and provides a solid foundation for cultivating a collaborative psychotherapeutic working alliance. The psychotherapist also is attuned to the role of the psy-

(Tool Box is continued on Page 12)

(Biopsychsocial Update -- continued from Page 9)
haviors in PHIV+ and PHIV- youths" (p. 810). Mellins and colleagues reason that

> incorporating HIV prevention interventions into ongoing mental health programs may be an effective strategy to reach PHIV+ youths and reduce HIV transmission risk. HIV prevention programming has typically not focused on child mental health, and youth mental health programs have typically not focused on HIV prevention. Child mental health providers could incorporate HIV risk reduction into ongoing treatment, using therapeutic strategies to impart risk reduction skills to these youth and their families. . . . Alternatively, incorporating family-based mental health strategies into more traditional sexual and drug risk reduction efforts could promote individual well-being of HIV+ individuals and reduce overall rates of HIV transmission. However, it is also noteworthy that PHIV- youths were at equal risk to PHIV+ youths for initiating sexual and drug use behavior, including unprotected sex. These uninfected children of HIV+ mothers are from similar stressful environments, at risk for their own HIV infection, but difficult to identify and ignored in most clinical and research efforts. . . . [These] data suggest that efforts need to be made to identify and engage this population in family-based prevention programs. (p. 817)

HIV Treatment News

Medical Care

Because "more than 50% of patients who start **efavirenz** treatment develop limiting **neuropsychiatric adverse events** (NPAEs)," Spanish investigators (Gutiérrez-Valencia et

(Tool Box -- continued from Page 11)
chotherapy relationship as this relates to existential isolation, including instances where the patient becomes aware of the limits of the psychotherapy relationship as a buffer against existential isolation when confronting HIV-related challenges. (pp. 343-344)

o **Psychotherapeutic Flexibility** – The existential approach provides a theoretical framework for organizing clinical understanding that is flexible with respect to the application of technique. This theoretically guided flexibility offers several advantages for HIV-related psychotherapy. First, psychotherapists frequently must draw upon a broad spectrum of techniques sequentially or in combination in HIV-related psychotherapy to address the often complex and rapidly changing needs of their patients. . . . Second, clinical circumstances may sometimes necessitate that the psychotherapist be willing to be flexible in selectively "bending the frame" of treatment to address patient needs . . . [, as when] scheduling psychotherapy visits in the hospital or at the patient's home when the patient is too ill to make office visits. Third, flexibility . . . lend[s] . . . to a culturally informed approach to conducting HIV-related psychotherapy . . .[,] essential in light of the rich heterogeneity of beliefs, norms, values, and experiences that flow from the sociodemographic diversity of individuals living with HIV/AIDS. (pp. 344-345)

o **Psychotherapeutic Strategies** – In existential psychotherapy, diverse therapeutic strategies may be utilized with the aims of expanding the patient's experiential awareness of self as a being-in-the-world and increasing the patient's awareness of the impact of personal choice in living. . . . Psychotherapy strategies are utilized to expand the patient's awareness of personal experience and address resistances to experiential awareness.

Strategies to expand awareness. Psychotherapy strategies aimed at illuminating the lived experience of the individual as a unique being-in-the-world are foundational in the existential psychotherapy approach. . . . [T]he psychotherapist works to suspend preconceptions and causal assumptions to listen carefully and deeply to the patient's descriptions of experience. . . . To enhance experiential awareness in their patients, psychotherapists also may utilize such strategies as inviting patients to describe how they are feeling in a given moment, focusing on experiencing of bodily sensations, encouraging use of "I" statements and present tense language in describing experiences, calling attention to nonverbal expressions of self (e.g., voice tone, hand gestures, posture), pointing out discrepancies in content and process (e.g., statement of "feeling fine" that does not match sad facial expression), role plays of emotionally activating situations, and experiential imagery exercises. . . . The objective is to distill the patient's unique existential situation as fully as possible to heighten awareness and to inform subsequent psychotherapeutic discourse.

When applied to the work of HIV-related psychotherapy[, the clinician] . . . focuses the patient on elaborating as fully as possible the experience of living with the illness as this relates to its physical/medical, social/cultural, and personal/psychological dimensions. . . .

