

# mental health AIDS

A Quarterly Update from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) Volume 13, Issue 1 – Fall 2011

## Biopsychosocial Update

### HIV Prevention News

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

Roland et al. (2011) note that “the **National HIV/AIDS Strategy** proposes to scale-up **post-exposure prophylaxis (PEP)**” (p. 76), but “the minimum intensity of counseling required to support risk reduction and maximize PEP adherence after sexual exposures is not known” (p. 77). To address this matter, Roland and colleagues “conducted a randomized, controlled . . . study comparing the impact of 2 [standard] versus 5 [enhanced] risk reduction counseling sessions. [The investigators] also compared PEP adherence among individuals randomized to a single session of clinician-delivered adherence counseling with 2 additional counselor-delivered sessions . . . [and] further compared the impact of the interventions among participants reporting more and less previous sexual risk to **determine whether different intervention intensity is indicated, depending on prior risk**” (p. 77).

The standard intervention consisted of two 20- to 30-minute, individually tailored sessions. “In session 1, the counselor and participant explored the details and context of the risk exposure, identified strategies to mediate risk behavior, and developed a written risk reduction plan, including identification of a support person. In session 2, the counselor pro-

vided the HIV test results. They reviewed risk behavior during the previous week and the effectiveness of the risk reduction plan and revised the plan accordingly” (p. 77). Those participants who were

randomized to enhanced counseling had 3 additional weekly sessions. In session 3, the patient discussed difficulties in implementing the risk reduction plan. The plan was revised, and participants were guided in identifying what they wanted to take away from the experience. In sessions 4 and 5, the participant developed an increasingly personalized plan to prevent risk behavior by identifying factors (e.g., settings, emotions, and substance use) that led to both low- and high-risk behavior. They discussed the degree of motivation to continue reducing risk. (p. 77)

As noted above, the counselor provided no additional counseling in the standard adherence arm, while

in the enhanced arm, counselors asked participants to describe the treatment regimen and follow-up appointment schedules and reviewed the rationale. . . . An individual needs assessment was completed by the counselor with use of a checklist to identify potential adherence problems. Subjects were taught to select

regular daily activities, such as meals and television programs, to be medication cues. Counselors taught the participants to be alert to barriers and competing demands that could decrease adherence. Counselors provided social support. In addition to 3 study visits, they called the participants at week 3 to reinforce adherence. To address social network influence on adherence, [the investigators] reframed adherence to be consistent with broader social norms and presented adherence as the smart thing to do. (p. 77)

Roland and colleagues “enrolled 457 individuals reporting unprotected intercourse within 72 h[ours] with an HIV-infected or at-risk partner. Participants were 96% male and 71% white” (p. 76). The investigators found that

2-session risk reduction counseling was not inferior in reducing risk behavior or HIV acquisition among persons reporting lower baseline sexual risk behavior. Among those reporting higher

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risk, 2- and 5-session risk reduction counseling was not equivalent. . . . For riskier individuals the 3 additional sessions after the baseline HIV test results are provided may be necessary for risk behaviors to decrease. That experience can be used to design personalized risk reduction plans and to motivate change. After only 2 counseling sessions, the sense of relief associated with the negative baseline test result may reduce motivation to decrease subsequent risk. (pp. 80-81)

Additionally, “adherence outcomes were similar, with noninferiority in the lower risk group and concerning differences among the higher-risk group” (p. 76).

The investigators observe that the generalizability of these findings is limited by the fact that the study population “of predominantly men who have sex with men [(MSM)] reflects the San Francisco epidemiology but does not include all the populations at highest risk identified in the National HIV/AIDS Strategy (i.e., African American and Latino populations)” (p. 81). Nevertheless, Roland and colleagues stress that “risk assessment is critical at PEP initiation. Standard counseling is only noninferior for individuals with lower baseline risk; thus, enhanced counseling should be targeted to individuals at higher risk” (p. 76). The in-

vestigators add that “PEP availability for . . . partners can be used to introduce a sexual risk discussion with HIV-infected clinic patients, facilitating the delivery of prevention-with-positive interventions. . . . Comprehensive PEP programs that provide or refer individuals for prevention services can also be used in HIV testing and partner services settings. Without integration, PEP may make an individual impact but is unlikely to contribute to reducing the incidence of HIV infection” (p. 82).

Adam, Murphy, and de Wit (2011) explored “whether **fantasizing about unprotected anal intercourse (UAI)** during online chatting is associated with UAI with partners met online” (p. 506) among 2,058 MSM responding to an online survey in France. The investigators found that “while intentions to use condoms with casual partners were high, one-third (32.1%) of respondents reported UAI with partners met online. Responding positively to online chatting about UAI was significantly associated with UAI with partners met online, controlling for intentions, attitudes, behavior and biographic characteristics” (p. 506). Adam and colleagues contend that “while MSM may not go online to seek UAI, some engage in online fantasizing about UAI that is associated with possible sexual risk-taking. This speaks critically to the assumption that online fantasizing has no behavioral implications, and un-

derscores the importance of [HIV] prevention that addresses the dynamics of online chatting” (p. 506). The investigators stress that “the aim of HIV prevention should not and cannot be to obliterate these fantasies that are important expressions of some men’s sexuality. Rather, the aim should be to make individuals aware of the potential risks for HIV transmission associated with engaging in fantasies about UAI online with a partner they intend to meet, and to support MSM who use the Internet to find sex partners to self-regulate their sexual behaviors online and in real life in ways that balance risk and pleasure” (p. 513).

Dilley et al. (2011), following up on a previous report summarized in the [Summer 2007](#) issue of *mental health AIDS* (Dilley et al., 2007) demonstrating the efficacy of a single-session of Personalized Cognitive Counseling (PCC) to reduce episodes of UAI among MSM who sought HIV testing, stratified their original sample by race/ethnicity to **compare the impact of the intervention on 196 white MSM and 109 MSM of color** (“23 African Americans, 36 Latinos, 22 Asians, eight Alaskan Natives/Native Americans/Hawaiian/Pacific Islander, and 20 of mixed or other unspecified race” [p. 970]). The investigators found that, among MSM of color “in the intervention group, the mean number of episodes of UAI declined from 5.1 to 1.6 at six months and was stable at 12 months (1.8). Among the [MSM of color] receiving standard counseling, the mean number of UAI episodes was 4.2 at baseline, 3.9 at six months and 2.1 at 12 months. There was a significant treatment effect overall” (p. 970), suggesting that PCC is “effective for all groups at six months and to a lesser degree, for [MSM of color] at 12 months” (p. 973). Dilley and colleagues (2011) observe that “by 12 months, the number of episodes of UAI is essentially the same (approx-

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mately two episodes of UAI in the previous six months) [in both the intervention and standard counseling groups]. It is possible that this represents the lowest risk level that can be achieved with a single counseling session in this group of high-risk men. The addition of a second 'booster' session six months after the initial counseling may be necessary in order to achieve a greater and more durable decline in risk" (p. 973). The investigators add that "all of the intervention counselors in this study were white and most were female, suggesting that programs do not need to limit counseling staff to the race/ethnicity of the target population" (p. 974).

"Evidence has been mixed regarding the link between depression and risky sex, although researchers have rarely considered the role of psychosocial vulnerabilities such as **self-efficacy for sexual safety** or **'escape' coping styles**,"<sup>1</sup> according to Alvy et al. (2011), who "examined the **association between depression and sexual risk** among . . . a [n ethnically diverse] national sample . . . of [1,540] HIV-positive and HIV-negative MSM who reported unprotected sex and drug use with sex partners" (p. 1171). The investigators "found evidence that depression is related to HIV transmission risk [and that s]elf-efficacy for sexual safety and cognitive escape mediated the link between depression and risk behavior, suggesting that psychosocial vulnerability plays an important role in the association of depression with sexual risk" (p. 1171). According to Alvy and colleagues, "cognitive escape . . . captures the use of sex and substances for escape purposes," and "converging lines of research support the causal relations asserted here: de-

pression can erode one's self-efficacy and lead to cognitive escape, both of which contribute to risky sexual behavior" (p. 1177).

The investigators speculate on reasons "why depression and sexual risk demonstrated an association in this dataset but have not in others" and attribute these findings to having "selected a sample known to be high in sexual risk and drug use – which could be characterized as 'externalizing' responses to depression – [for whom] an escape model may well characterize . . . risk behavior. This may differ for less explicitly risky samples of MSM, for whom depression may manifest in more 'internalizing' responses such as withdrawal" (p. 1177). Alvy and colleagues therefore believe that

screening for depressive symptomatology could enhance prevention efforts. . . . Many health care centers already screen for depression using instruments such as the PHQ-9 [Patient Health Questionnaire-9], and clinically significant scores on such measures could flag a need for services. Standard Cognitive Behavior Therapy (CBT) and anti-depressant medication could be used in this endeavor. . . .

. . . [F]indings . . . [further] suggest that cognitive escape strategies and low self-efficacy may be especially important to target in future HIV prevention initiatives among high risk MSM. . . . Having men attend to their coping strategies as a preventive intervention may be a fruitful adjunct to addressing general issues such as depression or specific issues such as condom use methods. . . .

