

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Adolescents & Young Adults

Johnson, Scott-Sheldon, Huedo-Medina, and Carey (2011) assembled “an updated review of the **efficacy of behavioral interventions to reduce sexual risk** of . . . HIV . . . **among adolescents**” between the ages of 11 and 19 years. The investigators incorporated “data from 98 interventions (51,240 participants) . . . derived from 67 studies”; all reports “were available as of December 31, 2008” (p. 77). In this meta-analysis, Johnson and colleagues found that

behavioral interventions reduce adolescents’ risk for STIs [sexually transmitted infections] more broadly, increase condom use, reduce or delay frequencies of penetrative sex, and increase skills to negotiate safer sex and to acquire condoms. . . . Although intervention success varied across studies, benefits were durable for as long as 3 years postintervention, with success generalizing across such aspects as gender and geographic region. Variation in intervention outcomes depended on sample and intervention dimensions.

. . . Effects [of interventions] were larger to the extent that the sample of adolescents was institutionalized (e.g., runaways and detainees), the intervention had

more sessions, and the intervention did *not* emphasize abstinence. . . . Success was also greater to the extent that the comparison group received an intervention that included content unrelated to HIV. Because many

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studies used a diluted HIV risk-reduction intervention as a comparison condition, it is likely that the findings reported herein underestimate the magnitude of sexual change that interventions prompt. (p. 81)

Johnson and colleagues clarify that “the research discussed here may best be described as gauging best practice prevention for adolescents who are HIV negative and are from a variety of racial and ethnic backgrounds. Including more than 20 years of research on adolescents, [this] review confirms the efficacy of behavioral interventions to prevent sexually transmitted acquisition of HIV in a group that may have the most to profit by remaining HIV-free” (p. 82).

Koenig et al. (2010) described “the prevalence and predictors of the **transmission-related behaviors of adolescents with HIV acquired perinatally (perinatal) or through risky behaviors** (behavioral)” (p. 380). The sample consisted of 166 adolescents between the ages

of 13 and 21 years who were receiving HIV care in three American cities. Among the 105 sexually experienced adolescents who reported a risk history (42 perinatal, 63 behavioral),

nearly half . . . had engaged in unprotected sex since learning that they had HIV. Most were cur-

rently sexually active, and over half of their recent sex partners had been exposed to HIV through unprotected sex with the study participants. Moreover, few recent sex partners had been told that their partners were HIV positive. Although sexual activity and risky sexual behaviors were more common among behaviorally infected adolescents, a substantial proportion of sexually active perinatally infected adolescents were also at risk of transmitting HIV. (p. 386)

Moreover, “of sexually experienced girls, 19 had been pregnant (5 of 24 perinatal, 14 of 31 behavioral)” and “recent unprotected sex was asso-

In This Issue:

Biopsychosocial Update	
HIV Prevention News.....	1
HIV Assessment News.....	9
HIV Treatment News.....	10
Tool Boxes	
HIV Prevention 2011:	
Hits, Misses, & Hopes.....	4
Resources.....	12
A Note on Content.....	19

ciated with sexual abuse during adolescence . . . and greater HIV knowledge . . . when transmission category, age, and sexual orientation were controlled” (p. 380).

Koenig and colleagues point out that

many perinatally infected adolescents will need assistance not only with HIV prevention (e.g., disclosure, condom negotiation) but also with reproductive health and pregnancy prevention. . . . Taken together, these findings suggest a greater personal and public health impact than previously recognized for adolescents with perinatally acquired HIV. Anticipatory guidance regarding developing sexuality and health must start early. Providers will need developmentally appropriate educational tools and resources and, as is true for adults, some youth may need more intensive behavioral interventions. (pp. 387-388)

The investigators continue:

Behaviorally infected youth and to some extent those who were older and nonheterosexual were at increased risk for unprotected sex. When conducting risk reduction counseling, providers must consider these characteristics as well as specific behaviors that place patients and their partners at risk. Drug and alco-

hol use, associated with sexual risk behavior in the general population of youth, . . . were also associated with current sexual activity – and among perinatally infected youth, sexual initiation – in this sample of HIV-infected adolescents, suggesting their relevance as targets for risk reduction.

. . . Further, experiences such as sexual abuse are predictive of risk behavior beyond effects associated with transmission mode, age, or sexual orientation. Sexual abuse, highly prevalent among HIV-positive persons, . . . characterized nearly half of the adolescents infected behaviorally and one-tenth of those infected perinatally. Often associated with substance use and mental health sequelae, . . . sexual abuse can lead to risky sexual behaviors through a variety of cognitive, behavioral, and psychosocial mechanisms. . . . [A] history of sexual abuse may serve as a reasonable marker for adolescents in need of more focused secondary HIV prevention intervention.

. . . [Finally,] youth who are knowledgeable about HIV should not be presumed to be at low risk. Counseling must support skills building so that knowledge can be translated into risk-reduction practices. (p. 388)

Kershaw et al. (2010) studied “**relationship dissolution** among [a racially and ethnically diverse, clinic-based sample of] 295 parenting and non-parenting adolescents over an 18-month period and how it related to STD [sexually transmitted disease] incidence” (p. 454). The investigators found that

nonparenting adolescents in a relationship with someone other than their baby’s father were more likely to have a relationship dissolution over an 18-month period compared to those in a relationship with the baby’s father. . . . Parenting adolescents who ended their relationship with their baby’s father were 3 times more likely to get an STD over the course of the study compared to parenting adolescents who remained with their baby’s father (39% vs. 13%). Comparatively, non-parenting adolescents who ended their relationship were only 1.4 times more likely to get an STD compared to non-parenting adolescents who remained with their partner (44% vs. 32%). (p. 454)

Kershaw and colleagues observe that

despite negative characterizations of male partners of adolescent mothers as absent or distant, [these] results suggest that most of their baby’s fathers were with the adolescent mother during the prenatal and early postpartum period, and they were more likely to remain with their partner than male partners of non-parenting adolescent women. However, dissolution rates for parenting adolescents with their baby’s father increased during the late postpartum period and began to approach dissolution levels of non-parenting adolescents by the 18-month follow-up visit.

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... These results have important implications for both HIV prevention programs and programs aimed to strengthen families. It has been shown that women are motivated to make positive behavioral changes during the pre-natal and postnatal period in order to have a healthy baby (e.g., better nutrition, increased exercise, reduced substance intake ...). [These] results suggest that young couples may also be motivated to maintain their relationship to have a happy and healthy child. Programs that seek to strengthen relationships by teaching communication skills, building coping strategies, and providing support may capitalize on this motivation and create stronger[,] longer-lasting partnerships. In addition, the early post-partum period may be a window of opportunity to include male partners in prevention programs aimed to strengthen interpersonal relationships and reduce HIV/STD risk behavior. ... There are several intervention programs that have been shown to successfully increase father involvement and strengthen relationships during the transition to parenting for adult populations. ... The adaptation of these programs for adolescents is needed. (p. 462)

Of course, the investigators “are not suggesting that all relationships can and should survive; however, programs could be created that develop skills to help couples adjust during stressful transitions such as parenting” (p. 464).

About Women & Men

“Guided by a modified information-motivation-behavioral [(IMB)] skills model,” Nöstlinger et al. (2010), writing for the Swiss HIV Cohort Study Group and the Eurosupport 5 Study Group, “identified predictors of **condom use among heterosexual**

people living with HIV with their steady partners” (p. 771). The IMB skills model

assumes that three factors essentially influence HIV preventive behavior: (1) information relating to HIV preventive behavior, (2) motivation to perform HIV preventive behavior, and (3) behavioral skills needed to perform the behavior. ... Qualitative research, undertaken prior to this study, was used to modify the IMB-model by adding factors theorized to determine condom use among [people living with HIV]. ... Based on these findings[,] HIV-specific variables (partners' HIV status, HIV disclosure, mental health and social support) were included in the model. (p. 772)

Survey questionnaires were completed anonymously by a convenience sample of 651 participants (44% male, 56% female) at 14 European HIV outpatient clinics. The investigators found that 59% of men and 63% of women “reported at least one sexual encounter with a steady partner 6 months prior to the survey,” and 59% of these men and 51% of these women “used condoms consistently with that partner” (p. 771). Additionally,

in both genders, condom use was positively associated with [a] subjective norm conducive to condom use [i.e., perceived social pressure to use condoms], and self-efficacy to use condoms. Having a partner whose HIV status was positive or unknown reduced condom use. In men, higher education and knowledge about condom use additionally increased condom use, while the use of erectile-enhancing medication decreased it. For women, HIV disclosure to partners additionally reduced the likelihood of condom use. Positive attitudes to

condom use and [a] subjective norm increased self-efficacy in both genders, however, a number of gender-related differences appeared to influence self-efficacy. (p. 771)

On this last point, the investigators found that “influences from social and cultural resources (i.e., [having] partner support and not having a migration background) were more relevant for women than for men in building self-efficacy. Men's self-efficacy, on the contrary, was influenced by aspects related to sexual and mental health” (p. 777), including having lower levels of anxiety, lower levels of depression, higher satisfaction with sexuality, and less self-perceived vulnerability.