Strategies to address resistance to awareness. In some instances discomfort makes patients less willing to access experiential awareness of certain aspects of being, such as existential anxiety that can arise in response to awareness of core existential concerns. . . .

Resistance often can be addressed by vivifying it, a strategy that involves illuminating instances in which patients are impeding themselves. . . . The aim is to increase the patient's awareness of resistances with the idea that the patient may then consider choosing the possibility of change. Vivifying resistance can be accom-

al., 2009) "sought to determine whether starting efavirenz treatment in a **stepwise dose schedule** decreases the incidence and severity of efavirenz-related NPAEs while maintaining the same virologic and immunologic efficacy" (p. 149). Study participants, 114 in all, at seven HIV primary care clinics in Spain were randomly assigned "to efavirenz, 200 mg/d on days 1 through 6, 400 mg/d on days 7 through 13, and 600 mg/d on day 14 and after, or to efavirenz, 600 mg/d, from day 1 plus 2 nucleoside or nucleotide reverse transcriptase inhibitors chosen by patient's physician" (p. 149). The investigators assessed neuropsychiatric symptoms (headache, dizziness, impaired concentration, feeling of drunkenness or hangover, anxiety, depression, hallucinations, disorientation) and sleep quality at baseline, 7, 14, and 30 days.

Gutiérrez-Valencia and colleagues found that "compared with the stepped-dose group, the full-dose group presented higher incidence and severity of dizziness (66.0% vs. 32.8% . . .), hangover (45.8% vs. 20.7% . . .), impaired concentration (22.9% vs. 8.9% . . .), and hallucinations (6.1% vs. 0% . . .) during the first week. From week 2, the incidence of efavirenz-related NPAEs was similar in both groups, although the severity was higher in the full-dose group. Virologic and immunologic efficacy seemed similar in both groups" (p. 149) when measured at 24 weeks. Although the study was small and prevented Gutiérrez-Valencia and colleagues from *confirming* similar efficacy between groups, the investigators conclude that "stepped-dose administration of efavirenz over 2 weeks significantly decreases the incidence and severity of NPAEs while apparently maintaining the same efficacy as the standard schedule" (p. 155).

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Adherence to Treatment

Springer, Chen, and Altice (2009) "prospectively examine[d] . . . social, behavioral, and biological factors associated with **changes in depressive symptoms** among [89] HIV-infected drug users enrolled in a clinical trial" (p. 979). "Of these, 58 (63%) met baseline criteria for severe or major depressive disorder (MDD). . . . [Depressive symptomatology] scores improved significantly from baseline to six months overall for the 89 subjects . . . and for the 58 who had MDD" (p. 976). "Associations with improvement in depressive symptomatology were found to include higher self-efficacy, having housing, remaining abstinent from illicit drugs, and improvements in CD4 count and adherence to prescribed ART [antiretroviral therapy]" (p. 979). Springer and colleagues conclude that "improvements in depressive symptoms could occur with improvement of alterable factors that are associated with strengthening adherence such as linkages to case management, mental health and substance abuse treatment services as well as through enhancement of social stabilization factors through social support and supportive housing" (p. 976).

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plished in two major ways, including calling attention to moments in which resistance is initially expressed (noting) and subsequently pointing out times when the resistance is repeated (tagging). . . .

Sometimes, however, resistance that persists may require a confrontation strategy. Confrontation refers to generating an impetus for pushing through resistance by heightening the patient's sense of concern about the resistance. . . . [C]onfrontation punctuates the ways in which the patient's resistances constrict possibility. (pp. 345-347)

Drawing a Line

Importantly, Farber (2009) delineates

limitations to use of the experiential and interpretive techniques commonly employed in existential psychotherapy. For instance, this approach would likely be contraindicated for patients with cognitive limitations affecting comprehension, such as HIV-associated neurocognitive complications (e.g., HIV dementia). Use of existential techniques in HIV-related psychotherapy also may be contraindicated for clinical problems that are more appropriately managed using more structured, supportive, or skills focused psychotherapy approaches. Examples of such problems include psychotic disorders (e.g., schizophrenia), significant difficulties with emotional and mood dysregulation (e.g., mania), or severe undermodulation of cognition, emotion, and/or behavior (e.g., high impulsivity). (p. 347)

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– Compiled by Abraham Feingold, Psy.D.