These findings suggest that escape coping processes and mental health generally are important to understanding sexual

behavior among high risk MSM. Given the ongoing spread of HIV, prevention efforts targeting depression and psychosocial vulnerability should be developed and tested. (pp. 1177-1178)

### **About Men**

Extending a line of research last described in the [Summer 2010](#) issue of *mental health AIDS*, Bogart, Galvan, Wagner, and Klein (2011) "investigated HIV-specific medical mistrust . . . , often exhibited as **conspiracy beliefs about HIV** (e.g., 'AIDS was produced in a government laboratory'), which may be indicative of general suspicion of HIV treatment and prevention messages" (p. 1180), among [a convenience sample of] 181 African American men living with HIV, with whom the endorsement of HIV conspiracy beliefs and condom use were assessed at intervals over a 6-month period. This study, in which many of the participants were MSM, "extends prior work by using a longitudinal assessment and by surveying people living with HIV" (p. 1184), according to the investigators, who

were able to demonstrate a solid and consistent relationship between mistrust and sexual risk over a 6-month period. Although causality cannot be established based on non-experimental data, [these] findings suggest that HIV conspiracy beliefs are partially driving risk behavior among Black males living with HIV. Genocidal conspiracies (about the origins of HIV, HIV as a form of genocide, and government withholding of a cure) appear to be at the root of the effect, whereas treatment-related conspiracies may not have a significant influence. (p. 1184)

Bogart and colleagues note that these findings

serve as a companion to prior

<sup>1</sup> For more information on the use of cognitive escape as a coping mechanism, see the **Tool Box** titled "New Thinking on Not Thinking About HIV Risk" in the [Fall 2006](#) issue of *mental health AIDS*.

work showing a longitudinal relationship between HIV conspiracy beliefs and non-adherence to antiretroviral treatment. . . . Interestingly, in a reverse from the present analysis, this prior work found that treatment-related conspiracies (and not genocidal conspiracies) were significant predictors of the relationship between conspiracies and nonadherence. HIV-specific medical mistrust is a multidimensional construct, and different aspects of such mistrust have distinct implications for prevention versus treatment behaviors. Genocidal beliefs appear to be more harmful to prevention efforts promoting condom use, whereas treatment-related conspiracies may be a greater barrier (and more pertinent) to medication adherence. Individuals who hold beliefs about the genocidal role of the government in the AIDS epidemic may be suspicious of public health prevention messages for an epidemic they believe the government itself created. However, such beliefs may not be as relevant to medication-taking behavior. (p. 1185)

Bogart and colleagues contend that “given the observed relationships of HIV conspiracy beliefs to sexual risk in this analysis, and adherence in prior work, both secondary prevention and treatment interventions for Black males living with HIV need to address cultural issues such as medical mistrust as a root cause of poor self-care” (p. 1185).

Reisner, Falb, and Mimiaga (2011) set out “to evaluate the prevalence of **early violent experiences** [i.e., occurring before the age of 18 years] among a nationally representative sample of [13,274] men in the United States, including co-occurring traumatic stressors, and . . . to investigate the role of early experi-

ences of violence in relation to incident HIV infection, including the potential mediating role of **post-traumatic stress disorder (PTSD)** in relation to incident HIV infection” (p. 341). The investigators found that

overall, the 12-month HIV incidence was <1% (0.35%); 44% of new infections were among racial/ethnic minorities and 31% among [MSM]. One-third of the sample (33.5%) reported one or more early life stressors (physical abuse, sexual abuse, neglect, verbal violence, or witnessed violence). In a weighted multivariable logistic regression model adjusted for age, education, family’s socioeconomic position, and sexual behaviors, each additional early life violent event was associated with . . . elevated odds of HIV infection. . . . Adding PTSD to this adjusted model, PTSD was highly associated with incident HIV infection. . . . There was evidence that PTSD partially mediated the relationship between early life events and HIV. (p. 340)

On the basis of these findings, Reisner and colleagues stress the need to provide

HIV prevention interventions and additional support to (1) all men, regardless of sexual behavior or racial/ethnic minority status, if they meet the criteria for PTSD; and (2) adolescent and young adult men who experienced early life violent events and therefore have a higher odds of acquiring HIV and who may benefit from HIV prevention interventions at earlier ages.

Many validated [CBT] interventions have been shown to be effective for the treatment of mood and anxiety disorders, . . . including [CBT] for traumatized children or adolescents . . . and

adults. . . . Incorporating HIV prevention into these evidence-based psychotherapeutic treatments for youth, or adapting these validated treatments as part of HIV prevention interventions that target young adult men, represents an important area of future intervention development research, especially given that mental health concerns not only contribute to HIV risk but also likely interfere with the uptake of HIV behavioral interventions for men and for MSM in particular. . . .

Last, an ecological-transactional model . . . posits that negative developmental consequences (e.g., development of posttraumatic stress symptoms or emotion regulation deficits that may pattern alongside HIV risk behavior) emerge when vulnerabilities outweigh protective factors. The social determinants (such as early violent stressors) of early behavioral patterns that may place individuals at risk of HIV infection early on in the life course deserve additional investigation. The present study demonstrates the patterning of incident HIV infection by early experiences of violence and mediated through PTSD diagnosis. More research is needed to assess other mechanisms through which early childhood experiences of violence and trauma-related mental health disorder may confer additional HIV risk through increased risk-taking behavior, particularly among minority populations who continue to bear a disproportionate burden of HIV infection in the United States. (pp. 348-349)

### **About Adolescents & Young Adults**

“Forming **implementation intentions** (i.e., action plans that specify when, where and how a person will

## Tool Box

### Resources

Becker, J.T., Dew, M.A., Aizenstein, H.J., Lopez, O.L., Morrow, L., & Saxton, J. (2011). Concurrent validity of a computer-based cognitive screening tool for use in adults with HIV disease. *AIDS Patient Care & STDs*, 25(6), 351-357. "We report here the results of an initial evaluation of the Computer Assessment of Mild Cognitive Impairment (CAMCI®), a computerized screening tool designed to assess abnormal cognitive decline with reduced respondent and test administrator burden" (p. 351). "The CAMCI takes approximately 20 min[utes] to complete and all tests are presented both visually and aurally. The CAMCI is administered using a modified tablet computer . . . with a touch-screen for response input. The CAMCI includes eight subtasks testing multiple cognitive domains (attention, verbal memory, non-verbal memory, incidental memory, executive function, and processing speed), and a series of self-report questions regarding memory loss, alcohol use, depression, and anxiety" (p. 352). "This preliminary study demonstrates that the CAMCI is sensitive to mild forms of cognitive impairment, and is stable over 24 weeks of follow-up. A larger trial to obtain risk-group appropriate normative data will be necessary to make the instrument useful in both clinical practice and research (e.g., clinical trials)" (p. 351).

Gilliam, P.P., Ellen, J.M., Leonard, L., Kinsman, S., Jevitt, C.M., & Straub, D.M. (2011). Transition of adolescents with HIV to adult care: Characteristics and current practices of the Adolescent Trials Network for HIV/AIDS Interventions. *Journal of the Association of Nurses in AIDS Care*, 22(4), 283-294. "The purpose of this study was to de-

scribe characteristics and current practices surrounding the transition of adolescents from the clinics of the Adolescent Trials Network for HIV/AIDS Interventions to adult medical care. This report focuses on the processes of transition, perceived barriers and facilitators, and anecdotal reports of successes and failures. Practice models used to assist adolescents during transition to adult medical care are described" (p. 283).<sup>1</sup>

Gray, W., Janicke, D., Fennell, E., Driscoll, D., & Lawrence, R. (2011). Piloting behavioral family systems therapy to improve adherence among adolescents with HIV: A case series intervention study. *Journal of Health Psychology*, 16(5), 828-842.

This case series "presents outcome and feasibility data for the first known adaptation of BFST [Behavioral Family Systems Therapy] to improve adherence to HAART [highly active antiretroviral therapy] among adolescents with HIV, an understudied population with known adherence problems" (p. 829). "Delivery of an adapted BFST intervention was acceptable to families and may be a promising treatment approach" (p. 828).

Jacobson, S.A. (2011). HIV/AIDS interventions in an aging U.S. population. *Health & Social Work*, 36(2), 149-156. "Scholarly research has identified the need for HIV/AIDS [prevention] interventions in the population of people over age 50, but few interventions have been established. The ecological perspective, which integrates intrapersonal, interpersonal, organizational, community, and policy factors, was used to review the current interventions and propose possible new HIV/AIDS prevention efforts for

<sup>1</sup> Recent publications examining the process of adolescents transitioning to adult HIV care are highlighted in the [Spring 2011](#) and [Summer 2011](#) issues of *mental health AIDS*.

older adults. Intrapersonal interventions are often based on the health belief model. The precaution adoption process model was explored as an alternative intrapersonal theory for modeling prevention efforts. Community interventions using diffusion of innovations theory are fully explored, and new interventions are proposed as an option for preventing HIV/AIDS in older adults. An agenda for future research and interventions is proposed" (p. 149).

Morin, S.F., Kelly, J.A., Charlebois, E.D., Remien, R.H., Rotheram-Borus, M.J., & Cleary, P.D. (2011). Responding to the National HIV/AIDS Strategy – Setting the research agenda [Editorial]. *Journal of Acquired Immune Deficiency Syndromes*, 57(3), 175-180.