With regard to intervention, Nöstlinger and colleagues urge clinicians to

work with their clients on facilitating and hindering factors of condom use. This should include focusing on subjective norm[s] and strengthening self-efficacy, and supporting [people living with HIV] in concrete planning on how to move from intentions to actions. However, this may mean different approaches for women and men, e.g., enhancing negotiation skills, partner support, and assertiveness for HIV-positive women, as well as working on sexual- and mental-health[-]related aspects in men. Couple counseling may offer an entry point here, as an opportunity to focus on managing protection behavior within the relationship, focusing on the couple's resources and strengths. Discussing individual perceptions of condom fit and feel may additionally increase the use of the diverse range of condoms available. ... Because facilitating factors can be multiple and complex[,] rather than singling out one specific risk

Tool Box

HIV Prevention 2011: Hits, Misses, & Hopes

"The HIV pandemic is likely to remain one of the major threats to global health, robbing millions around the world of the chance to lead healthy, productive lives. High-quality research is essential to assure a robust evidence-base to help national programmes select the most effective preventive interventions and implement them most strategically in appropriate populations."

— Hayes, Kapiga, Padian, McCormack, & Wasserheit, 2010, p. S91

Two recent biomedical research papers have set the HIV prevention world abuzz.

Grant et al. (2010) reported on the results of the multinational Preexposure Prophylaxis Initiative (iPrEx) trial, which demonstrated that

antiretroviral medications, specifically the combination of emtricitabine and tenofovir disoproxil fumarate (FTC-TDF, sold under the brand name Truvada®), taken orally on a daily basis by men and transgender women (born male) who have sex with men, can provide partial protection from HIV infection. The trial . . . was a placebo-controlled, double-blind, randomized trial involving 2,499 subjects in the Americas, South Africa, and Thailand. Of the 100 incident infections, 64 occurred in the placebo group and 36 in the FTC-TDF group, for an estimated efficacy of 44% with a 95% confidence interval of 15 to 63. In the FTC-TDF group, the study drug was pharmacologically detected in 51% of subjects who remained free of HIV infection but in only 9% of those who became infected. Thus, exposure to FTC-TDF was associated with a reduction in HIV acquisition, which supports the biologic plausibility of the primary result. (Michael, 2010, p. 2663)

Moreover, "pill use on 90% or more of days was recorded at 49% of visits on

behavior, a more comprehensive approach should allow for building on the couples' personal, cultural, and social resources to support them in improving their sexual health. (p. 778)

Golub, Walker, Longmire-Avital, Bimbi, and Parsons (2010) "examine[d] the role of **religious behav-**

which efficacy was 73%" (Grant et al., 2010, p. 2594); in other words, participants who adhered more closely to the drug regimen reduced their risk of contracting HIV even further. Importantly, all study participants "received a comprehensive package of prevention services" (Grant et al., 2010, p. 2597), including "HIV testing, risk-reduction counseling, condoms, and management of sexually transmitted infections [(STIs)]" (Grant et al., 2010, p. 2587).

These findings were reported shortly after those of Abdool Karim et al. (2010), who wrote on behalf of the Centre for the AIDS Program of Research in South Africa (CAPRISA) 004 Trial Group. These investigators conducted a double-blind, randomized controlled trial (RCT) involving 889 sexually active women. The study compared a 1% vaginal gel formulation of tenofovir with a placebo gel and was designed to assess the safety and effectiveness of tenofovir gel in preventing HIV infection among women. During 30 months of follow up, the investigators found that "tenofovir gel reduced HIV acquisition by an estimated 39% overall, and by 54% in women with high gel adherence" (p. 1168). Abdool Karim and colleagues concluded that "tenofovir gel could potentially fill an important HIV prevention gap, especially for women unable to successfully negotiate mutual monogamy or condom use" (p. 1168).

Think Local

The formulation and testing of pre-expo-

iors and beliefs, social support, and stress-related growth in predicting high-risk sexual behavior" (p. 1139) among 75 **transgender women**. The investigators report that

in a multivariate model, both social support and religious stress-related growth [e.g., '*Being a trans woman . . . I developed/*

sure prophylaxis (PrEP) and vaginal microbicides are two avenues of investigation that are contributing to an evolving comprehensive approach to HIV prevention in which "all appropriate interventions" are employed "to achieve maximum effect" (Hankins & de Zalduondo, 2010, p. S71). Additional intervention strategies – "including behaviour change programmes, sexually transmitted disease control, [male circumcision,] voluntary counselling and testing, harm reduction, prevention of mother-to-child transmission, blood safety, infection control in healthcare, structural interventions, and programmes for people living with HIV" (p. S71) – when used in combination and tailored to the epidemic at the local level, can contribute to HIV prevention efforts. This combination approach to HIV prevention was "inspired by the recognition that countries such as Uganda, Thailand, and Brazil had generated sharp, sustained declines in HIV incidence using an array of biomedical, behavioural, and structural approaches" (p. S71).

Not Quite There Yet

Focusing on behavior-change interventions more specifically, Ross (2010) presents a systematic review of evidence on the effectiveness of trials that included the sexual transmission/acquisition of HIV as an outcome. All nine RCTs were designed to reduce risky sexual behaviors and, by extension, HIV incidence; seven studies were conducted in Africa (four in Zimbabwe and one each in Uganda, Tanzania, and South Africa) and two in the Americas (one in Mexico and one in the United States). According to Ross, "five major intervention approaches . . . [were] used: community-wide sexual health education, adolescent sexual health interventions, interventions among groups most at risk, promotion of HIV testing and counseling, and interven-

increased my faith in God.' (pp. 1137-1138)] were significant negative predictors of unprotected anal sex, but religious behaviors and beliefs emerged as a significant positive predictor. The interaction between religious behaviors and beliefs and social support was also significant, and . . . analyses indicated that high-

tions among HIV-positive individuals. . . . Unfortunately, none of the nine behavioural randomized trials with HIV outcomes . . . [showed] a significant impact on HIV [incidence]" (p. S4).

In summarizing these disappointing findings, Hayes, Kapiga, Padian, McCormack, and Wasserheit (2010) point out that even though none of the interventions reduced HIV incidence, some trials showed

important effects on knowledge, attitudes, reported behaviour and STIs. A number of explanations are advanced [by Ross] for these disappointing results, including limitations in the delivery or intensity of interventions, limited follow-up time, the overriding influence of cultural norms and socioeconomic factors, inadequate power and a high intensity of intervention in control arms. The trial results emphasize the importance of biomedical endpoints in RCTs of behavioural interventions, because of the unreliability and bias associated with self-reported sexual behaviour. Detailed process evaluation and qualitative research are also critical to help interpret positive or negative results.

Areas for future research [according to Ross] include interventions targeting HIV-infected individuals (positive prevention); further work on effective counselling strategies for HIV-negative individuals accessing voluntary counselling and testing . . . services; interventions designed to reduce concurrent sexual partnerships; interventions among youth that address social norms and wider community influences; and approaches to help maintain risk reduction behaviours. (p. S84)

risk sex was least likely among individuals with high-levels of social support but low levels of religious behaviors and beliefs. (p. 1135)

Golub and colleagues believe that these

findings . . . have several impor-

Tailored to Fit

A recent paper on positive prevention comes from McKirnan, Tolou-Shams, and Courtenay-Quirk (2010), who "tested the efficacy of the **Treatment Advocacy Program (TAP)**, a 4-session, primary-care-based, individual counseling intervention led by HIV-positive MSM [men who have sex with men] '**peer advocates**' in reducing unprotected sex with HIV-negative or unknown partners (HIV transmission risk)" (p. 952).¹ As the investigators describe it,

the intervention consisted of four 60-90-min[ute] individual counseling sessions, 3-month "check-in" telephone calls, and 6- and 12-month coping follow-up counseling sessions. The comparison condition was a 12-month waitlist during which participants received standard HIV primary care at their respective clinics. Standard of care for HIV patients was very high at all three clinics in terms of quality of health care and available social supports. Assessments consisted of 45-min[ute] interviews in which an audio computer-assisted self-interviewing (ACASI) instrument was used at baseline, 6 months, and 12 months. . . .

