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 10, Issue 4 – Summer 2009

Biopsychosocial Update

HIV Prevention News

About Women & Men

In a small exploratory study, Orengo-Aguayo and Pérez-Jiménez (2009) interviewed each partner among five Puerto Rican HIV serodiscordant heterosexual couples to "explore how **relationship dynamics** and **gender constructs** influence how men and women involved in a . . . [sero]discordant . . . relationship . . . visualize their role[s] in the protection of their partners" (p. 30).[1]

Orengo-Aguayo and Pérez-Jiménez presented several

> key findings regarding gender roles: a) both non-traditional and traditional male and female gender roles were present in the participants[’] narratives and simultaneously manifested themselves throughout their behaviors and schemes, b) traditional male and female gender roles acted as barriers and as facilitators in the protection, and c) men tended to view attitudes and actions that reflect traditional male gender roles more as barriers in the protection and expressed a need to change them, while women tended to view attitudes and actions that reflect traditional female gender roles as facilitators in the protection and considered them necessary. In terms of relationship dynamics, key findings include that: a) a lack of communication, support, and collaboration had a negative impact in the protection of the partners while . . . b) the presence of these three factors greatly increased protection, and c) gender roles were intertwined in the relationship dynamics. (p. 36)

More specifically, "women visualized their role as one of convincing their partners to use protection as well as being strong and firm in the demand of its use. Men viewed their role as one of being more supportive and willing to use protection, but recognized their resistance towards the use of condoms." In this way, "traditional and non-traditional gender roles were assumed by both men and women. Traditional gender roles inhibited protection but were also used in positive ways to promote it" (p. 30).

On the basis of these findings, the investigators suggest that, by taking into consideration

> the context of a committed romantic relationship . . . and promoting factors such as communication, trust and support, . . . [clinicians] could promote the couple's desire to protect one another and this, in turn, could promote a modification . . . of traditional gender roles that would culminate in protection. Beginning to view HIV [prevention] as a collaborative process and not just as an individual process, mainly attributed as a responsibility of the woman, could lead to more effective prevention strategies with heterosexual discordant couples as well as . . . promote the shift of . . . traditional schemes that inhibit protection towards some non-traditional schemes that promote it. All of this with two common key factors: a) the presence of the other who is the object of the partners affect, love and respect and b) the reality of an illness that could be transmitted to the other partner if the appropriate measures are not taken into consideration. . . . Integrating factors such as relationship dynamics and gender constructs into interventions . . . [may] yield beneficial results such as an increase in the use of protection (e.g.[,] condoms) and help reduce the rate of HIV transmission. (p. 38)

[1] For more information on traditional gender constructs associated with Hispanic/Latino culture, see the **Tool Box** in this issue of *mental health* **AIDS** entitled "SAVA Latina: Addressing the Interplay of Substance Abuse, Violence, & AIDS Affecting Hispanic Women (Part 2)."

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It is not enough, however, to develop prevention interventions that are attuned to the context in which intercourse occurs. It is just as important to base interventions "on theoretical models that can be tested and evaluated on the dyadic level" (p. 183) in which risk behaviors take place, according to Harman and Amico (2009). These investigators developed and tested "an Information-Motivation-Behavioral skills (IMB) model of HIV risk behavior . . . specifically articulated for heterosexual couples in established relationships using data from both members of 75 [predominantly white middle-class] dyads. The multilevel **relationship-oriented information-motivation-behavioral skills** (RELO-IMB) **model** was evaluated at the individual and dyadic level of analysis to examine partner differences on core variables" (p. 173).[2] Harman and Amico found that "not only did the RELO-IMB model provide a good fit to the data when analyzed at the dyadic level, but that the structural relations among the core variables were quite different between the individual- and dyadic-level models" (p. 173). More specifically,