"The National HIV/AIDS Strategy (NHAS) has 3 goals: (1) reduce the number of people who become infected with HIV, (2) increase access to care and improve health outcomes of people living with HIV, and (3) reduce HIV-related health disparities. . . . In addition, the plan and its implementation strategy call for achieving more coordination of HIV programs across the federal government and between federal agencies and state and local governments. . . . Accompanying the strategy is an implementation plan that identifies the steps to be taken by federal agencies and all parts of society to support the priorities outlined in the strategy and sets targets for the 3 goals to be achieved by 2015 (e.g., lowering the number of new HIV infections by 25%). . . . We lay out a role for the National Institutes of Health in facilitating research that supports and informs the goals of the NHAS" (p. 175). In this editorial, it is noted that "care for mental health and substance abuse plays a central role in improving health outcomes. Research has shown that sub-

(Tool Box is continued on Page 6)

act) could be effective in **promoting condom use** on a large scale. However, the technique implies that people are able to form high quality implementation plans that are likely to induce behaviour change" (p. 443). On this point, de Vet et al. (2011) asked single young women living in the Netherlands who were between the ages of 16 and 30 years

"to form either an implementation intention for the target behaviour using condoms ( $n = 159$ ) or preparatory implementation intentions for buying, carrying, discussing and using condoms ( $n = 146$ )" (p. 443). The investigators report that, "in general, it appeared hard for young women to form high quality general implementation intentions for the tar-

get behaviour condom use. Implementation intentions for the preparatory behaviours were of better quality than general implementation intentions. Females who formed strong implementation intentions in the preparatory behaviours condition were more committed to these plans and perceived them as more useful. Plan commitment and per-

(Tool Box -- continued from Page 5)

stance abuse and depression are prevalent among patients with HIV in care. . . . Through the use of electronic medical record systems, assessments could be used to generate prompts for clinicians to direct attention to issues of adherence, mental health, and substance use. Clinic-based screening procedures could also include an assessment of HIV transmission risk acts and readiness for behavior change. . . . These assessments could lead to provider-based prevention messages tailored to the stages of change model, . . . previously shown to be both effective . . . and cost effective for HIV prevention in clinic settings” (p. 177).

Nokes, K.M. (2011). Symptom disclosure by older HIV-infected persons. *Journal of the Association of Nurses in AIDS Care*, 22(3), 186-192.

“The purpose of this article is to highlight the unique situation of older patients with HIV regarding symptom disclosure and the need for an integrated treatment plan that includes an environment that promotes patient-provider communication, better day-to-day self-care, and self-management strategies” (p. 186).

Phillips, K.D., Moneyham, L., & Tavakoli, A. (2011). Development of an instrument to measure internalized stigma in those with HIV/AIDS. *Issues in Mental Health Nursing*, 32(6), 359-366.

“The [10-item] Internalized Stigma of AIDS Tool has been developed and tested . . . [and i]ts reliability is supported by a strong internal consistency and stability over time. . . . Now that construct validity has been confirmed in HIV-infected women living in the rural southeastern United States, the instrument needs to be tested in various subgroups of people with HIV/AIDS and in different geographical settings” (p. 364) because

ceived usefulness predicted condom preparations at follow-up” (p. 443). de Vet and colleagues conclude that “it is important to ask individuals to form implementation intentions for the preparatory behaviours rather than for the target behaviour alone” (p. 443).

### About Women & Men

Noar, Crosby, Benac, Snow, and

“it may be of value in research and clinical assessment” (p. 359).

Román, E., & Chou, F.-y. (2011). Development of a Spanish HIV/AIDS Symptom Management Guidebook. *Journal of Transcultural Nursing*, 22(3), 235-239.

“The purpose of this study was to develop a Spanish version of the *Symptom Management Guidebook: Strategies for People Living with HIV/AIDS* guidelines and verify its content, perceived feasibility, and usefulness with HIV/AIDS care providers and people living with HIV/AIDS in Puerto Rico” (p. 235). A draft version of this document is “available to the public at no cost at the International HIV/AIDS Nursing Research Network home page (<http://www.aidsnursingucsf.org>)” (p. 236).

Safren, S.A., O’Cleirigh, C., Skeer, M.R., Driskell, J., Goshe, B.M., Covahey, C., & Mayer, K.H. (2011). Demonstration and evaluation of a peer-delivered, individually-tailored, HIV prevention intervention for HIV-infected MSM in their primary care setting. *AIDS & Behavior*, 15(5), 949-958. “Employing HIV-infected peer counselors in secondary prevention interventions for MSM [men who have sex with men] is appealing for scalable interventions. This demonstration project provides initial evidence for the ability to recruit HIV-infected MSM in care into a peer-based intervention study, and shows how a peer-based intervention can be delivered in the context of HIV care” (p. 949).<sup>2</sup>

Traube, D.E., Holloway, I.W., & Smith, L. (2011). Theory development for HIV behavioral health: Empirical validation of

<sup>2</sup> For more information on task shifting and the implementation of a peer-based HIV prevention intervention offered in the context of HIV care, see the **Tool Box** entitled “HIV Prevention 2011: Hits, Misses, & Hopes” in the [Spring 2011](#) issue of *mental health AIDS*.

Troutman (2011) applied an expanded version of “the attitude-social influence-efficacy (ASE) model<sup>2</sup>

<sup>2</sup> “The ASE model suggests that three sets of proximal factors – attitudes, social influences, and self-efficacy – are critical determinants of health behavior change. . . . Attitudes include positive and negative aspects of a behavior and consideration of cognitive and emotional beliefs. Social influences include social norms, perceived behavior of others (descriptive norms), and direct pressure

behavior health models specific to HIV risk. *AIDS Care*, 23(6), 663-670.

“This paper will provide an overview of current arguments and frameworks for testing and developing a comprehensive set of health behavior theories. In addition, the authors make a unique contribution to the HIV health behavior theory literature by moving beyond current health behavior theory critiques to argue that one of the field’s preexisting, but less popular theories, Social Action Theory (SAT), offers a pragmatic and broad framework to address many of the accuracy issues within HIV health behavior theory. The authors conclude . . . by offering a comprehensive plan for validating model accuracy, variable influence, and behavioral applicability of SAT” (p. 663).

Wright, E. (2011). Neurocognitive impairment and neuroCART. *Current Opinions in HIV/AIDS*, 6(4), 303-308.

Wright reviewed “recent cohort studies that have examined the relationship between combination antiretroviral therapy (cART) regimens with superior central nervous system (CNS) penetration (neuroCART) in the prevention, treatment and subsequent survival of patients with HIV-associated neurocognitive disorders (HAND) . . . [and found that t]he therapeutic importance of neuroCART in the treatment of HAND remains a vitally relevant, unanswered question. Recent cohort studies have demonstrated that neuroCART may improve survival in children and adults with HIV dementia, although adults may require several drugs to receive full therapeutic benefit. NeuroCART/cART may be neurotoxic in some populations. A randomized controlled trial to address the role of neuroCART in HAND is needed” (p. 303).

– Compiled by  
Abraham Feingold, Psy.D.

to achieve a theory-based understanding of **condom use among [293] low income, heterosexually**

or support to perform a behavior (injunctive norms). Finally, self-efficacy includes confidence in one’s ability to perform a behavior and/or difficulty in performing the behavior. These proximal factors are thought to influence behavioral intentions and progression through the stages of change, and ultimately are theorized to impact behavior and behavioral change.

**active African-American [sexually transmitted disease] clinic patients”** (p. 1045). The investigators report that this model does indeed provide

a theoretical lens through which condom use in this population can be understood. . . . [T]he set of theoretical factors examined in the current study held many meaningful associations with stage of change. The general pattern of many of the theoretical factors was one of a linear increase across the stages of change, with scores being lowest in Precontemplation and highest in Action/Maintenance. . . . [Additionally,] results indicated that the most critical factors to consistent condom use with *main partners* were cons and descriptive norms, while the most critical factors to *casual partner* condom use were cons, self-efficacy, and negotiation strategies.

. . . The stage perspective suggests that rather than behavior change being a dichotomous event where individuals simply change their behavior, individuals progress through five stages of change on their way toward a behavioral change. These include: *Precontemplation*: Not intending on changing; *Contemplation*: Intending on changing in the future; *Preparation*: Intending on changing in the near future and currently making steps toward that goal; *Action*: Recently changed one's behavior; *Maintenance*: Changed behavior and have been practicing the behavior for an extended period of time. . . . The ASE model suggests that as attitudes, social norms, and self-efficacy grow more positive, individuals will progress through the stages of change. As such factors become more negative, individuals will likely backslide to earlier stages of change. The model further suggests that while attitudinal variables (e.g., decisional balance) are most important in facilitating early stage movement (e.g., Precontemplation to Contemplation), skill-oriented variables (e.g., self-efficacy) are most important for facilitating later stage movement (e.g., Preparation to Action). . . .

Studies have demonstrated that in the safer sex arena, factors in addition to those encapsulated in the ASE model must be considered for a comprehensive understanding of behaviors such as condom use. Specifically, numerous studies have demonstrated the importance of *interpersonal* factors to condom

This suggests that interventions addressing main partner condom use with heterosexual African Americans spend significant time on barriers (cons) to using condoms as well as perceptions that others use condoms with main partners. Similarly, interventions addressing casual partner condom use should address barriers (cons), confidence to use condoms in varying situations (condom self-efficacy), and perceived and actual condom negotiation skills.