Six ethnically diverse, HIV-positive MSM peer counselors (treatment advocates) delivered the intervention at the three clinic sites. Advocates' education levels varied from high school to postgraduate training, with ages ranging from 24 to 40 years. Treatment advocates . . . received 40 h[ou]r[s] of training on motivational interviewing and cognitive-behavioral

¹ "This trial was run in conjunction with a sister project testing a version of the TAP intervention for African American men and women with lower socioeconomic status (Raja, McKirnan, & Glick, 2007)" (McKirnan et al., 2010, p. 953).

tant implications for the development of HIV prevention interventions for transgender women. First, these data support the development of a 'strengths-based approach' to risk reduction for this population, which draws on the potential for social support – most likely in the form of peer support – to reduce sexual risk

techniques for sexual safety and HIV coping, nonjudgmental communication, confidentiality, research and counseling ethics, and referral resources. Ongoing supervision was provided via weekly meetings with doctoral- and master's-level licensed therapists. . . .

All counseling sessions were structured by a menu-driven PowerPoint program to maximize stimulus value, to create clear structure for protocol compliance, to individually tailor the sessions to the client, and, eventually, to facilitate program dissemination. . . . [The investigators] attempted to increase motivation by presenting risk reduction in the context of overall HIV coping. . . . Each module concluded with a specific behavioral planning exercise. The intervention comprised eight modules: Three were used during the initial three sessions. . . . During Session 4, the counselor and participant chose one of five "focus" modules. Advocates used structured exercises or probes within each module to "hyperlink" to tailored content within each module or to open one of the focus modules. The complete PowerPoint intervention materials are available at <http://www.uic.edu/depts/psch/tap/index.html>. (pp. 953-955)

Attending to Trending

According to McKirnan and colleagues (2010), "the use of peer advocates was intended to provide coping models and to decrease the isolation that may accompany an HIV diagnosis" (p. 953). The incorporation of peers into a mental health-focused HIV prevention model also reflects the evolving practice of task-shifting. "Task[-]shifting has been advocated as one strategy for address-

(Tool Box is continued on Page 6)

behavior. . . . Peer support theories . . . focus on the potential for reciprocal peer social support to reduce stigma and increase social acceptance and emotional well-being.

Second, these data underscore the importance of interventions that promote spirituality and per-

ceptions of religious stress-related growth. Interventions that focus on strengthening spiritual components of the self have been successful in the treatment of addiction, and have been demonstrated to be associated with decreased HIV risk behavior (Margolin, Beitel, Schuman-Olivier, & Avants, 2006; summarized in the [Winter 2007](#) issue of *mental healthAIDS*). And

third, these data suggest the importance of community-level interventions that educate religious institutions about the transgender community. Improving the ability of religious beliefs and behaviors to act as facilitators of risk reduction – rather than as barriers to it – is critical to the long-term health and well-being of transgender women. (pp. 1141-1142)

Expanding on an earlier study (Otto-Salaj et al., 2008), summarized in the [Fall 2008](#) issue of *mental healthAIDS*, Otto-Salaj et al. (2010) described “**responses of 172 single heterosexual African American men, ages 18 to 35 [years], to condom negotiation attempts.** Strategies used included reward, coercive, legitimate, expert, referent, and informational strategies, based on Raven’s (1992) influence

(Tool Box -- continued from Page 5)

ing the health care worker shortages impeding scaling up of ART [antiretroviral therapy] programs in resource-constrained settings. . . . The World Health Organization (WHO) guidelines advocate task-shifting from physicians and nurses to community health workers, including [people living with HIV/AIDS], to provide HIV services at the community level” (Selke et al., 2010, p. 483).

“With the shortage of health care providers [in low- to middle-income countries], task sharing and shifting becomes essential in the delivery of services and care” (Relf et al., 2011, p. e16), including the provision of mental health services. As an example, Patel et al. (2010) report on “the effectiveness of an intervention led by lay health counsellors in primary care settings to improve outcomes” (p. 2086) of persons with depressive and anxiety disorders in Goa, India. “The collaborative stepped-care intervention offered case management and psychosocial interventions, provided by a trained lay health counsellor, supplemented by antidepressant drugs by the primary care physician and supervision by a mental health specialist” (p. 2086); this intervention was compared to care as usual in a cluster randomized trial in which 12 public and 12 private facilities were randomized equally between the intervention and control conditions. The investigators found that study participants with confirmed depressive and anxiety disorders “in the intervention group were more likely to have recovered at 6 months than were those in the control group. . . . The intervention had strong evidence of an effect in public facility attenders . . . but no evidence for an effect in private facility attenders”

(p. 2086). According to Patel and colleagues, these findings “indicate the effectiveness of a lay health counsellor-led collaborative stepped-care intervention for common mental disorders in public primary health-care facility attenders in India. This evidence should be used to improve services for common mental disorders in settings for which mental health professionals are scarce” (p. 2094).

Task-shifting is not confined to the developing world. In the United States as well, task-shifting in the delivery of HIV-related services has been implemented as a cost-cutting measure. As readers may recall, task-shifting of HIV-related mental/behavioral health intervention activities to paraprofessional counselors (Dilley et al., 2007; highlighted in the [Summer 2007](#) issue of *mental healthAIDS*) and peer outreach workers (Naar-King, Outlaw, Green-Jones, Wright, & Parsons, 2009; highlighted in the [Fall 2009](#) issue of *mental healthAIDS*) has been evaluated favorably.

Peering into the Future

Returning to the study on TAP (see p. 5), in which interventions were delivered by HIV-positive MSM peer advocates, McKirnan and colleagues (2010) “randomized 313 HIV-positive MSM to TAP or standard care. HIV transmission risk was assessed at baseline, 6 months, and 12 months (251 participants completed all study waves)” (p. 952).² “At study completion,” the investigators found that “TAP participants reported greater transmission risk reduction than did those re-

² Although Ross (2010) stresses the importance of biomedical outcomes when quantifying the impact of HIV prevention interventions, measures of self-reported sexual behavior continue to be utilized much more frequently by investigators.

ceiving standard care. . . . Transmission risk among TAP participants decreased from 34% at baseline to about 20% at both 6 and 12 months. Transmission risk ranged from 23% to 25% among comparison participants” (p. 952).

Expanding on these findings, McKirnan and colleagues suggest that this “counseling intervention for sexual safety and general coping among MSM infected with HIV” (p. 953)

provided promising evidence that a peer-led, computerized, and tailored intervention for HIV-positive MSM may reduce HIV transmission behaviors. Intervention effects were partially mediated by a decrease in drug abuse and an increase in self-efficacy for sexual safety, suggesting two important foci for further development of the intervention. These effects were not simply a matter of lessened overall sexual activity and, by being more pronounced for actual transmission risk, suggested that participants were specifically modifying their most risky behaviors. (p. 959)

The developers acknowledged that

the resources . . . devoted to training and supervision [within this program] may exceed those available in many community or primary care settings. This may limit potential dissemination. However, the computer format can be easily disseminated and tailored to specific settings or populations . . . , and the counseling approaches . . . used are standard in any clinical or counseling psychology training program. Thus, university or medical school collaborations may provide a mechanism for pro-

model.¹ The purpose was (a) to identify strategies influencing participant

¹ Otto-Salaj and colleagues (2008) describe the Power/Interaction Model of Interpersonal Influence (Raven, 1992) as follows: "Raven proposes six bases of power from which people derive strategies attempting to influence the behavior of others: (a) reward; (b) coercion; (c) legitimate; (d) expert; (e) referent; and (f) information. According to Raven, *coercive* and *reward power* can refer to real physical threats and tangible rewards, but they also can include personal rejection or approval. *Legitimate power* is derived from the structural

acquiescence to request and (b) to identify predictors of participant compliance/refusal to comply with negotiation attempts" (p. 539). In this study,

relationship between the influencing agent and the target; the agent may implicitly or explicitly communicate that she or he has a 'right' to ask the target to engage in some behavior, and that the target has an obligation to comply. *Expert power* is acting on the assumption that the power-holder is 'correct,' while *referent power* refers to engaging in a behavior

participants viewed six videotape segments showing an actress, portrayed in silhouette, speaking to the viewer as a "steady partner." After each segment, participants completed measures of request compliance, positive and

because of a sense of connection or relationship with the influencing agent. Finally, *informational power* is based on the logical argument that the influencing agent can present, either directly or indirectly, to the target in order to implement change" (p. 152).

gram implementation in even resource-poor community settings. Further, the National Institutes of Health, the CDC, and a variety of private funding agencies emphasize "technology transfer" or "capacity building" as core funding areas. (p. 960)

McKirnan and colleagues add that they

attempted to integrate a treatment advocate session with each primary care visit[, but] . . . found this approach to take substantial clinic cooperation, and many men had moved toward a biannual or even annual primary care visit schedule, which may be too sparse for HIV prevention needs. As a consequence, most follow-up visits were "free-standing" rather than part of a primary care visit, and [the investigators] could not test the efficacy of true integration of prevention into primary care. Although primary care is an important venue for prevention, community recruitment and follow-up may be important adjuncts for broader scale secondary prevention. (p. 960)

Although the investigators appropriately point up "limitations both to [the] findings and, potentially, to this intervention approach" (p. 960), they conclude that "TAP reduced transmission risk among HIV-positive MSM, although results are modest. Many participants and peer advocates commented favorably on the computer structure of the program. [McKirnan and colleagues] feel that the key elements of TAP – computer-based and individually tailored session content, delivered by peers, in the primary care setting – warrant further exploration" (p. 952).