> in contrast to traditional IMB models . . ., the RELO-IMB places motivation in the role of a mediating variable, rather than behavioral skills. Results supported this positioning of HIV-prevention related motivation. . . .
>
> There was also evidence that information and behavioral skills operated on both the individual- and dyadic-levels, whereas motivation exerted the most influence at the dyadic-level. . . .
>
> The direct path between information and motivation suggests that when couples don't know much about HIV transmission, they may be more motivated to use condoms to protect themselves from the unknown. Couples with higher levels of knowledge may have been less motivated to use condoms possibly because they have already addressed potential risk factors with each other (e.g., tested for HIV together), or perhaps they might feel more invulnerable to infection with the knowledge that they have. . . .
>
> Behavioral skills appeared to also operate somewhat differently at the individual and dyadic levels. Structurally, behavioral skills about risk communication and condom use had different relationships with condom use at the dyadic level only, with the former being marginally negative . . ., and the latter being significantly positively related. While not reaching significance, the trend suggested that couples with lower behavioral skills concerning communication about sexual risk history may be more motivated to use condoms in their relationships. . . .
>
> Interestingly, . . . one partner's motivation did not affect the other partner's condom use. This finding has substantial implications, for it may not be enough to intervene with one member of a couple and expect that changes in their motivation will influence their partner's outcomes. . . . Because motivation to use condoms in the RELO-IMB model was best modeled at the dyadic level, these results illustrate that <u>both partners would need to be targeted in HIV interventions in order to demonstrate efficacy and effectiveness</u>. (pp. 181-182)

In short, according to Harman and Amico,

> interventions that are based on individual-level theoretical models may not be as effective as . . . [interventions] based on dyadic models, and may possibly even harm individuals in such relation-

[2] "Similar to individual level applications of the IMB model . . ., HIV prevention information, motivation, and behavioral skills predict preventive behavior. Information includes knowledge about transmission modes and methods of prevention, and motivation to engage in preventive behavior is determined by attitudes about the behavioral and social norms or support to engage in the behavior. Behavioral skills to perform preventive acts are also required to engage in preventive behavior" (Harman & Amico, 2009, p. 174).

The RELO-IMB "developed and evaluated in the current research specifically proposes that relationship-oriented information, motivation, and behavioral skills will prove to be critical determinants of risk and prevention behavior within couples. The specific structural relations between these core constructs will vary as one moves from the individual level (assessment of individuals within a dyad with no accounting for their co-variation) to the dyadic level (linking each member of a couple together and viewing the couple as the 'unit' of observation). Because of the anticipated co-variation between the individuals composing couples, . . . [Harman and Amico] anticipated that the dyadic model would provide a better, more appropriate fit to the data" (Harman & Amico, 2009, p. 175).

mental health **AIDS** is produced four times a year under Contract No. 280-02-0800/280-02-0802 with the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The content of this publication does not necessarily reflect the views, opinions, or policies of the CMHS, SAMHSA, or HHS.

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

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> ships. For example, if an intervention was based on the individual-level IMB model that was estimated in this study, a goal might be to increase behavioral skills and information, which appeared to increase motivation. However, at the dyadic level, behavioral skills operated in a more complicated fashion, and higher levels of information . . . [were] related to lower levels of motivation to use condoms. (p. 183)

The investigators conclude that "this is the first theoretical model of HIV risk behavior to be analyzed at the dyadic level, and the results suggest ways to effectively design intervention strategies for individuals in intimate relationships" (p. 173). Although these results "must be replicated with diverse groups of adult dyads" (p. 182), Harman and Amico suggest that, when working with men and women in relationships, "interventions . . . could target the couple's norms and attitudes about condom use in order to increase motivation and subsequent condom use behaviors" (p. 183).

About Adolescents & Young Adults

Malow et al. (2009) "assessed the impact of an 8-week **community-based translation of Becoming a Responsible Teen** (BART), an HIV intervention that has been shown to be effective in other at-risk adolescent populations. A sample of **Haitian adolescents** living in the Miami area was randomized to a general health education control group (n = 101) or the BART intervention (n = 145),[3] which was based on the . . . IMB . . . model" (p. 110). The investigators found that

> there was a substantial positive influence on important IMB constructs by the specialized BART-A program tailored for Haitian adolescents. At the 4-week postintervention point, membership in the intervention group positively and significantly affected all variables tested in the model. These variables included key IMB components of greater knowledge, greater intentions to use condoms in the future, higher safe[r] sex self-efficacy, and an improved attitude about condom use as a safety measure. Also, in terms of behavioral skills, the intervention group showed much higher scores and significant improvement in the ability to use a condom, a key aspect of HIV risk reduction. (p. 117)

Malow and colleagues conclude that "changes in condom attitudes, enhanced self-efficacy in adopting safer practices, and improvements in condom use skills shown in this study suggest that BART may be a useful initial tool in encouraging adoption of safer practices" (p. 119) among Haitian adolescents living in the United States.