Moreover, analyses comparing differences among adjacent stages were also conducted in order to advance an understanding of what differentiates individuals in one stage from those in the next stage. . . . The pattern of results suggests some support for the proposition that early stage movement is based more upon perceptions of condom use

use behavior. . . . Such studies suggest that interpersonal factors such as condom use communication and negotiation are critical to the enactment of condom use. This is likely the case because unlike most health behaviors, which are enacted by individuals, safer sexual behaviors such as condom use are enacted within the context of a dyad where relational (and thus communicative) dynamics play a major role.

In addition, the dynamics of sexual interactions have also been found to vary greatly whether the context is a main/steady relationship or a casual sexual relationship. Studies have consistently demonstrated that condom use is less likely to take place with 'known' partners (i.e., steady partners) as compared to casual partners who are not known well. . . . Thus, the application of behavioral theories (such as ASE) to condom use must consider interpersonal factors such as condom negotiation as well as the relationship context (i.e., main/steady, casual).

Finally, given . . . the importance of structural factors such as socioeconomic status (SES), incarceration, and housing to sexual risk behavior and HIV/AIDS . . . , such factors should be considered in studies of condom use. . . . Such variables were measured in the current research in order to examine the ability of such factors to contribute to a more complete understanding of condom use” (Noar et al., 2011, pp. 1046-1047).

(e.g., pros, perceived norms), whereas later stage movement is based more upon perceived and actual skill acquisition (e.g., condom self-efficacy, negotiation strategies). Thus, in order to advance stage movement, messages for Precontemplators may be most effective if they focus on benefits of condom use and normative condom influences, while messages for those in the Preparation stage may be most fruitful if they boost confidence (self-efficacy) in using condoms and teach skills for negotiating condom use with one's (main or casual) sexual partner. (p. 1054)

Finally, important news was released on May 12, 2011, when the National Institute of Allergy and Infectious Diseases (NIAID) announced that

men and women infected with HIV **reduced the risk of transmitting the virus to their sexual partners by taking oral antiretroviral medicines** when their immune systems were relatively healthy, according to findings from a large-scale [international] clinical study. . . . The clinical trial, known as HPTN 052, was slated to end in 2015 but the findings are being released early as the result of a scheduled interim review of the study data by an independent data and safety monitoring board (DSMB). The DSMB concluded that it was clear that use of antiretrovirals by HIV-infected individuals with relatively healthier immune systems substantially reduced transmission to their partners [i.e., “earlier initiation of antiretrovirals led to a 96 percent reduction in HIV transmission to the HIV-uninfected partner”]. The results are the first from a major randomized clinical trial to indicate that treating an HIV-infected individual can reduce the risk of sexual transmission of HIV to an

uninfected partner.

Of note is that fact that “the vast majority of the couples (97 percent) were heterosexual, which precludes any definitive conclusions about effectiveness in [MSM]” (NIAID, 2011).

### **HIV Assessment News**

#### ***Psychiatric Assessment & Intervention***

“The Steps Study is a prospective, observational cohort study of **persons newly diagnosed with HIV infection**” (p. 1161), write Bhatia, Hartman, Kallen, Graham, and Giordano (2011), who looked at linkage to care (i.e., “attending at least one clinic appointment in each of

the first two 90-day intervals following diagnosis” [p. 1161]) among this ethnically diverse, urban cohort of 180 newly diagnosed individuals. The investigators found that

at least half and as many as two-thirds of persons newly diagnosed with HIV infection and not yet linked to care screen positive for **depression**. Compared to the general population . . . , [these] results confirm that newly diagnosed HIV-positive persons are 2-3 times more likely to be at high risk for depression. In addition, depression is correlated with self-reported difficulty accessing care, known risk factors of poor follow-up (e.g., sub-

stance abuse . . . ), and trends towards poorer linkage to care during the first 180 days after diagnosis. Though these last results did not reach statistical significance, the observed trend and the other study results strongly suggest that depression shortly after HIV diagnosis predicts delayed linkage to HIV care. (p. 1167)

Bhatia and colleagues suggest that

screening for depression should be undertaken at diagnosis of HIV seropositivity itself to identify persons at risk for poor follow-up and target them for unique interventions designed to bolster

### **Tool Box** **Positively Golden: Advances in Aging with HIV (Part 2)**

Part 1 of this series (presented in the [Summer 2011](#) issue of *mental health AIDS*) highlighted recent research findings on medical and neurocognitive concerns associated with HIV and aging. A characterization of “successful cognitive aging” with HIV was presented, as were performance-based measures to identify functional impairment attributable to aging and HIV, and cognitive remediation strategies for use with clients who exhibit cognitive decline while aging with HIV.

This concluding segment describes a “positive aging” framework not specific to HIV disease; a strengths-based model of coping, along with three meaning-centered strategies grounded within this model: gratitude, forgiveness, and altruism; the infusion of “positive aging” concepts into qualitative and quantitative research on adults aging with HIV; and the first controlled trial to assess if an age-appropriate, coping improvement group intervention could benefit older adults living with HIV/AIDS who present with depressive symptoms.

#### **Positive Aging Strategies**

According to Hill (2011),

positive aging . . . is an extension of the positive psychology movement, which focuses on issues specific to

old age. . . . In aging, many . . . transitions are a consequence of age-related decline – and to preserve well-being and happiness in the presence of this diminished functional capacity, particularly in advanced age, means dealing with unavoidable loss. . . . [P]ositive aging characteristics . . . [include]: (a) the ability to mobilize latent or dormant coping potentialities, (b) flexibility in thinking and behaving, (c) a decision-making style that affirms personal well-being even when choices represent departures from familiar activities that may no longer be possible when functionality for these activities is irretrievably compromised, and (d) an optimistic viewpoint about issues embedded in decline. (p. 70)

In short,

**positive aging** emphasizes subjective constructs of well-being. At its root, positive aging is descriptive of psychological adaptation to the inevitable consequences of late-life decline. A basic assumption in positive aging is that because decline is unavoidable, it is more adaptive to accept diminished functioning as part of one’s lifestyle routine rather than denying, controlling, or mediating it. This does not mean that one should

ignore opportunities for controlling disease symptoms, or preserving functionality as one ages, but knowing when to make a shift that incorporates age-related decline into one’s lifestyle routine is a central feature for preserving well-being, even though the qualitative nature of one’s everyday functioning is unalterably diminished. (pp. 72-73)

To preserve a subjective sense of well-being when one is challenged by age-related decline, Hill points to “a strengths-based model of coping . . . and . . . three prominent meaning-centered life-span strategies grounded within this framework: gratitude, forgiveness, and altruism. These strategies are primarily designed to impact psychological state” (p. 73).

In characterizing a **gratitude intervention**, Hill observes that

from a positive aging framework, gratitude is a powerful flexibility strategy that . . . can assist individuals in focusing on positive attributes of events or circumstances even when those events have been associated with objective loss. The underlying dynamic of a gratitude intervention is similar to the reconstrual principle in cognitive-behavioral therapy: that is, reframing automatic maladaptive thoughts to disconnect them from negative affect and therefore generate latent emotional resources to

engagement in care. While the “triple diagnosis” of HIV, substance abuse, and mental illness . . . has been recognized in other areas of HIV management, the results here underscore the importance of and interplay between these three diagnoses in the context of linkage to care and argue for implementing a comprehensive approach to patient care as soon as possible after diagnosis of HIV infection. (p. 1168)

Semple, Strathdee, Zians, McQuaid, and Patterson (2011) “examined **methamphetamine use and sexual risk behaviors as correlates of OCD [obsessive-compulsive dis-**

preserve well-being. . . . Although gratitude interventions have not been evaluated for older adult issues, per se, such interventions hold promise for addressing issues related to caregiver burden, chronic depression and/or anxiety, and issues associated with death and dying and the bereavement process. (p. 73)

“The goal of a positive aging **forgiveness intervention**,” according to Hill, “would be one of learning to accept deficits as a result of age-related deterioration” (p. 74). Research on

forgiveness in later life has focused on . . . address[ing] difficult life transitions: loss of independent function, physical pain due to chronic disease, relieving the psychological burdens associated with caregiving, and repairing damaged relationships. . . . [F]orgiveness training may be especially relevant for acute issues that challenge well-being, such as the management of grief. . . . One aspect of this model involved construing forgiveness as multidimensional; that is, forgiveness could be engaged to help negotiate lifespan transition issues (e.g., moving from one’s own home to a residential care facility) where there may be a need to forgive one’s self (for an accident that may have precipitated the move), others (for initiating a residential care placement), or natural circumstances (the unavoidable

**order]** in a sample of 245 HIV-positive . . . MSM . . . in San Diego [California]” (p. 1153), “a convenience sample of . . . volunteers in a sexual risk reduction intervention” (p. 1158). The investigators found that

clinical levels of OCD were associated with more frequent use of methamphetamine, more depressive symptoms, and more risky sexual behaviors when “high” on methamphetamine, but fewer sexual acts in a 2-month period [attributed by the investigators to low sexual desire, which is associated with OCD and may have been self-remedied by the use of methamphetamine]. This

consequences of age-related frailty). Forgiveness in any of these instances could be a resource for recruiting psychological reserves to cope with age-related deficits and preserve well-being and could benefit decision-making processes in the negotiation of such issues. (p. 74)

Hill notes in particular that “forgiveness intervention strategies have been described for caregivers of persons suffering from AIDS” (p. 74).