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— Compiled by
Abraham Feingold, Psy.D.

negative affect, and attributions concerning the model and themselves. No significant differences were found in men's ratings across all vignettes. However, differences in response existed across subgroups of individuals, suggesting that, although the strategy used had little impact on participant response, the act of suggesting condom use produced responses that differed across participant subgroups. Subgroups differed on levels of AIDS risk knowledge, [STD] history, and experience with sexual coercion. Also, the "least willing to use" subgroup was highest in anger-rejection and least likely to make attributions of caring for partner. (p. 539)

Otto-Salaj and colleagues conclude that "effective negotiation of condom use with a male sexual partner may not be determined as much by specific strategy used as by partner characteristics" (p. 539) and that

when including condom use negotiation components in HIV risk-reduction programs, using a "one size fits all" approach in advocating use of negotiation strategies – no matter what the strategy – may not be as efficacious in promoting behavior change as using a repertoire of several different negotiation tactics and taking into account partner characteristics and relationship context in choice of strategies to use. Providing a "menu of options" may be key in facilitating successful adoption and use of strategies appropriate for specific relationships. Further, additional research is recommended on the specific characteristics of partners that predict strategy efficacy and the effects of relationship context on strategy use and efficacy of specific strategies. (p. 549)

About Women

Teti, Bowleg, and Lloyd (2010) examined data from a subsample of 26 women from among the 184 who participated in "*Protect and Respect . . .*, a safer-sex intervention for women living with HIV/AIDS (WLH/A)" (p. 205), described in the [Fall 2010](#) issue of *mental health AIDS*. Participants were predominantly low-income, African American women who acquired HIV through heterosexual intercourse; these women "discussed their experiences of social discrimination and the **impact of discrimination** on their lives, psychological well-being, and risk behaviors during group intervention sessions" (p. 205). The investigators found that "social discrimination manifested in the women's lives as poverty, HIV/AIDS-related stigma, and gender inequality. These experiences caused intense psychological distress and limited WLH/A's ability to implement the safer-sex skills that they learned during the intervention" (p. 205).

Teti and colleagues reason that

women cannot use the HIV disclosure skills that they learn in an intervention if they are too afraid to talk about their HIV status with their partners. [This] study indicates that the most promising safer-sex interventions for WLH/A will be those that address women's behavioral prevention needs as well as the sociocultural contexts and experiences of women's lives that affect their well-being and risk behavior. In this analysis, these experiences included challenges such as poverty, HIV/AIDS stigma, and emotionally abusive and violent relationships. Thus, effective HIV-prevention programs for women might have the following components: information about resources in the community that could address their immediate resource needs like

housing or financial assistance; discussions about how to increase their general skills and education; links to case management and other community services; individual and group dialogue to discuss and process their experiences with discrimination, how it affects them, and how to manage those feelings; help identifying abusive relationships; and links to help when participants are ready to leave abusive relationships. Group story-sharing formats may be particularly appropriate spaces for women to share their challenging experiences and brainstorm solutions together, enhancing women's social support and facilitating their confidence and empowerment.

Of course, these remedies, although important, still focus on the individual. In addition to individual and behavioral interventions, sociostructural interventions such as housing programs, economic empowerment, community-level anti-HIV/AIDS-stigma campaigns, and violence prevention interventions are also valid and essential HIV-prevention strategies for WLH/A. . . .

More than 25 years into the HIV/AIDS epidemic, designing interventions to respond to the complex sociostructural context of women's sexual risk behaviors remains a prevention challenge. (p. 216)

About Men Who Have Sex With Men

In Southern California, Gorbach et al. (2011) assessed **behavior change** among 193 men who have sex with men (MSM) **during the first year following their diagnosis with HIV**. Study participants were largely white, well educated, and over 30 years of age. The investigators found that "transmission behaviors

. . . decreased and serosorting [choosing partners who are also living with HIV] increased after diagnosis . . . [but] recent [unprotected anal intercourse] with serostatus unknown or negative partners rebounded after 9 months. . . . There was no evidence in this cohort that the viral load of these recently infected men guided their decisions about protected or unprotected anal intercourse" (p. 176). Moreover, "at baseline, just over one third of the men reported using methamphetamine with a partner at last sex and continually during the year of follow-up with the percentage remaining remarkably stable. For HIV-infected men, this suggests that they are not accessing adequate treatment for substance use, illustrating the need for better treatment and services for this problem amongst HIV-infected men" (p. 180). Gorbach and colleagues conclude that these results "highlight the importance of the first 6 months after diagnosis as a time when behavior change occurs. It also suggests a need for programs to support the maintenance of such changes after this window of opportunity and particularly after 9 months of follow-up. The choices made by these potentially highly infectious men about the type of sex they practice and with whom they practice it affects their likelihood of transmitting to others" (p. 180).

On the matter of employing viral load measurements to guide decisions around condom use, Hallett, Smit, Garnett, and de Wolf (2011) used observational cohort data from the Netherlands and mathematical modeling techniques to estimate "how the **risk of HIV transmission** from homosexual men receiving antiretroviral treatment is **related to patterns of patient monitoring and condom use**" (p. 17). "The model incorporates viral load trends during first-line treatment, patient monitoring and different scenarios for the way in

which condom use may depend on recent viral load measurements. The model does not include the effect of [STIs] on HIV transmission" (p. 17).

Hallett and colleagues discerned that "for MSM receiving treatment, the risk of transmitting HIV to their long-term partner is 22% (uncertainty interval: 9-37%) if condoms are never used. With incomplete use (in 30% of sex acts) the risk is reduced slightly, to 17% (7-29%). However, the risk is as low as 3% (0.2-8%) when men receiving treatment use condoms only 6 months beyond their last undetectable viral load measurement. The risk is further reduced when 3 months is the time period beyond which condoms are used" (p. 17). The investigators point out that "compared with always using condoms, the viral-load-dependent strategy allows slightly more HIV transmission (2-3% vs 1%). However, as condoms are needed much less of the time (10% vs 100%), adherence to this strategy may be better" (p. 19).

Importantly, Hallett and colleagues emphasize that

the key message to patients should remain that always using condoms when receiving treatment is the best way to protect partners from the risk of HIV transmission. However, an additional message is that using condoms is most crucial when patients have not recently (within the past 3 months) had an undetectable viral load measurement. This message refines the intuitive association between successful treatment and reduced transmission . . . and could substantially improve protection for infected partners. This advice must be supported by frequent viral load monitoring (at least every 6 months, but preferably every 3 months) of all patients receiving treatment. (p. 20)

HIV Assessment News

HIV Counseling & Testing

"On November 29, 2010, the [U.S.] Food and Drug Administration (FDA) announced the approval of the **INSTI™ HIV-1 Antibody Test**, a new, single use rapid test for the detection of antibodies to . . . HIV-1 . . . in human venipuncture whole blood, fingerstick blood, or plasma specimens. The newly approved test provides results in as little as 60 seconds, in contrast to the six previously approved rapid HIV tests, which typically deliver results in about 10-20 minutes" (FDA, 2010b).

Psychiatric Assessment

DeLorenze, Satre, Quesenberry, Tsai, and Weisner (2010) "examined **mortality** among HIV-infected patients with private health insurance who received medical care in an integrated health plan, who had full access to psychiatric and [substance use] disorder services, and who had received diagnoses of psychiatric disorder and substance dependence or abuse by a clinician" (p. 711). The investigators found that

25.4% ($n = 2,472$) of the 9,751 study subjects had received a psychiatric diagnosis (81.1% had major depression, 17.1% had panic disorder, 14.2% had bipolar disorder, and 8.1% had anorexia/bulimia); and 25.5% ($n = 2,489$) had been diagnosed with [a] substance use disorder; 1,180 (12.1%) patients had received both psychiatric and substance diagnoses. In comparison to patients with neither a psychiatric diagnosis nor a [substance use] diagnosis, the highest risk of death [over the 12-year study period] was found among patients with dual psychiatric and substance use diagnoses who had no psychiatric treatment visits and no substance treatment. . . . Among dually diagnosed patients, receiving psychiatric and/or substance use disorder treat-

ment somewhat reduced the risk of death compared to patients with neither diagnosis. The lowest risks of death were observed among patients with a single diagnosis who had received corresponding treatment. (p. 705)

This reduction in mortality risk associated with psychiatric and substance use treatment provided to “single and dual diagnosed patients . . . remained statistically significant even after adjustment for age, race, immune status, HIV viral load, antiretroviral therapy [(ART)] use, and other potential confounders” (p. 709). “Study findings suggest that screening for psychiatric and substance problems at the initiation and during the course of HIV/AIDS treatment and providing psychiatric and substance use disorder treatment may extend life for these vulnerable patients” (p. 705).