Brady, Dolcini, Harper, and Pollack (2009) "examined whether **uncontrollable stressful life events** were associated with sexual risk taking among adolescents across a 1-year period, and whether **supportive friendships** modified associations" (p. 238). The investigators interviewed 159 sexually active African American teens who were recruited through random digit dialing in a low-income inner-city neighborhood and found that, "among adolescents who reported low levels of supportive friendships, uncontrollable stressors were associated with greater levels of sexual risk taking over time. In contrast, uncontrollable stressors were not associated with sexual risk taking among adolescents who reported high social support from friends; risk taking was typically moderate to high among these adolescents" (p. 238). Brady and colleagues suggest that

> adolescents with few resources for support may benefit from programs in which adults take an active role in providing support and teaching life skills, including adaptive strategies for coping with stress. Such programs should address the potentially high number of stressful life events that adolescents may experience and anticipate that some events involving family members (e.g., serious illness, mental health problems, incarceration) may limit adolescents' access to adults who are ordinarily resources for support. It may be necessary to build or enhance adolescents' familial and extra-familial support networks to promote adaptive strategies for coping with stress. Adolescents with many resources for support, particularly from friends, may benefit from peer-based health

[3] "BART is a cognitive-behavioral HIV risk reduction intervention specifically designed for use in nonschool community settings. . . . For the Haitian adolescent study, the research team conducted extensive preliminary work over an approximate 1-year period to develop BART-A. . . . Developing the adaptation involved complex language and cultural translation procedures to engage the youth, parents, and practitioners from the Little Haiti community, with particular focus on stigma/acculturation stress.

The adaptation process had the goal of producing change in the same intervention-associated mediating variables (e.g., information, motivation, and behavior) as in the original BART intervention by using similar activities (e.g., role-playing scenarios, instruction, exercises) but with the implementation tailored to cultural values, beliefs, and other important characteristics identified in the sample. . . .

The final iteration, BART-A, included the following components: (a) risk education, (b) group activities to help identify triggers of unsafe sex, (c) condom use practice, (d) role playing of sexual negotiation and refusal, (e) problem solving approaches to manage risky situations, (f) discussion of risk in intimate relationships, and (g) behavior change maintenance. Skills building in the safer sex role-play scenarios was contextualized to culturally prescribed gender norms/roles and cultural/spiritual terminology (e.g., linguistically appropriate and culturally defined terms for relationships and sexual behaviors)" (Malow et al., 2009, pp. 113-114).

promotion programs that seek to influence norms surrounding risk behavior within friendship networks. . . . This may serve to offset potential peer socialization to engage in risk. (p. 246)

Mehrotra, Noar, Zimmerman, and Palmgreen (2009) looked at "demographic, personality, and sexual risk factors as predictors of partner-specific (main vs. casual) HIV/STD [sexually transmitted disease] **risk perceptions** in a sample of 1,489 young adults" (p. 39). As the investigators expected, "perceptions of HIV/STD risk were higher in the context of 'casual' as compared with 'main' partnerships" (p. 39), in which "reduced salience of health issues, feelings of safety, and conflict avoidance" (p. 49) tend to decrease the employment of safer sexual practices. Of interest were the findings that even though "univariate analyses demonstrated that gender, race/ethnicity, sensation seeking, impulsivity, number of partners, and condom use all influenced HIV/STD risk perceptions, only gender, condom use, and race/ethnicity remained significant in multivariate analyses" (p. 39).