Moving on to the **altruism intervention**, Hill observes the association of altruism

with the motivation behind acts of volunteerism. . . . An extensive literature has examined the benefits that have followed when older persons have engaged in naturally occurring volunteer activities. . . . These studies provide preliminary evidence that volunteering is a potent source for generating meaning and purpose in life and that engagement in volunteer activities, even as one’s own health is declining, can be a source of well-being. . . .

An element of altruism that is not commonly considered in this clinical realm . . . is learning how to “receive” help from others. In this way, older help recipients could, themselves, be instruments of altruistic acts from others (e.g., helpers need someone to help). However, among the barriers

profile suggests that efforts to treat methamphetamine use and promote safer sex practices in this target population may require efforts to mitigate and treat severe OCD symptoms. . . .

Participants who met the threshold for a clinical level of OCD symptoms were also more likely to report seeking out risky sexual venues and risky sexual partners when “high” on methamphetamine. The novelty-seeking and exciting nature of risky sexual behaviors in the context of methamphetamine use may be reinforcing, thus making these behaviors more resistant to change.

*(Biopsychosocial Update is continued on Page 12)*

ers associated with this kind of approach to altruism is the social stigma that can be associated with receiving help. . . . Some researchers have suggested . . . that the ability to receive help is a skill that, if learned, has the potential to promote subjective well-being even when the recipient cannot reciprocate the helper. . . . It may be that the construal of help-receiving as a form of altruism is adaptable for older persons who are substantially physically or cognitively impaired. (pp. 74-75)

### **Positive Aging Among HIV-Positive Persons**

In parallel to themes articulated by Hill (2011), Emler, Tozay, and Raveis (2011) analyzed interview data from 25 older adults living with HIV/AIDS and identified seven themes reflecting **resilience and strengths related to aging with HIV/AIDS**. Themes included “self-acceptance, optimism, will to live, generativity, self-management, relational living, and independence” (p. 101). Elaborating on these findings, Emler and colleagues utilize language reflective of a positive aging perspective:

Self-acceptance emerged as an important theme in the lives of these older adults. . . . The concept of accepting aging and advancing HIV, in addition to enveloping past life experiences, can be characterized as

*(Tool Box is continued on Page 10)*

(Tool Box -- continued from Page 9)

. . . wisdom or the ability to recognize and utilize one's own strengths and limitations. This aspect of self-acceptance allowed individuals to move forward with their lives rather than remaining stuck and mired in regrets from prior actions and behaviors.

Optimism was an important theme reflecting a positive outlook and future mindedness. Manifested as the ability to look forward and set goals, it fostered efforts to maintain good health. . . .

Closely connected with optimism is the will to live. The importance of survival and doing battle with the disease emerged as testimony to the tenacity of these individuals. Their will to live and their underlying purpose in doing so are consistent with the element of meaningfulness as derived from the resilience literature. In this context, meaningfulness represents the realization that one's life has a purpose and there is something for which to live.

. . . For a number of the individuals in this study, their purpose for living was associated with generativity – a sense of concern for the well-being of future generations. . . . Providing education and advocacy were identified as an important element in their lives. . . . Although generativity is typically external (giving back), several individuals noted an internal element. They saw themselves as a part of history, something larger than themselves. By sharing that history, their legacy was passed on through education. The prejudice, stigma, and discrimination endured by many of these informants, due to their HIV disease and sexual orientation, were part of their lived experiences and constitute the legacy they were motivated to share.

Continued optimism and the desire to assist others were inextricably tied to self-management. Individuals relied upon their internal strengths for continued adherence to HIV medication regime[n]s and avoidance of previously detrimental lifestyle elements, such as drug use and un-

safe sex. . . . Although the men and women in this study acknowledged the importance of others, many observed that they were responsible for their own self-preservation.

The theme of relational living attests to the fact that these individuals are aware of the significance of others in their lives. Family, sexual partners, friends, and social groups were all regarded as sources of strength. Their optimism for the future and the sense of responsibility these individuals expressed helped them forge new relationships and reestablish others previously strained due to prior behavior. . . . The present analysis revealed that meaningful relationships go beyond family and sexual partners and include the support received from support groups and other social ties.

Finally, seemingly juxtaposed to the value of relational living is the theme of independence. Although having others to rely on for help and guidance is important, self-reliance emerged as of consequence in these individuals' lives. (pp. 108-109)

Emler and colleagues contend that “despite the seriousness of the diagnosis and consistent challenges with comorbidities, stigma, and depression . . . , these individuals exhibited resilience, finding strengths within themselves and their support systems to address the challenges of HIV disease. Practitioners should carefully consider the integration of a strengths assessment into practice strategies, thereby building on resilience and personal strengths in HIV-positive older adults” (p. 110).

#### **Coping Comparatively Well**

In a study drawn from “an Australian population-based sample of 693 HIV-positive gay men” (p. 1236), “while on some measures, the quality of life for older HIV-positive gay men . . . was poorer, particularly in terms of heightened comorbidity and a greater tendency to live in poverty, the majority of measures suggested otherwise, with older men rating their overall health and well-being similarly to their younger counterparts” (p. 1241) and “coping comparatively well as they continue to age with HIV” (Lyons, Pitts, Grierson, Thorpe, & Power, 2010, p. 1236).

Similarly, Mavandadi, Zanjani, Ten Have, and Oslin (2009) studied “a heterogeneous sample of [109] adults diagnosed with HIV infection . . . to explore associations among age, various dimensions of social support, and psychological and functional well-being. . . . To explore age group differences, participants were stratified by age (< 54 vs. 55+ years)” (p. 91). The investigators found that “despite endorsing greater medical comorbidity, older adults reported significantly lower depressive symptomatology and greater positive affect and were less likely to report seeing a behavioral health specialist than their younger counterparts. No age group differences emerged for instrumental support [i.e., receiving assistance with tasks] or amount of social interaction. However, older adults reported higher subjective support, which in turn was associated with lower depressive symptomatology, greater positive affect, and nonutilization of behavioral health services” (p. 91).

Mavandadi and colleagues expand on the perceived “quality of social relationships [among adults aging with HIV, which] may be particularly important for successful psychological adaptation to HIV” (p. 91), as follows:

Although previous work with individuals with HIV/AIDS has demonstrated that structural aspects of social ties, such as living situation (i.e., alone vs. with others) and network size, may be compromised among older relative to younger individuals with HIV/AIDS, . . . no significant differences in living situation or the frequency of social interactions were observed for participants in the current sample. Furthermore, there were no notable differences in the amount of instrumental support received by those in the younger and older cohorts. However, . . . significant age group differences in the quality, or subjectively perceived supportiveness, of social ties did emerge. Older adults reported significantly greater subjective support relative to their younger counterparts, a finding that is consistent with other investigations of age-related variation in the quality of social support over time. . . . Moreover, although greater subjective support was associated with fewer depres-

sive symptoms, more vigor, and lower odds of having seen a behavioral health specialist across age groups, with the exception of an association between social interactions and vigor, there were no other significant associations among instrumental support or the frequency of social interactions and these variables. This latter set of findings parallels results from prior work and suggests that perceived satisfaction with social support may be more strongly associated with psychological well-being than the amount of support received. (p. 96)

Mavandadi and colleagues conclude that "these findings point to the value of examining multiple facets of the social environment of individuals diagnosed with HIV/AIDS, as opposed to focusing solely on structural aspects" (p. 97).

### **Daunting Disparities**

Despite the encouraging findings that have emerged from the qualitative and quantitative research delineated above, not all adults aging with HIV have the social support they require or are coping with their life circumstances as well as these studies suggest.

As an example, Haile, Padilla, and Parker (2011) conducted a small qualitative study in which they "analyse[d] the life history narratives of 10 poor gay and bisexual older adult Black men living with HIV in New York City, focusing on what it means to live with the stigmas of race/ethnicity, HIV status, sexual nonnormativity and poverty" (p. 431). "The interview guide was designed to ensure consistent exploration of particular domains of interest, including: stigma, experiences with clinical providers and social services, social support and coping and quality of life" (p. 432). The investigators identified three overarching themes:

First, participants described the ways in which stigma marks them as 'just one more body' within social and medical institutions, emphasising the dehumanisation they experience in these settings. Second, respondents described the process of 'knowing your place' within social hierarchies as a means through which they are rendered tolerable. Finally, interviewees described the

dynamics of stigma as all-consuming, relegating them to the 'quagmire of an HIV ghetto'. These findings emphasise that despite advances in treatment and an aging population of persons living with HIV, entrenched social stigmas continue to endanger the well-being of Black men who have sex with men [(MSM)]. (p. 429)

Haile and colleagues stress that

the ubiquity of contexts within which stigmatisation takes place suggests the existence of an underlying, antecedent social structure that extends beyond the borders of the Black and lesbian, gay, bisexual and transgendered communities that are typically the focus of discussions of stigma among Black [MSM]. [This] study . . . contributes to the conceptualisation of the stigma experiences of older Black [MSM] with HIV/AIDS as multiple and pervasive, potentially illustrative of a general structure of systematic disadvantage that has a much greater impact on their overall health and well-being than current frameworks imply. (p. 438)

In addition to the structural interventions these findings necessitate, coping intervention approaches appropriate for and evaluated with HIV-infected older adults experiencing psychological and social distress are clearly needed.