HIV Treatment News

Medical Care

On November 10, 2010, the FDA

approved Egrifta (**tesamorelin**) to treat HIV patients with **lipodystrophy**, a condition in which excess fat develops in different areas of the body, most notably around the liver, stomach, and other abdominal organs. The condition is associated with many antiretroviral drugs used to treat HIV. Egrifta, the first FDA-approved treatment for lipodystrophy, is a growth hormone releasing factor . . . drug that is administered in a once-daily injection. . . . Whether Egrifta decreases the risk of cardiovascular disease or improves compliance with antiretroviral drugs has not been studied. . . . The most commonly reported side effects in the studies included joint pain (arthralgia), skin redness and rash at the injection site (erythema and pruritis), stomach pain, swelling, and muscle pain

(myalgia). Worsening blood sugar control occurred more often in patients treated with Egrifta than with placebo. (FDA, 2010a)

With a convenience sample of 25 children living with HIV and 25 uninfected children, all between 7 and 17 years of age and matched on age and gender, Chenneville et al. (2010) assessed relationships among **medical decisional capacity** (DC; i.e., “the ability to understand, appreciate, and make meaningful decisions about one’s health” [p. 1359]), intellectual ability, developmental stage, and social-emotional functioning. The investigators found that “while there is a significant correlation between intellectual functioning and understanding of disease-related information, there do not appear to be any significant differences in DC between children with HIV and those without despite lowered intellectual and adaptive functioning among children with HIV. Developmental stage, as opposed to age, appears to be a more important correlate of DC overall, while social-emotional functioning appears unrelated to this construct” (p. 1365).

“While policy and practice recommendations may be premature given that results reflect pilot data, this line of research clearly has important implications. From a legal standpoint, the results of this type of research, regardless of the direction of findings, have the potential to provide lawmakers with important data about the DC of minors to participate in a meaningful way in the medical decisions that affect their lives. Legally, the current presumption is that minors are not competent to participate in medical decision-making” (p. 1365). Although preliminary, findings from this study “suggest that children living with HIV have the capacity to meaningfully participate in their healthcare despite lower intellectual and adaptive functioning” (p. 1359).

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Neuropsychological Impairment

According to Clark, Cohen, Westbrook, Devlin, and Tashima (2010), **impaired facial emotion recognition abilities** have been identified in patient populations with frontostriatal dysfunction, which can occur in persons living with HIV. These investigators examined “facial emotion recognition in 50 nondemented HIV-seropositive adults and 50 control participants relative to their performance on a nonemotional landscape categorization control task. [The investigators] examined the relation of HIV-disease factors (nadir and current CD4 levels) to emotion recognition abilities and assessed the psychosocial impact of emotion recognition abnormalities” (p. 1127). Clark and colleagues found that “compared to control participants, HIV patients performed normally on the control task but demonstrated significant impairments in facial emotion recognition, specifically for fear. HIV patients reported greater psychosocial impairments, which correlated with increased emotion recognition difficulties. Lower current CD4 counts were associated with poorer anger recognition” (p. 1127). “Taken together, these data provide strong indication that HIV-associated neuropathological changes could be contributing to emotional processing problems among individuals with HIV” (p. 1133). Moreover, “the normal performance by HIV patients on the landscape task strengthens . . . interpretation of the specificity of the observed emotion recognition impairment in HIV” (p. 1133). Results from this study

also indicated that decreases in fear recognition demonstrated by HIV patients were significant even after controlling for increases in depression symptoms, . . . [although] depression symptoms contributed modestly to emotion recognition impair-

ments in HIV patients . . . [and appear] to have been limited mostly to reducing accuracy for facial expressions of disgust. . . . [S]uch findings are compelling, as they suggest that some of the emotion recognition difficulties experienced by individuals with HIV might be remediated with improved treatment of their symptoms of depression. (p. 1133)

Importantly, the investigators

observed that HIV patients reported significantly higher rates of interpersonal difficulties than control participants. Furthermore, interpersonal difficulties in the HIV group, but not in the [healthy control] group, were highly correlated with emotion recognition abilities. Specifically, greater difficulties in anger recognition in the HIV group were associated with higher reports of distress regarding the ability to maintain a sense of intimacy and social connectedness in significant relationships, suggesting that impairments in emotion recognition serve to increase psychosocial difficulties in HIV patients. . . . [These] findings have important implications for the assessment and treatment of HIV patients who are referred to psychotherapy, especially in the current era of HIV treatment in which individuals with HIV are living much longer with their disease as a result of improvements in antiretroviral medications. (p. 1134)

With regard to these medications, Clark and colleagues “observed a modest relation between facial emotion recognition abilities and current CD4 levels. This observation implies that an opportunity exists to improve emotion recognition abilities in some patients through improvements in HIV treatment” (p. 1135).

Adherence to Treatment

“Using outcome data from 603 participants enrolled in a randomized controlled trial of a behavioral intervention” (p. 146) designed to reduce the risk of HIV transmission, Carrico et al. (2011) examined whether “inconsistent patterns of ART utilization account for the effects of depression and stimulant use on higher HIV viral load” (p. 149) over a period of 25 months. The investigators found that

elevated affective symptoms of depression independently predicted ART discontinuation . . . , and use of stimulants at least weekly independently predicted intermittent ART utilization. . . . After controlling for the average self-reported percentage of ART doses taken and baseline . . . CD4+ . . . count, elevated depressive symptoms predicted a 50% higher mean viral load, and weekly stimulant use predicted a 137% higher mean viral load. These effects became nonsignificant after accounting for inconsistent patterns of ART utilization, providing evidence of partial mediation. (p. 146)

Carrico and colleagues conclude that these findings

indicate that adjuvant mental health and substance abuse treatment will be needed to promote sustained ART utilization, achieve viral suppression, and address HIV transmission risk behavior among individuals with psychiatric comorbidities. In the context of HIV medical care, this will require implementation of rapid screening tools for depression and substance abuse and efficient methods for linkage to mental health and/or substance abuse treatment. Although findings from the present study indicate that inconsistent ART utilization partially explains the ef-

fects of depression and stimulant use on higher HIV viral load, this does not rule out other plausible biological or behavioral pathways. . . . Future research should examine other plausible biobehavioral pathways that may partially account for the effects of these **psychiatric risk factors for HIV disease progression** to inform the development of more comprehensive intervention efforts aimed at optimizing health outcomes among HIV-positive persons. (pp. 149-150)

According to Tsai et al. (2010), “previous longitudinal observational analyses have inadequately adjusted for time-varying confounding by depression severity, which could yield biased estimates of treatment effect” (p. 1282) when **antidepressants** are used to address depressive symptoms and potentially **improve adherence to ART** among persons living with HIV. “Application of marginal structural modeling to longitudinal observation data can, under certain assumptions, approximate the findings of a randomized controlled trial” (p. 1282); for this reason, the investigators “fit a marginal structural model to data from a longitudinal cohort of [158] homeless and marginally housed persons with HIV to estimate the effect of treatment with antidepressant medications on ART adherence and viral suppression” (p. 1283). The investigators found that “antidepressant medication treatment resulted in a 2-fold greater probability of achieving viral suppression” (p. 1288) in this cohort. “In supplemental analyses, [Tsai and colleagues] found evidence of improved adherence along a continuum of HIV care: antidepressant medication treatment increased the probability of ART uptake nearly 4-fold and also resulted in a 25-percentage point increase in self-reported ART adherence and a nearly 2-fold-increased probability of achieving complete adherence”

(p. 1286). Tsai and colleagues conclude that “antidepressant medication treatment increases viral suppression among persons with HIV. This effect is likely attributable to improved adherence to a continuum of HIV care, including increased uptake and adherence to [ART]” (p. 1282). Importantly, the investigators stress that “even though [these] estimates have a causal interpretation under certain assumptions, randomized controlled trial evidence is needed to definitively conclude that pharmacologic treatment of depression has beneficial effects on HIV treatment adherence and HIV treatment outcomes” (p. 1287).

In another prospective investigation, Bottonari, Safren, McQuaid, Hsiao, and Roberts (2010) “sought to examine the **impact of life stress** (acute life events, chronic stress, and perceived stress), **depression, and coping style on adherence to HIV treatment regime[n]s over time**” (p. 486). Bottonari and colleagues interviewed and administered questionnaires at baseline and again at 3 months to 87 treatment-seeking individuals living with HIV who were receiving care in an urban HIV clinic. The investigators found that “acute life events and chronic stress prospectively predicted decreases in treatment adherence more strongly among individuals in a major depressive episode ($n = 21$) compared to non-depressed individuals ($n = 66$). Coping style did not appear to be the mechanism by which life stress influenced adherence among depressed HIV-infected individuals” (p. 486).