Expanding on these factors associated with risk perception, Mehrotra and colleagues observe that

> females' risk perceptions from both main and casual sexual partners [were] higher than that of males. However[,] the risk perception was greater in the case of casual sexual relationships than in main sexual relation-

Tool Box

SAVA Latina: Addressing the Interplay of Substance Abuse, Violence, & AIDS Affecting Hispanic Women (Part 2)

Part 1 of this series (presented in the Spring 2009 issue of *mental health* **AIDS**) reviewed the literature linking substance abuse, violence, and AIDS (SAVA), including recent work delineating pathways that tie together violence and HIV risk. The focus then shifted to violence and its effects on immigrant Hispanic women (Latinas) living in the United States, cultural factors that contribute to the risk for both violence and HIV in this population, and screening questions (in Spanish) that have demonstrated utility in identifying women who have been abused.

This concluding segment summarizes the impact of violence on the health (including mental health) of women in general and Latinas in particular, unmet mental health needs in this population, and the evolving state of intervention research, including culturally specific interventions for clinicians working in the crosscurrents of these health and social problems.

Meeting Unmet Mental Health Needs

Macy, Ferron, and Crosby (2009) reviewed and synthesized 28 "empirical, peer-reviewed, research articles" (p. 38) "that appeared from early 2000 through the fall of 2006" (p. 30) and "reported findings from rigorous research methods and diverse samples, to investigate the chronic health consequence of partner violence among adult women" (p. 38). These findings

> showed that women who experienced partner violence were likely to have poor overall physical and mental health as compared with women who have not experienced partner violence. Violence survivors were more likely to have disabling physical health problems such as chronic pain, migraines, sexually transmitted diseases, and gastrointestinal disorders than d[id] . . . those without violence histories. Moreover, women who had experienced partner violence had an increased rate of disabling mental illnesses, including depression, anxiety, PTSD [posttraumatic stress disorder], substance abuse disorders, and were more likely to struggle with suicidality. Furthermore, partner violence survivors were found to be at an increased risk of health problems in a variety of scenarios: the more recent their experience of partner violence, if the women experienced chronic or severe partner violence, or if the women experienced multiple forms of violent victimization (for example, child abuse, sexual assault, and partner violence) over their lifetimes. (p. 38)

What about the health status of Latinas who have experienced intimate partner violence (IPV)?

In an exploratory study, Bonomi, Anderson, Cannon, Slesnick, and Rodriguez (2009) surveyed a random sample of 3,429 women participating in a large U.S. healthcare system that included 139 Latinas and found that

> in models adjusted for age and income, women with a lifetime IPV history had significantly worse health compared to non-abused women across many health indicators; for example, Latina women with a lifetime IPV history had Short Form-36 Health Survey (SF-36) subscale scores that were 5.62 (mental health) to 7.77 (vitality) points lower than those for non-abused Latina women; depression prevalence more than two times higher; and more physical symptoms. Adverse IPV-related health was significantly worse for Latina than non-Latina women for overall mental health functioning . . ., vitality . . ., and emotional functioning . . . according to SF-36. (p. 43)

Hazen, Connelly, Soriano, and Landsverk (2008) examined associations between different forms of IPV and psychological functioning in a sample of 282 Latinas between the ages of 18 and 45 years. The investigators found that "physical violence was associated with symptoms of depression and hostility, and psychological abuse was related to depression, hostility, and somatization. Sexual violence was generally not associated with psychological functioning . . . [, and t]he different types of [IPV] were not related to participants' self-esteem" (p. 282). It bears mentioning that the investigators "did not include a

measure of [PTSD], . . . nor did [they] assess impairment related to mental health symptoms" (p. 294), two steps that would have enlarged the perspective on IPV and its impact on women's functioning. Additionally, in contrast to a number of other studies,

> sexual violence was not significantly related to the mental health symptoms considered in this study, with the exception of having a negative relationship with phobic anxiety. . . . Also contrary to previous findings . . ., experiences with [IPV] were not related to women's self-esteem. These differential findings may be at least partly accounted for by the fact that [the investigators] controlled for childhood maltreatment experiences[,] . . . unlike researchers who found a relationship between [IPV] and self-esteem. Childhood sexual abuse was associated with lower self-esteem in the current sample, consistent with numerous studies on the consequences of child sexual abuse. . . . For many individuals, childhood trauma may have a more profound impact on self-esteem than adult victimization. (p. 294)

On the topic of trauma, "a possible link between violence-related [PTSD] and comorbid depression on immunity to HIV acquisition and HIV disease progression warrants further investigation" (Campbell et al., 2008, p. 221).