### **Efficacious & Age Appropriate**

With a three-city sample of 295 men and women aged 50 years and older who were living with HIV/AIDS, Heckman et al. (2011) conducted a randomized controlled trial (RCT) to determine "if a 12-session **coping improvement group intervention** (n = 104)<sup>1</sup> reduced

<sup>1</sup> In the 12-session coping improvement group intervention, "separate intervention groups were conducted for MSM, heterosexual men, and women. In . . . formative research, HIV-infected older adults expressed a reluctance to participate in an AIDS mental health group intervention if groups were heterogeneous in sexual orientation. . . . Each 90 min[ute] intervention group consisted of six to eight participants and was co-facilitated by two clinicians. Most intervention facilitators had a Masters degree in Psychology or Social Work and had provided mental health support services to persons living with HIV/AIDS for more than 10 years. The intervention's 12 sessions addressed the following topics: participant-

**depressive symptoms** in HIV-infected older adults compared to an **interpersonal support group intervention** (n = 105)<sup>2</sup> and an **individual therapy upon request** (ITUR) control condition (n = 86)<sup>3</sup>" (p. 102). Importantly, "the project did *not* exclude individuals with alcohol or substance use disorders, active bipolar disorder, psychotic symptoms, or individuals receiving psychotherapy because it sought to assemble (Tool Box is continued on Page 12)

facilitator introductions and participants' sharing of personal histories (Sessions 1 and 2); appraisal and changeability of stressors related to one's HIV infection (e.g., treatment side effects) and stressors related to normal aging (e.g., comorbid health conditions; Sessions 3 and 4); developing and implementing adaptive problem- and emotion-focused coping skills (Sessions 5 through 9); optimizing coping efforts through the use of interpersonal supports (Sessions 10 and 11); and termination issues and the voluntary sharing of personal contact information (e.g., e-mail addresses, telephone numbers; Session 12)" (Heckman et al., 2011, p. 105).

<sup>2</sup> In the 12-session interpersonal support group intervention, "each 90 min[ute] group was conducted separately for MSM, heterosexual men, and women and was co-facilitated by two Masters-level clinicians. For each session, the first 45 min[utes] focused on a topic assigned by the co-facilitators (e.g., HIV-related nutrition, treatment adherence, sexual risk reduction). During this time, participants viewed a brief, commercially-available videotape on the assigned topic and discussed how the videotape required adaptation to be relevant for HIV-infected older adults. For the final 45 min[utes], participants discussed how the session's topic pertained to their personal lives. Similar to the coping intervention, all participants were encouraged to share personal contact information at the end of the final session to facilitate communication among participants upon intervention termination" (Heckman et al., 2011, p. 105).

<sup>3</sup> In the individual therapy upon request (ITUR) control group, participants "received no active intervention but had access to standard psychosocial services available in the community (e.g., AIDS-related support groups, 12-step programs, individual therapy) and received three brief telephone contacts during the intervention period to ensure that no clinical concerns had developed. No limitations were imposed on participants' use of community-based services. ITUR controls experiencing acute periods of distress were encouraged to contact the study team to request brief and time-limited individual therapy (not to exceed 12 sessions)" (Heckman et al., 2011, pp. 104-105).

(Tool Box -- continued from Page 11)

a more diverse and inclusive sample representative of HIV-infected older adults likely to participate in AIDS-mental health interventions offered in community settings” (pp. 103-104). Moreover, in comparisons with

national epidemiologic data . . . , the study’s cohort appeared to be representative of persons 50-plus years of age living with HIV/AIDS in the United States. Most participants were African American (49%), male (67%), and earned less than \$10,000 per year (54%). The average participant was 55.3 years of age (range = 50-76), had completed 13.0 years of education, and had been living with HIV for 12.5 years. Fifty-one percent of participants self-identified as gay or bisexual. Forty-four percent of participants self-reported taking one or more psychotropic medications at pre-intervention (most commonly anti-depressants and anxiolytics). (p. 106)

The investigators found that

whether conducted with all participants (N = 295) or only a subset of participants diagnosed with mild, moderate, or severe depressive symptoms (N = 171), . . . analyses . . . found that both coping improvement and interpersonal support group intervention participants reported fewer depressive symptoms than ITUR controls at post-intervention, 4-month follow-up, and 8-month follow-up. The effect sizes [i.e., measures of impact] of the differences between the two active interventions and the control group were greater when outcome analyses were limited to those participants with mild, moderate, or severe depressive symptoms. At no assessment period did coping improvement and interpersonal support group interven-

tion participants differ in depressive symptoms. (p. 102)

It bears mentioning that “most participants (97%) were receiving concurrent mental health treatments outside of the study, such as pharmacotherapy; using complementary treatments, medications, or supplements; and seeing one or more mental health professionals, making this RCT an investigation of ancillary group therapy for HIV-infected older adults. While no significant group differences in the use of mental health support services were found at pre-intervention, some gains reported by participants may be attributable to these outside services and not the study’s interventions” (p. 110). Furthermore, “attendance at intervention sessions was infrequent in many participants; 41% of coping intervention participants attended 8 or fewer of the 12 sessions. It is also noteworthy that ITUR controls evinced an 8-month retention rate that was noticeably higher than those observed in the two active interventions” (p. 110).

Nevertheless, in this “first controlled trial to test if an age-appropriate, coping improvement group intervention could reduce depressive symptoms in HIV-infected older adults,” Heckman and colleagues conclude that

the coping intervention was superior to an individual therapy upon request condition (a condition in which almost one-third of participants received roughly five sessions of individual therapy) and comparable to a 12-session interpersonal support group intervention. AIDS service and gerontological organizations may consider offering either intervention to their older clients living with HIV/AIDS, knowing that both intervention approaches have now been shown to reduce depressive symptoms in this age group (particularly those with elevated levels of depressive symp-

age their risky behaviors and their obsessions and compulsions. . . .

Although this study focused on methamphetamine use and sexual risk behaviors as correlates of OCD, it was depressive

symptoms). To reduce the resource intensity of each intervention, AIDS service organizations and other agencies that serve HIV-infected older adults might consider offering either group intervention using only one group facilitator; there is no evidence that two facilitators are necessary for either group intervention, although this is common practice in most AIDS service organizations. As the number of new HIV infections and AIDS cases in older adults continues to increase, future research should continue to identify efficacious and age-appropriate interventions for HIV-infected older adults and disseminate these interventions to community-based organizations that can offer them to their older clients living with HIV/AIDS. (p. 110)

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Abraham Feingold, Psy.D.

symptoms . . . that yielded the strongest relationship with OCD. . . . From a clinical perspective, methamphetamine users who present with depressive symptoms should also be screened for OCD symptoms. Treatment programs that aim to reduce meth-

(Biopsychsocial Update -- continued from Page 9)

Accordingly, the effectiveness of sexual risk reduction programs may be enhanced by addressing OCD symptoms and teaching self-regulation techniques (e.g., cognitive reframing, delaying) that help individuals to man-

amphetamine use and depression might combine psycho-pharmacological and psychotherapeutic treatments for OCD. A review of pharmacological therapies . . . concluded that administration of fluvoxamine or sertraline (two commonly used SSRIs) is the recommended treatment for OCD, with augmentation for refractory patients using risperidone, olanzapine, or quetiapine. The recommended psychotherapeutic treatment for OCD is . . . CBT. . . . CBT has been shown clinically effective with OCD patients using various methods of delivery, including individual, group, and telephone. (pp. 1157-1158)

"In a [convenience] sample of **perinatally HIV-infected (PHIV+) and perinatally HIV-exposed, uninfected (PHEU) adolescents,**" Mellins et al. (2011) "examined the **co-occurrence of behavioral health risks** including mental health problems, onset of sexual and drug use behaviors, and (in PHIV+ youth) nonadherence to antiretroviral therapy (ART). Participants, recruited from 2007-2010, included 349 youth, ages 10-16 years, enrolled in a cohort study examining the impact of HIV infection and ART" (p. 413).<sup>3</sup> The findings were these:

Nearly half the participants met study criteria for at least one behavioral health risk, most frequently, mental health problems (28%), with the onset of sexual activity and substance use [most frequently alcohol] each reported by an average of 16%. Among the sexually active, 65% of PHIV+ and 50% of PHEU youth reported unprotected sex. For PHIV+ youth, 34% reported recent ART nonadherence, of

<sup>3</sup> Two more studies by Mellins and colleagues that involved this cohort are highlighted in the [Winter 2010](#) issue of *mental health AIDS*.

whom 45% had detectable HIV [loads]. Between 16% (PHIV+) and 11% (PHEU) of youth reported at least two behavioral health risks. Older age, but not HIV status, was associated with having two or more behavioral health risks versus none. Among PHIV+ youth, living with a birth mother (versus other caregivers) and detectable viral load were associated with co-occurrence of behavioral health risks. (p. 413)

"These results suggest that children born to HIV-infected women, regardless of their own HIV status, are at risk for multiple behavioral health risks" (p. 418), according to the investigators, who observe that

mental health problems during adolescence place youth at heightened risk for chronic mental health disorders in adulthood, as well as sexual risk behavior, and thus, require early identification and appropriate, evidence-based interventions to promote youth health and mental health, as well as prevent sexual risk behaviors that can lead to HIV transmission. . . . [These] data suggest that incorporating routine mental health assessments into health care systems may be critical to the early diagnosis and treatment of mental health problems as well as prevention among those at risk. (p. 418)

Conversely, the finding that more than 70% of this sample scored in the normal range on a mental health instrument suggests that "despite the likely presence of significant stressors in their lives (e.g., maternal HIV, poverty, family disruption), protective factors that support mental health and prevent early onset of sexual behavior and substance use may be present among many families of PHIV+ or PHEU youth. Fur-

ther study of resilience is necessary to identify protective factors (e.g., social support, family involvement), with the goal of developing effective prevention programs" (p. 418).