Kumar and Encinosa (2009) "examined whether the relationship between HAART [highly active antiretroviral therapy] medication adherence and **antidepressant treatment** varied with **HAART regimen complexity**" among a sample of 1,192 HAART recipients within a nationally representative sample of 2,864 adults receiving HIV medical care in 1996. The investigators

> found that the negative effects of poor emotional well-being or depressive symptoms [on antiretroviral adherence] were offset with antidepressant use with increasing levels of HAART medication complexity. With a unit increase from the mean in the medication complexity, adherence odds among individuals with poor emotional well-being but using antidepressants were 9% higher than . . . [among] individuals with better well-being . . . and individuals with poor emotional well-being but not using antidepressants. . . . Similarly, as medication complexity increased from the mean, adherence odd[s] among those reporting more depressive and/or anxiety symptoms [but using antidepressants] were about 9% higher than among individuals with no/lower depressive symptoms . . ., and were about 12% higher than among individuals with more depressive and/or anxiety symptoms [but not using antidepressants]. . . . These results suggest that antidepressant use has increasingly beneficial effects at higher levels of medication complexity. (p. 139)

In short, although "individuals with poorer mental health generally have poor HAART adherence," Kumar and Encinosa found that "adherence improved with the use of antidepressants as the HAART complexity increased" (p. 131).

Also extolling the antiretroviral adherence benefits of mental health treatment are Himelhoch et al. (2009), who "examined whether having a **psychiatric disorder** among HIV-infected individuals is associated with differential rates of **discontinuation of HAART** and whether the **number of mental health visits** impact these rates" (p. 1735). The 4,989 study participants, drawn from five outpatient HIV settings in the U.S., were largely nonwhite (74.0%) and male (71.3%); 9% were diagnosed with serious mental illnesses (SMI; i.e., schizophrenia spectrum disorders or bipolar disorders); 24.8% were diagnosed with depressive disorders; and the remaining 66.2% did not receive a psychiatric diagnosis. The investigators measured time until discontinuing HAART, adjusting for demographic factors, history of injecting drug use, and lowest recorded CD4 cell count, and found that

> among those receiving HAART . . . relative to those with no mental illness, the . . . probability for discontinuation of HAART was significantly lower during the first and second years following initiation of HAART among those with SMI and significantly lower during the first year among those with depressive disorders. The probabilities did not significantly differ in years 3 and 4 among any of the diagnostic groups. These findings suggest that among those receiving HAART, those with mental illness are significantly more likely to stay in clinic care in the early years of HAART treatment. . . .
>
> . . . [T]o further evaluate why those with mental illness may be more likely to remain on HAART, . . . [the investigators] evaluated whether the number of mental health visits impacted the rates of discontinuation of HAART . . . [and] found that among those with a mental illness, patients with six to 11 mental health visits in a year were 22% less likely to discontinue HAART, whereas those with 12 or more mental health visits in a year were 40% less likely to discontinue HAART compared with patients with no mental health visits. . . . [These] findings suggest that a dose-response relationship may exist, such that patients with ongoing mental health treatment with consistent and frequent follow-up benefited the most. In contrast, those patients who were seen less consistently, those receiving five or fewer mental health visits in a year[,] were no more likely to discontinue HAART compared with those without a mental illness. Those receiving only one mental health visit in a year in fact were significantly more likely to discontinue HAART compared with those with no mental health visits. This latter group may represent patients who had the most difficulty engaging in mental healthcare and may require more careful follow-up from their HIV providers. (p. 1740)

Himelhoch and colleagues conclude that "among those who initiate HAART, individuals with mental illness were significantly less likely to discontinue HAART or clinical care in the first and second years relative to those without mental illness. Mental health visits were associated with decreased risk of discontinuing HAART, suggesting the importance of ongoing and consistent mental health treatment among HIV-positive people with co-occurring mental health conditions" (p. 1741).