These findings, among others, can help clinicians to anticipate “both who is more likely to experience adherence lapses and when those lapses will occur. . . . [S]tudies suggest that depression-prone HIV-infected patients are at greater risk for problematic adherence, but that

Tool Box

Resources

Albarracín, D., Tannenbaum, M.B., Glasman, L.R., & Rothman, A.J. (Eds.). (2010). Modeling the interplay of individual, interpersonal, and structural level factors in HIV diagnosis, prevention, and treatment. *AIDS & Behavior*, 14(Suppl. 2), S185-S249.

“In this supplement . . . , three teams of experts in HIV behavioral research present theoretical frameworks that address each of the three levels of influences on HIV-related behavior and examine its relation to each of the other levels. In this paper, we summarize and compare the frameworks and present a model that highlights the dynamics of the relations between the structural and individual levels of influences and their implications for interventions in the HIV domain” (pp. S239-S240).

Anand, P., Springer, S.A., Copenhaver, M.M., & Altice, F.L. (2010). Neurocognitive impairment and HIV risk factors: A reciprocal relationship [Review]. *AIDS & Behavior*, 14(6), 1213-1226.

“The impact of HIV and several cofactors, including substance abuse and mental illness, on cognitive function is discussed in the context of HIV risk behaviors, medication adherence, and risk-reduction interventions. . . . Not only do increased risk behaviors and sub-optimal adherence exacerbate cognitive impairment, but cognitive impairment also reduces the effectiveness of interventions aimed at optimizing medication adherence and reducing risk. . . . [T]o be effective, risk-reduction interventions must therefore take into account the impact of cognitive impairment on learning and behavior” (p. 1213).

Buvé, A., Kapiga, S., & Hayes, R. (Eds.). (2010). HIV prevention – Where are we now? *AIDS*, 24(Suppl. 4), S1-S92.

“The main objective of this special journal supplement is to review the

particular lapses in adherence will likely occur in the context of life stress. In other words, while practitioners need to be attentive to adherence issues among their depressed patients, they should be most focused on difficulties that may arise when these patients are con-

evidence base on . . . different approaches to prevention of sexual transmission of HIV among adults. Following [an] introductory note, . . . seven review articles . . . discuss the following . . . areas of HIV prevention research: 1) Behavioural interventions; 2) STI [sexually transmitted infection] control for HIV prevention; 3) use of ART [antiretroviral therapy] for HIV prevention; 4) topical microbicides; 5) HIV vaccines; 6) male circumcision; [and] 7) combination prevention. . . . The final article . . . draws together some of the key messages from the seven review articles and . . . discuss[es] what we should be doing the same and what we should be doing differently in the years to come” (p. S3).

Card, J.J., Solomon, J., & Cunningham, S.D. (2011). How to adapt effective programs for use in new contexts. *Health Promotion Practice*, 12(1), 25-35.

“This article details a set of science-based pragmatic steps in adapting an existing, empirically validated intervention to better suit a new context, while preserving what made – or is believed to have made – it effective in the first place. Although its examples are drawn from the HIV prevention and care field, its principles and methods are extendable to the adaptation of other effective health promotion and disease prevention interventions” (p. 26).

Cysique, L.A., Murray, J.M., Dunbar, M., Jeyakumar, V., & Brew, B.J. (2010). A screening algorithm for HIV-associated neurocognitive disorders. *HIV Medicine*, 11(10), 642-649.

“HIV physicians have limited time for cognitive screening. Here we developed an extra-brief, clinically based tool for predicting HIV-associated neurocognitive impairment (HAND) in order to determine which HIV-positive individuals require a more comprehensive neurological/neuropsychological (NP) assessment. . . . The final algorithm uti-

fronted with life stress” (p. 493). Conversely, because “life stress has a relatively stronger effect on treatment adherence when HIV-infected individuals are depressed compared to when they are psychologically well,” Bottonari and colleagues emphasize that “providers must strive

lized age, current CD4 cell count, past central nervous system HIV-related diseases and current treatment duration and required approximately 3 min[utes] to complete, with a good overall prediction accuracy of 78% (against the gold standard; NP-impairment status derived from standard NP testing) and a good specificity of 70%. . . . This noncognitive-based algorithm should prove useful to identify HIV-infected patients with advanced disease at high risk of HAND who require more formal assessment. We propose staged guidelines, using the algorithm, for improved HAND therapeutic management . . . [and] recommend the use of this first version for HIV-infected Caucasian men with advanced disease” (p. 642).

Daniels, J., Crum, M., Ramaswamy, M., & Freudenberg, N. (2011). Creating REAL MEN: Description of an intervention to reduce drug use, HIV risk, and rearrest among young men returning to urban communities from jail. *Health Promotion Practice, 12*(1), 44-54. “Investigators designed the Returning Educated African American and Latino Men to Enriched Neighborhoods (REAL MEN) program, a jail and community program to reduce drug use, HIV risk, and rearrest. By helping participants examine alternative paths to manhood and consider racial/ethnic pride as a source of strength, REAL MEN addressed the assets of these young men as well as their challenges” (p. 44).

Dawson Rose, C., Gutin, S.A., & Reyes, M. (2011). Adapting positive prevention interventions for international settings: Applying U.S. evidence to epidemics in developing countries. *Journal of the Association of Nurses in AIDS Care, 22*(1), 38-52.

“HIV prevention efforts with people living with HIV are critical, and positive prevention . . . interventions have expanded globally to address this growing need. This article provides an overview of U.S.

[positive prevention] literature addressing evidence-based interventions. . . . The research suggests that the lessons learned from these U.S.-developed interventions can be modified to develop theoretically sound interventions. These interventions must be culturally specific and include a collaborative approach for best results” (p. 38).

Dolcini, M.M., Gandelman, A.A., Vogan, S.A., Kong, C., Leak, T.-N., King, A.J., DeSantis, L., & O’Leary, A. (2010). Translating HIV interventions into practice: Community-based organizations’ experiences with the diffusion of effective behavioral interventions (DEBIs). *Social Science & Medicine, 71*(10), 1839-1846. “Guided by the ADAPT framework,¹ we examined agencies’ assessment, preparation, and implementation of interventions. Our qualitative interview-based study focused on six community-based agencies in California (United States) funded to implement three group-level HIV interventions. Findings showed considerable variation in the extent to which agencies engaged in assessment and broad-based preparation and in the ease with which agencies implemented the interventions. The findings provide insight into the process that agencies undergo in the translation of effective behavioral interventions and illustrate how agencies can inform logic models that guide translation. We also identify relevant dimensions of existing models . . . that have value for agencies that are translating research to practice” (p. 1839).

¹ “The ADAPT framework is a logic model describing the steps involved in the adoption, adaptation, and implementation of a behavioral intervention. . . . [It] was designed to provide a comprehensive view of the steps involved in organizations’ adoption of innovative programs” (Dolcini et al., 2010, p. 1840). For more information on the ADAPT framework, see the **Tool Box** entitled “Tailoring Evidence-Based HIV Behavioral Risk-Reduction Interventions to Local Capacity & Target Audience Characteristics” in the [Summer 2007](#) issue of *mental health AIDS*.

El-Sadr, W.M., Mayer, K.H., & Adimora, A.A. (Eds.). (2010). The HIV epidemic in the United States: A time for action. *Journal of Acquired Immune Deficiency Syndromes, 55*(Suppl. 2), S63-S150. “The articles included in this supplement focus on some of the populations who have been most heavily impacted by the domestic HIV epidemic, including disenfranchised women of color, men who have sex with men, transgender persons, and substance users. . . . The underlying theme is that HIV is spread in diverse communities, influenced by multiple biological, behavioral, cultural, societal, economic, and structural factors, and that curbing the epidemic will require an extensive variety of tactics carefully titrated to the needs of communities and individuals.

The newly released National HIV/AIDS Strategic Plan, the first in the history of the epidemic in the United States, offers a fitting framework for action. This supplement . . . is an attempt at articulating a path ahead” (p. S63).

Fair, C.D., Sullivan, K., & Gatto, A. (2010). Best practices in transitioning youth with HIV: Perspectives of pediatric and adult infectious disease care providers. *Psychology, Health & Medicine, 15*(5), 515-527.

“Perinatally and behaviorally infected teens will ultimately need to transition to adult infectious disease care. The current study offers insight into transition best practices as defined by those with expertise in the field” (p. 525). “Findings indicate that promoting medical independence among adolescents, close communication between pediatric and adult providers, and addressing system[-]level concerns, including helping patients’ families navigate health insurance and other social services, as well as having a separate clinic for adolescents with HIV, constitute best practices for transitioning youth with HIV from pe-

(Tool Box is continued on Page 14)

to improve identification of clinically significant depression and high levels of stress among their patients in order to further improve treatment adherence intervention efforts” (p. 494). “These findings demonstrate that life stress has toxic effects for depressed individuals and

suggest that treatment adherence interventions with depressed individuals could be enhanced via development of stress management skills” (p. 486). Fortunately, some “psychological interventions to increase adherence have been designed to reduce depression and to increase

general stress management skills (e.g., Safren et al., 2009[; summarized in the [Fall 2010](#) issue of *mental health AIDS*])” (p. 493).