When mental health needs are identified among Latinas who have experienced IPV, are the needs being met? To answer this question, Lipsky and Caetano (2007) analyzed data from 7,924 "black, Hispanic, and non-Hispanic white women ages 18 to 49 who were [married or] cohabiting" (p. 822) and took part in SAMHSA's 2002 cross-sectional National Survey on Drug Use and Health to examine "risk factors and ethnic differences in the relationship between [IPV] and unmet need for mental health treatment (perceived need for but did not receive treatment) in the general population" (p. 822). The investigators found that women who had experienced IPV were twice as likely as those who had not "to report unmet need, after analyses controlled for socioeconomic factors and substance abuse. In ethnic-specific models, only Hispanic and non-Hispanic white women who experienced partner violence were more likely than their nonabused counterparts to report unmet need for treatment" (p. 822). More specifically, "Hispanic women who experienced partner violence were four times as likely as nonabused Hispanic women to report unmet need. . . . Hispanic women who reported using illicit drugs were 3.7 times as likely as nonusers to have unmet need for mental health treatment" (p. 825). Lipsky and Caetano conclude that "women who experienced partner violence, especially Hispanic women, are at increased risk of not receiving needed mental health care" (p. 822).

"The findings in this study add to the current literature regarding the substantial unmet need for mental health treatment – not only among abused women in the U.S. population overall, but also among Hispanic women in particular."
—— Lipsky & Caetano, 2007, p. 827

Treating Transgressions in Tandem

Gielen et al. (2007) reviewed four studies testing interventions intended to address the intersecting issues of HIV and IPV; two of these models (Melendez, Hoffman, Exner, Leu, & Ehrhardt, 2003; Theall, Sterk, & Elifson, 2004) were summarized in the Winter 2004 and Spring 2005 issues of *mental health* **AIDS**, respectively. Gielen and colleagues discerned, however, that among the interventions they reviewed, "none addressed sexually transmitted HIV and partner violence risk reduction simultaneously" (p. 178), leaving these investigators to conclude that "there is no best practice evidence on interventions that simultaneously address women's IPV and HIV sexual risk despite the strong evidence that for many women these issues are intertwined" (p. 195). They suggest that, "until such evidence can be developed, practitioners should at a minimum follow IPV screening and referral protocols that exist for health care providers. Because IPV is associated with reduced ability to implement safer sex behaviors, HIV risk-reduction practitioners should incorporate IPV education, screening, and referral into their program[s]" (p. 195).

Melendez and colleagues (2003) put it this way:

> Considering the high prevalence

(Tool Box is continued on Page 6)

ships. . . . [T]his may be due to high awareness among females that they are more susceptible to contracting HIV/STDs via heterosexual contact. Additionally, greater condom usage was related to higher levels of risk perception[,] . . . imply[ing] that risk perception and precautionary behavior are linked in a meaningful way.

Race/ethnicity was a significant predictor of risk perception in the case of main sexual partners but not in the case of casual relationships, implying that African . . . Americans perceive main sexual relationships as more risky than do Whites. . . . One can speculate that interventions . . . regarding the risk posed in main sexual relationships are . . . increasing the salience of this risk among African Americans. (pp. 49-50)

Speaking to the potential for risk in main sexual relationships, Mehrotra and colleagues point to several areas that should be addressed in interventions:

> First, it is important to determine when casual relationships become main/steady relationships[, since researchers have] . . . found that for adolescents and young adults the cutoff point for discontinuing condom use in favor of hormonal birth control was at about 3 weeks. Thus, in a short period of time youngsters tend to place a lot more trust in relation-

(Biopsychosocial Update is continued on Page 8)