When behavioral health risks are identified, however, Mellins and colleagues stress the need for

targeted service programs for both PHIV+ and PHEU youth, particularly those that address mental health problems, safe[r] sex behavior, and nonadherence. There are now a number of studies that have identified important predictors of the behavioral health risks assessed in this paper, including cognitive function, . . . caregiver supervision and monitoring, . . . caregiver mental health, . . . and parent-child relationship factors, . . . many of which could be targeted in these services. To date, only a few efficacy-based interventions have been developed that target caregiver-child relationship factors as well as supervision and monitoring to support mental health and reduce risk behavior in PHIV+ youth and youth living with HIV+ caregivers, . . . as well as nonadherence in PHIV+ youth . . . and none of the interventions developed for PHIV+ youth have been tested in large scale randomized control trials. Further study using prospective cohorts may be necessary to identify specific psychosocial mediators among older youth that could be targeted in interventions for multiple behavioral health risks among adolescent children of HIV-infected women, particularly HIV-infected adolescents. (p. 420)

### **HIV Treatment News**

***Medical Care, Including Care for Hepatitis C***  
On May 13, 2011, the U.S. Food and Drug Administration (FDA)

approved Victrelis (**boceprevir**) to treat certain adults with chronic hepatitis C [virus (HCV)]. Victrelis is used for patients who still have some liver function, and who either have not been previously treated with drug therapy for their [HCV] or who have failed such treatment. Victrelis is approved for use in combination with peginterferon alfa and ribavirin. . . . Victrelis is a pill taken three times a day with food. The therapy is part of a class of drugs referred to as protease inhibitors, which work by binding to the virus and preventing it from multiplying. The most commonly reported side effects in patients receiving Victrelis in combination with pegylated interferon and ribavirin include fatigue, low red blood cell count (anemia), nausea, headache and taste distortion (dysgeusia).

On May 20, 2011, the FDA

approved Edurant (**rilpivirine**) in combination with other antiretroviral drugs for the treatment of HIV-1 infection in adults who have never taken HIV therapy (treatment-naive). Edurant belongs to a class of HIV drugs called non-nucleoside reverse transcriptase inhibitor (NNRTI). The drug works by blocking HIV viral replication. Edurant is to be used as part of a highly active ART (HAART) regimen that is designed to suppress the amount of HIV (viral load) in the blood. Edurant is a [25 mg] pill taken once a day with food. . . . The most commonly reported side effects in patients taking Edurant included depression, difficulty sleeping (insomnia), headache and rash.

On May 23, 2011, the FDA

approved Incivek (**telaprevir**) to treat certain adults with chronic

[HCV] infection. Incivek is used for patients who have either not received interferon-based drug therapy for their infection or who have not responded adequately to prior therapies. Incivek is approved for use with interferon therapy made up of peginterferon alfa and ribavirin. . . . The sustained virologic response for patients treated with Incivek across all studies, and across all patient groups, was between 20 and 45 percent higher than current standard of care.

The studies indicate that treatment with Incivek can be shortened from 48 weeks to 24 weeks in most patients. Sixty percent of previously untreated patients achieved an early response and received only 24 weeks of treatment (compared to the standard of care of 48 weeks). The sustained virologic response for these patients was 90 percent.

When a person achieves a sustained virologic response after completing treatment, this suggests that the [HCV] infection has been cured. . . .

Incivek is a pill taken three times a day with food. . . . The most commonly reported side effects in patients receiving Incivek in combination with peginterferon alfa and ribavirin include rash, low red blood cell count (anemia), nausea, fatigue, headache, diarrhea, itching (pruritus), and anal or rectal irritation and pain. Rash can be serious and can require stopping Incivek or all three drugs in the treatment regimen.

**Psychiatric/Psychological/  
Psychosocial/Spiritual Care  
Adherence to Treatment**

Carrico et al. (2011) "administered a validated screener to examine **psychiatric correlates of** . . .

**HAART . . . utilization and viral load"** (p. 1113) among a diverse community-recruited sample of 227 **homeless and marginally housed adults** living with HIV in San Francisco. The investigators found that "sleeping on the street . . . and screening positive for a stimulant use disorder . . . were independently associated with lower odds of HAART utilization. Conversely, enrollment in the AIDS Drug Assistance Program . . . and receipt of mental health treatment . . . were independently associated with increased odds of HAART utilization. Among those on HAART, screening positive for a severe mental illness [(SMI)] was independently associated with a 6-fold higher viral load" (p. 1113). Carrico and colleagues continue:

Taken together, it appears that structural and psychiatric barriers compromise HIV treatment success, even in a resource-rich environment in which integrated care and antiretroviral medications are more accessible than most areas of the world.

Although the present cross-sectional investigation provides some of the first data regarding the association between specific psychiatric diagnoses and HIV disease management, longitudinal studies are needed to examine whether and how specific psychiatric diagnoses independently predict more rapid HIV disease progression. Further research is also needed to replicate these findings and determine if impaired HAART adherence mediates the association between SMI and elevated HIV viral load.

Irrespective of whether elevated viral load among those with SMI is due to stress-induced immune suppression, impaired HAART adherence or other mechanisms, findings from this study have im-

portant clinical implications. Adjuvant interventions that address social and structural barriers as well as target prevalent psychiatric comorbidities in this population could promote HAART utilization and reduce viral load among HIV-positive impoverished persons. Optimizing individual-level health outcomes among HIV-positive impoverished persons may lead to greater reductions in community HIV viral load, which is critical to the success of ‘test and treat’ approaches to HIV prevention. (pp. 1116-1117)

Keuroghlian et al. (2011) undertook “an initial examination of **the relationship between PTSD, dissociative symptoms, and antiretroviral adherence** among [38] persons living with HIV/AIDS” (p. 945) and found that “the presence of PTSD symptoms was significantly associated with a decreased probability of HIV medication adherence, and this relationship was moderated by dissociative symptoms. Participants with high levels of dissociation showed a significant association between PTSD symptoms and lower odds of HIV medication adherence, whereas those with low levels of dissociation had no association between PTSD symptoms and adherence” (p. 945). Although more research is needed, these findings point to the importance of conducting

screening and assessment of PTSD, dissociation, and depressive symptoms among [persons living with HIV]. Moreover, therapies that reduce trauma symptoms, including dissociative symptoms, are likely to significantly enhance adherence to HIV medications. There is substantial evidence for the effectiveness of cognitive-behavioral strategies in decreasing reactivity to stressful stimuli by increasing emotional regulation and de-

veloping adaptive coping behaviors to deal with triggers that result in PTSD or dissociative symptoms. . . . Moreover, exposure-based therapy has demonstrated efficacy in the treatment of PTSD. . . . This treatment involves repetitive exposure to stimuli associated with the original trauma in order to facilitate emotional reengagement with trauma-related memories, reduce avoidance symptoms, improve affective regulation, and increase cognitive processing of past traumatic experiences, thereby reducing intrusive thoughts and hyperarousal symptoms. . . .

When PTSD occurs in conjunction with dissociative symptomatology, exposure therapy may have decreased effectiveness because of the individual’s reduced capacity to engage emotionally with trauma-associated memories. . . . Given [the] finding that dissociation moderates the relationship between PTSD and adherence, phase-based treatment, consisting of initial skills training in affective and interpersonal regulation, with subsequent coping skills to deal with triggers that activate dissociative symptoms, may enhance healthy behaviors for HIV disease management and prove to be the treatment of choice for targeting nonadherence in [persons living with HIV] with histories of trauma. (pp. 946-947)

Holstad, Dilorio, Kelley, Resnicow, and Sharma (2011) “examined the efficacy of a **motivational group intervention** based in motivational interviewing [(MI)] and delivered by trained nurses to promote adherence to antiretroviral medications and use of risk reduction behaviors. The sample consisted of [203] primarily African American women who had a low income and had been HIV

infected for about 9 years and taking antiretroviral medications for an average of about 6 years” (p. 893). The KHARMA (Keeping Healthy and Active with Risk Reduction and Medication Adherence) intervention

consisted of eight group sessions using [MI] delivered in a group format. It was designed to empower women to make decisions and develop strategies about taking ART as prescribed and consistently using risk reduction behaviors, such as condom use and to overcome resistance/ambivalence to both. The sessions lasted about 1.5-2 h[ours], and were led by trained MI nurses. The first and last session focused on both adherence and risk behavior, three sessions were devoted to adherence only and three to risk reduction behaviors only, including a session on disclosure[,] which is important to risk reduction as well as adherence. Each session included a discussion of goals and goal setting related to the topic. MI techniques were incorporated into every session. In keeping with the autonomy support spirit of MI, participants as a group chose which topic they wanted to address first. The majority of groups ( $n = 14$ ) chose medication adherence as the first topic. (p. 887)