Stress Management

On the subject of stress, Brincks, Feaster, and Mitrani (2010) investi-

(Tool Box -- continued from Page 13)

diatric to adult care" (p. 515). These findings "are descriptive in nature and not linked with empirical outcomes. However, they . . . offer providers a point of comparison for their clinics' practices" (p. 525).

Freudenreich, O., Goforth, H.W., Cozza, K.L., Mimiaga, M.J., Safren, S.A., Bachmann, G., & Cohen, M.A. (2010). Psychiatric treatment of persons with HIV/AIDS: An HIV-Psychiatry Consensus Survey of current practices. *Psychosomatics*, 51(6), 480-488.

"Only sparse evidence from controlled clinical trials is available to guide the psychiatric treatment of persons with HIV/AIDS. . . . The authors assessed and determined current treatment trends in AIDS psychiatry. . . . Members of the Organization of AIDS Psychiatry (OAP) participated in a web-based survey. . . . Of 159 members, 62 (39%) responded to the survey. Consensus emerged regarding first-line treatment for depression (escitalopram/citalopram), for psychosis and secondary mania (quetiapine), and for anxiety (clonazepam). . . . Consensus statements can serve as a preliminary step toward providing some standardization of care for persons with HIV/AIDS" (p. 480).

Halkitis, P.N. (2010). Reframing HIV prevention for gay men in the United States. *American Psychologist*, 65(8), 752-763. "We must enact an innovative and proactive vision and framework for HIV prevention that moves us beyond the undertakings rooted in social-cognitive paradigms that have informed this work for the past 25 years. A new framework for HIV prevention must give voice to gay men; must consider the totality of their lives; must delineate the underlying

logic, which directs their relation to sex and HIV; and must concurrently respect their diverse life experiences. This approach should be rooted in a biopsychosocial paradigm, should be informed by both theory and practice, and should be directed by three theoretical lenses – a theory of syndemics,² developmental theories, and contextual understandings of HIV disease. Taken together, these elements are a call to action for research and practice psychologists who are working to improve the lives of gay men" (p. 752).

Jimenez, J.C., Puig, M., Ramos, J.C., Morales, M., Asencio, G., Sala, A.C., Castro, E., Vélez Santori, C., Santiago, L., & Zorrilla, C. (2010). Measuring HIV felt stigma: A culturally adapted scale targeting PLWHA in Puerto Rico. *AIDS Care*, 22(11), 1314-1322.

"The objective of this study was to culturally adapt and validate a scale to measure HIV-related felt stigma in a group of people living with HIV/AIDS (PLWHA) in Puerto Rico. . . . [The] 17-item . . . *HIV Felt-Stigma Scale (HFSS)* . . . measures four dimensions: *personalized stigma*, *disclosure concerns*, *negative self-image*, and *concern with public attitudes*" (p. 1314). "Mental health professionals can use it to identify stigmatized individuals in order to anticipate future HIV-related mental health problems. The culturally sensitive and validated *HFSS* . . . fills a gap that existed in assessing felt stigma in Spanish-speaking PLWHA. The next step is to test it on other Spanish-speaking populations of PLWHA in the USA" (pp. 1320-1321).

² For more information on the term "syndemic," see the **Tool Box** entitled "SAVA Latina: Addressing the Interplay of Substance Abuse, Violence, & AIDS Affecting Hispanic Women (Part 1)" in the [Spring 2009](#) issue of *mental health AIDS*.

Maturo, D., Powell, A., Major-Wilson, H., Sanchez, K., De Santis, J.P., & Friedman, L.B. (2011). Development of a protocol for transitioning adolescents with HIV infection to adult care. *Journal of Pediatric Health Care*, 25(1), 16-23.

"An identified gap in the literature is that no studies to date have examined the unique transitioning needs of adolescents who were infected with HIV during the adolescent period. The purpose of this article is to address this gap in the literature by describing the development and implementation of a transitioning protocol for adolescents who were infected with HIV during adolescence in a University-based, multidisciplinary, family-centered adolescent clinic" (p. 17).

Reich, W.A., & Ahn, E.K. (2010). Interpersonal concordance in HIV-affected families participating in a structured conflict management intervention. *Journal of HIV/AIDS & Social Services*, 9(2), 153-168.

"A process model guided a qualitative study of a 10-week multifamily conflict management intervention, Family Pride. A central construct is interpersonal concordance, defined as the consensus within a family on their views of self and one another. Parent/caregivers and children described themselves and each other near the beginning and at the conclusion of this intervention. . . . A focused investigation of one family demonstrated a shift in their perceptions toward greater interpersonal concordance. Further analyses revealed a general shift toward more cooperative views of self and other family members, and toward greater interpersonal concordance" (p. 153).

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gated "a cross-sectional **stress and coping model for HIV-positive African-American mothers** recruited from HIV service facilities in South Florida ($n = 214$) and their family members ($n = 294$)" (p. 517). "The following hypotheses were tested: (1) avoidance coping significantly mediates the relationship between stress and psychological distress for individuals, and (2) . . . [the family average of individual] stress [levels]

moderates the relationship between avoidance coping and psychological distress for the individual such that higher use of avoidance coping is associated with greater psychological distress for individuals from families with high average stress" (p. 519).² "For all constructs, indi-

² "In the psychology literature, a distinction is often made between the situation in which A directly influences B (in which case, mediation is claimed) and that in which A influ-

viduals reported on themselves and multilevel modeling techniques were used to account for similarities between members of the same family" (p. 517).³

ences the association between B and O ([or Outcome,] in which case, moderation is claimed)" (Kraemer et al., 2001, p. 850).

³ "Because measures of all . . . variables were obtained from individuals, many of whom were members of the same family unit, the data are nested. Analyzing data that are nested

With regard to “whether avoidance coping behaviors and cognitions mediated the relationship between stress and psychological distress for African American women with HIV and their family members[,] . . . higher levels of stress were significantly associated with higher levels of both avoidance coping and psychological distress[; and h]igher levels of avoidance coping were significantly associated with higher levels of psychological distress” (pp. 523-524). As for

the second goal of this study[, which] was to investigate the role of mean [or average level of] family stress as a moderator in the relationship between avoidance coping and psychological distress[, t]he finding of significant moderation suggested that as the average stress level across all individuals within a family increased, so did the negative effect of avoidance coping on psychological distress. For individuals from families that reported higher average stress, the use of avoidance coping behaviors and cognitions are more detrimental to psychological well-being when compared with individuals from families that have lower average stress. Thus, heightened stress of one family member can increase overall family stress and have a negative effect on the functioning of other family members. This finding also suggests that in families where stress is low, avoidance coping may not be such a harmful approach, but that avoidance coping by individuals in families with higher aggregate

requires the use of multilevel modeling to account for similarities or dependencies in the responses of individuals who come from the same family. . . . Multilevel analysis allows for accurate estimation of the person-level effects by appropriately handling the dependencies or similarities among responses from individuals from the same family” (Brincks et al., 2010, p. 521).

stress may be particularly problematic. (p. 525)

Brincks and colleagues suggest that

regardless of the precise process at work, the implication of this moderation effect for clinical practice with families affected by HIV/AIDS is that clinicians need to be cognizant of the patient’s stress within the context of the family. Individuals are affected not only by their own stresses and strains but also by those of others in their family, and, in essence, the problems of family members pile up on the individual.