Care for Caregivers

Mitchell and Knowlton (2009) "examined relationships among **caregiver stigma**, **disclosure**, and **depressive symptoms** in a cross-sectional sample of 207 informal caregivers of people living with HIV/AIDS (PLWHAs) in Baltimore, Maryland. Caregivers were primarily African

American, low-income, urban adults" (p. 611). Mitchell and Knowlton

> found that stigma was associated with higher levels of depressive symptoms among informal HIV caregivers and that greater disclosure of caregiving status was associated with fewer depressive symptoms. . . .
>
> The study results also indicated that disclosure moderated the relationship between stigma and depressive symptoms such that those individuals with greater stigma who had also disclosed their caregiver status to others experienced fewer depressive symptoms. These results suggest that future interventions should facilitate caregiving disclosure where appropriate, particularly for caregivers who report greater stigma but have not disclosed their caregiver status to others. In addition, anecdotal evidence from the study indicated that some participants expressed interest in disclosing their caregiver status and requested guidance in how or when to disclose.
>
> Formation of support groups for family and friends of PLWHAs may be one way to facilitate disclosure. . . . Support groups may enable caregivers to discuss their stresses openly with people who may empathize with them. However, individuals in this high-risk, high-needs population may need more structured interventions than basic support groups to help them decide when to disclose, the possible risks and benefits of disclosure, and optimal ways of disclosing. . . . Also, learning how to minimize the stresses of negotiating HIV caregiving responsibilities, especially from nondepressed caregivers, could be a valuable component of interventions designed to reduce depressive symptoms among HIV caregivers. (p. 614)

Coping, Social Support, & Quality of Life

Of interest are findings from Lloyd-Richardson et al. (2009), who conducted a randomized controlled trial "to test the efficacy of two **smoking cessation interventions** in a[n] . . . HIV+ . . . sample: standard care (SC) treatment plus nicotine replacement therapy (NRT) versus more intensive motivationally enhanced (ME) treatment plus NRT" (p. 1891). The study involved a racially and ethnically diverse sample of 444 smokers from eight HIV primary care clinics in southeastern New England. "SC participants received two brief sessions with a health educator. Those setting a quit date received self-help quitting materials and NRT. ME participants received four sessions of motivational counseling and a quit-day counseling call. All ME intervention materials were tailored to the needs of HIV+ individuals" (p. 1891). The investigators found that "motivationally enhanced treatment plus NRT did not improve cessation rates over and above standard care treatment plus NRT in this HIV+ sample of smokers. Providers offering brief support and encouraging use of nicotine replacement may be able to help HIV+ patients to quit smoking" (p.1891).

Also assessing intervention parsimony are Löckenhoff, Ironson, O'Cleirigh, and Costa (2009), who "examined the association between **five-factor personality domains and facets**[3] and **spirituality/religiousness**[4] as well as their joint association with **mental health**" (p. 1411) among a sample of 112 adults living with HIV. Study participants were between the ages of 18 and 66 years and diverse with regard to racial/ethnic background and educational status. The investigators found that "spirituality/religiousness showed stronger associations with Conscientiousness, Openness, and Agreeableness than with Neuroticism and Extraversion. Both personality traits and spirituality/religiousness were significantly linked to mental health, even after controlling for indi-

[3] The personality domains associated with the Five-Factor Model and their respective facets are as follows: Neuroticism (Anxiety, Angry Hostility, Depression, Self-Consciousness, Impulsiveness, Vulnerability); Extraversion (Warmth, Gregariousness, Assertiveness, Activity, Excitement Seeking, Positive Emotions); Openness (Fantasy, Aesthetics, Feelings, Actions, Ideas, Values); Agreeableness (Trust, Straightforwardness, Altruism, Compliance, Modesty, Tender-Mindedness); Conscientiousness (Competence, Order, Dutifulness, Achievement Striving, Self-Discipline, Deliberation). "Interpretation on the domain level yields a rapid understanding of the individual, while interpretation of specific facet scales gives a more detailed assessment" (Costa & McCrae, 1995, p. 21).