The Health Promotion Program (HPP) control group sessions

were equivalent in length and time to the MI group and were led by trained nurses and a health educator. This group used health education techniques of lecture/discussion/educational games and focused on nutrition, exercise, stress recognition, and women’s health issues tailored to the HIV positive woman. Participants received a manual containing content and supplementary

materials for each session. Adherence and [risk reduction behaviors] were not addressed in the HPP and facilitators were instructed to redirect the group if these issues came up. (p. 887)

To promote retention in both conditions, participants

received monetary and non-monetary incentives for attendance at each session. Non-monetary incentives included meals, transportation tokens, toiletry items, childcare, water bottles, and a tote bag received at the first session. In addition, a massage therapist conducted shoulder, neck or chair massages before two sessions and a beauty consultant demonstrated make-up and skin care tips before one session. Participants in the intervention group also received a purse size inspirational calendar, motivational journal, motivational adherence video . . . , male and female condoms, dental dams, and lubricants. (p. 888)

Over a 9-month period, “medication adherence was measured directly by electronic [drug] monitoring [(EDM)] and indirectly by means of CD4 and viral load results abstracted from medical records” (p. 893); risk reduction behavior was measured by self-report. Although “no significant group by time effects were observed” (p. 885),

those with high MI group attendance [ $\geq$  seven sessions] demonstrated better outcomes. MI is an interpersonal experience and one must be present to engage in this experience. MI techniques promote collaboration, autonomy, acceptance, and self-confidence to deal with ambivalence regarding a behavior change in a non-confrontational manner. In high attendees, these techniques

might have contributed to the overall higher mean adherence levels and greater use of protection during sexual activity. On the converse, in low attendees, the reverse occurred; those with an inadequate dose of the group MI had poorer outcomes than the control group.

. . . Though not conclusive, the findings provide some support for the efficacy of MI in a group format for both improving adherence, particularly to dose scheduling, and use of abstinence and protection/condoms when consistent attendance is maintained. . . .

In addition, the control group in this study was a strong health promotion program tailored to the needs of HIV infected women. It is possible that, because it focused on health related variables (nutrition, exercise, stress, women’s health), overall health awareness increased in this group and translated into improved self-care behaviors such as adherence and safer sex. Perhaps the use of EDM and monitoring of medications could also have stimulated adherence in the control group. Thus, improvements were seen for CD4 cells in HPP, and greater differences in outcomes were not seen between groups or over time. In the future, a combination of both group topics into a comprehensive health program for HIV infected women that employs MI seems reasonable, particularly with the increase in morbidity due to cardiovascular and metabolic effects of the antiretroviral medications. Other research might compare use of MI in a group format with traditional individualized MI, to promote both ART adherence and use of risk reduction behaviors and compare costs of the two formats. (p. 894)

### Stress Management

“Acute and chronic life stressors have a detrimental effect on the health of people living with HIV. Psychosocial resources such as mastery, coping, and social support may play a critical role in moderating the negative effects of stressors on health-related quality of life,” according to Gibson et al. (2011), who “evaluate[d] the potential **moderating effects of psychosocial resources on the relationship between stressors and health-related quality of life**” (p. 371) among 758 men and women receiving HIV primary care in greater Toronto, Ontario, Canada. “The top three stressors reported by participants were trying to take on too many things at once (51%), not having enough money to buy the things they needed (51%), and having something happen during childhood that scared them so much that they thought about it years later (42%)” (p. 371). Gibson and colleagues “found that a high proportion of the participants reported experiencing stressors in their lives and that having higher numbers of stressors was associated with lower physical and mental health-related quality of life” (p. 377). Moreover, “mastery<sup>4</sup> and maladaptive coping had significant moderating effects on mental health but not on physical health” (p. 371). Taken together, “these findings lend support to the idea that providing people with HIV with the skills to deal with stressors in an effective manner may improve their mental health and well-being. . . . This suggests that counseling programs could have a significant positive effect on health by reducing the reliance on maladaptive coping strategies while promoting the use of adaptive coping skills. Further research in this area could inform treatment and help cus-

<sup>4</sup> In this study, mastery was defined as “the extent to which people feel in control over forces that significantly affect their lives, and is thought to be a psychological resource related to personal control and self-efficacy” (Gibson et al., 2011, pp. 371-372).

tomize specific stress management programs for HIV” (p. 378). In the meantime, Gibson and colleagues believe that

clinicians can play a central role by being mindful of the various types of stressors patients living with HIV are faced with, helping them recognize and acknowledge these stressors when they arise, and working with them to minimize health-care related stressors, such as the negative effect of stressful life events on adherence to antiretroviral medications. . . . On the other hand, clinicians and other health care professionals can also collaborate to develop mental health interventions that focus on strengthening peoples’ own psychological resources. For example, people could be taught techniques to remain optimistic while coping with competing demands on their time and balance performance expectations. This approach would concentrate on enhancing a sense of mastery and coping skills instead of targeting the stressors directly. Previous studies have reported effectiveness of coping effectiveness training (CET), cognitive-behavioral stress management (CBSM), and time-limited dynamic psychotherapy (TLDP) in reducing perceived stress, burnout, anxiety, mood disturbance, and depressive symptoms among people living with HIV. (p. 379)

#### Coping Strategies, Social Support, & Quality of Life

In closing, a study by Braden, Overholser, and Silverman (2011) “examine[d] protective factors associated with **the will to live** among [68] AIDS patients, including physical functioning, depression, and quality of life” (p. 173) and found that “lower levels of depression were related to positive perceptions of . . . physical health and less severe

physical pain. Quality of life accounted for a significant portion of variance in reasons for living. Reasons for living scores were strongly related to quality of life in several key domains, including achievement, self-expression, interpersonal relationships, and environment” (p. 179). Braden and colleagues observe that even though study participants were diagnosed with AIDS, “general physical health was not significantly related to symptoms of depression. Physical pain and [negative] perceptions of health were the only physical health variables significantly related to depression” (p. 179). Instead, the investigators emphasize that

maintaining a high sense of quality of life may be important for protecting the will to live in AIDS patients. Although past studies have argued that AIDS patients with decreased physical functioning have less will to live, more recent findings have emphasized the **greater importance of psychological health.** . . . In the current study, the relationship between physical functioning and reasons for living approached significance, but physical functioning did not account for a significant amount of variance in reasons for living. . . . After receiving medical treatment, some AIDS patients report an increase in mental health quality of life even when physical health quality of life has decreased. . . . AIDS patients can maintain the will to live despite inevitable deficits in physical health and adaptive functioning.

. . . Quality of life was the strongest predictor of reasons for living in the sample of AIDS patients, accounting for 36% of the variance. Quality of life is a multifaceted phenomenon reflecting life satisfaction in a variety of areas. Important components of

overall quality of life include self-esteem, goals and values, money, work, play, learning, creativity, helping, love, and friends. The assessment and treatment of quality of life in AIDS patients is useful because of its relationship to both physical health and the will to live. The present findings suggest that improvement in quality of life domains could be a treatment goal during initial and end of life stages of care in AIDS patients. . . . Although antidepressant medications may temporarily decrease mood symptoms, medications may not always improve quality of life in other domains. Psychological interventions may be able to target a variety of quality of life domains.

More important reasons for living were related to a high sense of quality of life in four domains (achievement, self-expression, environment, and interpersonal relationships). Interventions aimed at improving quality of life may encourage positive coping strategies and increase the will to live among AIDS patients. For example, treatment may help patients increase self-expression and enhance interpersonal relationships. Personal achievements may promote reasons for living in AIDS patients. Optimistic thinking . . . and positive health perceptions . . . are related to less severe depression in AIDS patients, whereas catastrophizing . . . is related to more severe depression. Quality of life may be improved by helping patients learn to accurately perceive changes in health, and to appreciate improvements in health. The current study did not examine treatment outcomes in AIDS patients. Thus, suggestions for improved psychological treatment of AIDS patients should be taken with caution. (pp. 181-182)

Nevertheless, Braden and colleagues conclude that

AIDS patients who learn to express their thoughts and feelings may be more likely to enjoy life despite their medical diagnosis. Therapists can encourage patients to develop an awareness of their emotions and an ability to effectively communicate. Satisfaction in social relationships may preserve the will to live in AIDS patients by helping them make sense of their experience and by fostering a sense of meaning in life. The will to live may be maintained in AIDS patients who feel satisfied with their immediate environment. Patients can be encouraged to discover rewarding activities to incorporate into their life. AIDS patients who are able to experience satisfaction in various areas of their lives can preserve the will to live in the midst of living with a chronic, incurable illness. (p. 183)

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U.S. Food & Drug Administration. (2011, May 20). *FDA approves new HIV treatment* [News release]. Retrieved from <http://www.fda.gov/NewsEvents/Newsroom/>

## Tool Box

### A Note on Content

This publication is designed to help frontline providers of HIV-related mental health services, allied professionals, and consumers stay up to date on research related to HIV care in developed-world settings. The content for the "Biopsychosocial Update" is 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 provided by Florida International University researcher Robert M. Malow, Ph.D., ABPP. Other sources are identified when appropriate.

Press Announcements /  
[ucm256087.htm](http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm256087.htm)

U.S. Food & Drug Administration. (2011, May 23). *FDA approves Incivek for hepatitis C* [News release]. Retrieved from <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm256299.htm>

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

[www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm256299.htm](http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm256299.htm)

– Compiled by  
Abraham Feingold, Psy.D.

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



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