These results support the need to address not only the HIV+ woman’s manner of coping with stress, but also the responses of family members as individuals, and as members of a system in which people affect each other. Persons living with HIV/AIDS and their family members face numerous challenges in their daily lives that can impact their health and emotional functioning. These problems are compounded among minority families who are disproportionately affected by HIV/AIDS, poverty, and the difficult social conditions of urban life. . . . Family-based interventions can assist families in resolving stresses and strains through . . . negotiation of disagreements, role-play for handling hassles with persons outside of the family, and increasing support among family members by highlighting their shared stresses and goals. These findings underscore the importance of helping families, particularly those who are experiencing high levels of stress, to develop skills for confronting rather than avoiding problems. The first step in this process is to engage families in attending family sessions. . . . In

high stress families, the therapist should strive for soothing encounters, and let the family know even before the first session that family meetings will be relaxed and aimed at reducing the tension associated with family conflicts. The therapist might emphasize themes of wellness, promoting a positive family environment, and family healing. . . . [The] negotiation of disagreements and role-play should likewise be relatively peaceful and interrupted when tension becomes too high. Recognizing and validating the family’s common worries and the hassles they confront can help to validate and normalize their reactions. The therapist might help family members describe how they react to stress so that others in the family can re-interpret negative behaviors as stress-related and offer support or at least not escalate disagreements. The family can also be assisted in anticipating difficult events such as an upcoming move, change in employment, an impending hospitalization, or drug abuse relapse, and developing a management plan. (pp. 525-526)

Coping, Social Support, & Quality of Life

According to Pyne et al. (2011), “in general adult primary care, **collaborative care for depression** is effective . . . and cost-effective. . . . Collaborative care models are based on the chronic care model, . . . facilitating collaboration between primary care and specialty mental health care providers to improve the quality of depression care and outcomes. Compared with referral specialty mental health care models, collaborative care allows patients to receive care in more accessible and less stigmatizing settings” (p. 23). In efforts “to support HIV and mental health clinicians in delivering evidence-based depression treatment”

(p. 25), Pyne and colleagues conducted

a single-blind randomized controlled effectiveness trial at 3 Veterans Affairs HIV clinics (**HIV Translating Initiatives for Depression Into Effective Solutions** [HITIDES]). The HITIDES intervention consisted of an off-site HIV depression care team (a registered nurse depression care manager [(DCM)], pharmacist, and psychiatrist) that delivered up to 12 months of collaborative care backed by a Web-based decision support system.⁴ Participants who completed the baseline telephone interview were

⁴ "The depression care team communicated with treating clinicians via electronic medical record progress notes. The DCM communicated with patients via telephone. The HITIDES depression care team made treatment suggestions. Treatment decisions were made by the HIV or mental health clinicians at each site.

The DCM delivered the following intervention components: participant education and activation, . . . assessment of treatment barriers and possible resolutions, depression symptom and treatment monitoring, substance abuse monitoring, and instruction in self-management (e.g., encouraging patients to exercise and participate in social activities). . . . The DCM used prewritten scripts, which are standardized instruments that were supported by the Web-based decision support system (NetDSS, available at <https://www.netdss.net>) during these telephone encounters.

The intervention used a stepped-care model for depression treatment. . . . The 5-step model included the following components plus DCM monitoring: (1) watchful waiting, (2) depression care team treatment suggestions (counseling or pharmacotherapy, considering participant preference), (3) pharmacotherapy suggestions after review of depression treatment history by the clinical pharmacist, (4) combination pharmacotherapy and specialty mental health counseling, and (5) referral to specialty mental health. . . . Although the depression care team did not suggest watchful waiting, patient/provider treatment negotiations could result in this approach. At any time, HIV health care providers were free to refer participants directly to specialty mental health care. The stepped-care model was used to increase treatment intensity when participants did not respond to treatment" (Pyne et al., 2011, p. 25).

249 HIV-infected patients with depression, of whom 123 were randomized to the intervention and 126 to usual care. Participant interview data were collected at baseline and at the 6- and 12-month follow-up visits. (p. 23)

The investigators found that "intervention participants were more likely to report treatment response (33.3% vs 17.5%) . . . and remission (22.0% vs 11.9%) . . . at 6 months but not 12 months. Intervention participants reported more depression-free days during the 12 months. . . . Significant intervention effects were observed for lowering HIV symptom severity at 6 months . . . and 12 months. . . . Intervention effects were not significant for other secondary outcomes," which included "health-related quality of life, health status, . . . and antidepressant or HIV medication regimen adherence" (p. 23).

Elaborating on these findings, the investigators observe that

improved depression response and remission outcomes at 6 but not 12 months suggests that depression symptoms improved more rapidly in the intervention group compared with the usual care group. By 12 months, usual care participants caught up with intervention participants in terms of response and remission rates. . . . Possible explanations include the following. First, the intervention was tested in settings where clinicians clearly accepted the need for improving depression recognition and treatment in the HIV clinic setting. Second, depression screening was completed on a hard copy form that most patients presented to their HIV clinician at every visit; therefore, over time, the HIV clinicians became more familiar with depression diagnosis and tracking treatment response. Third, DCM notes for intervention patients

resulted in HIV clinicians becoming more familiar with treatment options for all patients in the HIV clinic. (p. 28)

Pyne and colleagues conclude that "the HITIDES intervention improved depression and HIV symptom outcomes and may serve as a model for collaborative care interventions in HIV and other specialty physical health care settings where patients find their 'medical home'" (p. 23).

"Among men living with HIV, increased coping self-efficacy . . . following a cognitive behavioral intervention has been related to decreased distress, anxiety, anger, and confusion, but comparable studies had not been carried out with HIV+ women," according to Jones et al. (2010), who examined "the impact of changes in [self-efficacy] following a **cognitive behavioral stress management plus expressive supportive therapy** (CBSM+) intervention on depression and anxiety in low-income urban predominantly minority women living with AIDS" (p. 1499). Self-efficacy is defined by the investigators as "beliefs about one's capabilities and potential to meet situational demands," which influence "effort, perception of control, personal choices, thought patterns, depression, and perceived stress. . . . [Self-efficacy] refers to a personal judgment about a person's perceived ability to mobilize resources over events and has been related to both general and specific behaviors" (p. 1499).

In this study, 451 women living with AIDS "were randomized to a group CBSM+ or individual informational intervention condition and completed baseline, post-intervention and long-term follow-up (12 months) assessments of depression, anxiety and [self-efficacy]" (p. 1499). Jones and colleagues describe the 10-week manualized group therapy intervention as follows:

The Stress Management and Relaxation Training/Expressive-Supportive Therapy (SMART/EST) Women's Project was designed to respond to the unique experiences of minority women living with AIDS through culturally tailored training in stress management and the acquisition of more effective coping and problem-solving strategies, learning cognitive behavioral skills (e.g., re-framing stressors) to gain new perspectives, and developing effective ways to create and maintain social support systems. The intervention improves [self-efficacy] through teaching participants active- and emotion-focused (changing how one feels about the stressor) coping strategies (e.g., cognitive restructuring, relaxation exercises, and assertiveness). The expressive/supportive component ("+") encouraged participants to express feelings of depression, isolation, helplessness, and hopelessness . . . and to learn successful styles of adaptive coping (changing to respond to the stressor) employed by other group members. (p. 1500)

The investigators found that

women who were assigned to the CBSM+ group condition and increased their level of cognitive behavioral [self-efficacy] [i.e., "(self-efficacy) to combat AIDS, for cognitive behavioral skills, and for antiretroviral medication adherence" (p. 1502)] reported significant decreases in anxiety and depression at post-intervention and long-term follow-up in comparison with controls who did not improve. Results suggest that both cognitive behavioral skills and a concomitant increase in the perceived level of [self-efficacy] in the use of those skills are predictive of distress reduction. (p. 1499)

Focusing more specifically on women and their children, Mitrani, McCabe, Robinson, Weiss-Laxer, and Feaster (2010) present the findings of a sub-sample analysis "from a randomized trial to examine whether **Structural Ecosystems Therapy** (SET), a family intervention intended to improve medication adherence and reduce drug relapse of . . . HIV+ . . . women recovering from drug abuse, provided benefits for families with children" (p. 746). As readers may recall, "SET was developed in recognition of the central role that families play in the lives of HIV+ women, and the potential to improve the women's well[-]being by correcting problematic and stress-inducing interactions as well as facilitating supportive interactions. The majority of women with HIV are mothers who are raising children, and these children are vulnerable to mental health and behavioral problems. The purpose of this sub-sample analysis was to examine whether both mothers and children could benefit from SET" (pp. 752-753).⁵

According to Mitrani and colleagues, data from the original randomized trial (Feaster et al., 2010) "had mixed results," in that "women in SET did not experience better drug use or medication adherence outcomes as compared to those in a Health Group (HG) control condition, but did show improvement in CD4 T-cell count and in theoretical mechanisms of action on drug relapse[.] including accessing substance abuse services in response to relapse and separating from drug-using household members" (p. 747). In this sub-sample analysis, data from a convenience sample of

42 children and 25 mothers were analyzed at baseline, and 4, 8,

⁵ For more information on SET, presented in connection with a secondary analysis of data from another randomized controlled trial conducted by this research group, see the [Summer 2010](#) issue of *mental health AIDS*.

and 12 months post-baseline. Results . . . suggested that SET was more efficacious than the . . . control condition in decreasing children's internalizing and externalizing problems and reducing mothers' psychological distress and drug relapse. Children in SET reported improvements in positive parenting as compared to the children in HG, but there were no differences in mother-reported positive parenting, or parental involvement as reported by either the children or mothers. These findings suggest that family interventions such as SET may be beneficial for mothers and children. An adaptation of SET specifically for families with children could further enhance benefits and improve acceptability and cost-effectiveness. (p. 746)

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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.

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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