[4] "In broad terms, the concept of religiousness captures adherence to traditional religious creeds, often centered around a specific community of faith. . . . At a more specific level, religiousness encompasses both a specific belief system and a set of behaviors (e.g., prayer, church attendance) associated with these beliefs. Spirituality, in contrast, typically refers to subjective, non-church-centered experiences of the transcendent which imbue everyday life with a sense of deeper meaning. . . . Some conceptualizations of spirituality also encompass a sense of communion with humanity and compassion for others. . . . Although spirituality and religiousness are not mutually exclusive . . ., there is growing evidence suggesting that they are empirically distinct concepts. . . . This differentiation is particularly relevant when studying populations affected by HIV/AIDS, who often face stigmatization by institutionalized religion . . . and may be more likely to describe themselves as spiritual but not religious" (Löckenhoff et al., 2009, p. 1413).

"Consistent with the notion that religiousness and spirituality capture related but distinct aspects of an individual's relation to the sacred, the two concepts show differential associations to Five-Factor Model personality traits. . . . [I]n general, high Agreeableness appears to show somewhat stronger associations to religiousness than to spirituality, high Openness shows the opposite pattern, high Conscientiousness is related to both concepts, whereas low Neuroticism and high Extraversion show weaker associations to either construct" (Löckenhoff et al., 2009, p. 1414).

vidual differences in demographic measures and disease status," (p. 1411), although "personality traits were more strongly associated with mental health than [spirituality/religiousness] scores and accounted for a unique portion of the variance that did not overlap with [spirituality/religiousness]" (p. 1426).

Delving into the facet-level associations, Löckenhoff and colleagues found

> religiousness . . . associated with low scores on the Neuroticism facet . . . Impulsiveness and high scores on the Agreeableness facets . . . Altruism and . . . Compliance. Also, . . . aspects of spirituality were associated with high scores on the Openness facets . . . Fantasy, . . . Aesthetics, and . . . Feelings. Further, . . . high scores on the Agreeableness facet . . . Tender-Mindedness and the Conscientiousness facet . . . Competence were associated with both spirituality and religiousness. Based on these correlates, both religious and spiritual individuals feel in charge of their lives and show high levels of sympathy and concern for others. In addition, primarily religious individuals are uniquely characterized by the ability to resist temptations coupled with the tendency to deescalate social conflicts and assist others in need. Primarily spiritual individuals, in turn, show vivid imagination, appreciation for beauty, and receptiveness to their inner feelings. (p. 1430)

"Further, aspects of spirituality and religiousness were found to mediate some of the links between personality and mental health in this patient sample" (p. 1411).[5] More specifically, mediation analyses revealed that "the effect of Openness on . . . mental health . . . was mediated by Sense of Peace, Compassion, and Faith in God. Further, the effect of Agreeableness on . . . mental health . . . was mediated by Faith in God. Finally, the effect of Conscientiousness on . . . mental health . . . was partially mediated by Sense of Peace, Faith in God, and Religious Behavior" (p. 1429). According to the investigators, these findings "have important practical implications because the mediation analyses suggest that the benefits of [spirituality/religiousness] for mental health are largely dependent on a person's underlying personality traits. This implies that any interventions aimed at inducing a turn toward religion in order to improve mental health may be misguided. Instead, . . . professionals may want to assess their clients' personality profile to determine who may benefit most from access to spiritual and/or religious support and guidance" (p. 1432).

[5] The "Ironson-Wood Spirituality/Religiousness Index . . . consists of 25 items grouped into two spirituality scales and two religiousness scales. Among the spirituality scales, 'Sense of Peace' (9 items) is characterized by a serene outlook on life and a sense of meaning, whereas 'Compassionate View of Others' (5 items) assesses tolerance, compassion, and a feeling of connectedness with humanity. Among the religiousness scales, 'Faith in God' (6 items) is characterized by a belief in God and his role in aiding recovery from illness, whereas 'Religious Behavior' (5 items) assesses participation in religious rituals and services" (Löckenhoff et al., 2009, p. 1419).

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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/Hepatitis/STD/TB Prevention News Update* (http://www.cdcnpin.org/news/NewsList.asp); *Kaiser Health News* (http://www.kaiserhealthnews.org/); and information e-mailed by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

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

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