(Tool Box -- continued from Page 5)

of [IPV] and the fact that abused women may not be easily identifiable, it is critical that issues relating to abusive partners be included in *all* HIV/STD prevention programs that target women. This does not eliminate the need for interventions specifically designed for abused women, especially for those who are currently in an abusive relationship. [IPV] can take many forms and can have far-reaching effects upon safer sex negotiation. Even if a woman has not experienced abuse from a partner, fear of abuse can regulate behavior and prevent safer sex negotiation. Therefore, it is essential that HIV/STD interventions for women deal with the larger issues surrounding [IPV] such as female empowerment, sexual rights, and gender roles, *as well as* provide concrete guidelines for approaching the subject of safer sex with an angry or potentially abusive partner.[1] (p. 510)

Making the Most of *Machismo & Marianismo*

Reviewing the literature on IPV among Latinos, Klevens (2007) reports that "published papers on interventions that include Latinos are scant" (p. 115) and "interventions that have been especially developed for Latinos are less common" (p. 116). The development and rigorous evaluation of such interventions are essential, Klevens writes, because even though

> the core experience may be similar, intimate partner relationships must be understood within the context of a group's situation in our society. For many Latinos in the United States, IPV is often colored by experiences of immigration (frequently illegal), acculturation, and socioeconomic disadvantage. Although it is plausible for interventions developed for other ethnic groups to work for Latinos, these efforts should be accompanied by activities to address these additional issues. Moreover, Latinos are a very heterogeneous group. More research is needed to establish potential differences in the experiences of IPV among subgroups of the Latino population. (p.119)

On this point, and with specific reference to Latinas, Moreno (2007) stresses that "HIV and IPV programs should include trauma-informed prevention. Prevention efforts must derive from the sociocultural definition of risk, cultural scripts regarding gender and power differentials, and the sociocultural context of the relationship, which includes issues of machismo and marianismo" (p. 350). More specifically,

> machismo and marianismo are complex phenomena that, besides being linked as influencing risk factors for HIV and IPV, can also serve as a buffer of protection. . . . For women functioning under the *marianista* tradition, the role does not allow her to know about sexual matters, nor does it allow her to negotiate safe[r] sex. In addition, she might have to bear abuse for the sake of the relationship and the family. On the other hand, as a protective factor, a *marianista* has only one sexual partner, which reduces her risk for infection. For Latino men who are traditional *machistas,* the role can act as a protective factor against HIV/AIDS, because it encourages them to be a *"caballero"* (gentleman), who is responsible toward social obligations and behaviors that protect the family from harm. (p. 341)

González-Guarda, Peragallo, Urrutia, Vasquez, and Mitrani (2008) pick up on this point, urging that

> activities that promote the more positive aspects of *machismo,* such as protecting and providing for the family, and *marianismo*, such as the power to produce life, can be used when designing prevention strategies for HIV and IPV among this population. . . . Interventions also need to help women develop skills that empower them to play a greater role in sexual decision making (e.g., greater knowledge about risk factors for HIV, communication, and condom negotiation skills) and promote healthy relationships among intimate partners (e.g., compromise, shared decision making, honesty, respect). (p. 264)

González-Guarda and colleagues, among others, stress the importance of targeting male partners when developing culturally specific prevention interventions for Latinas. In fact,

> targeting the partner's substance abuse and risky sexual behaviors through treatment and prevention may be more important in addressing HIV and IPV among Hispanic women than specifically targeting their own behaviors (e.g., substance abuse and condom use). . . . [I]nterventions [also] need to be developed to target Hispanics across different age groups, socioeconomic conditions, and levels of acculturation. Additionally, more "Americanized" strategies must be incorporated in these interventions to target the prevention and/or treatment of substance abuse among more highly acculturated subgroups within this population. (p. 263)

With regard to Latinas, Lipsky and Caetano (2007) stress "the need for developing culturally sensitive and specific outreach to ethnic minority communities about the effects of partner violence on women's mental health and how to access these services" (p. 827), although Klevens (2007) observes that, in developing these services, "factors that often lead Latinas to delay seeking help need to be considered" (p. 119).

***¡Seguridad Primera!*Safety First!**

In fact, interesting violence-related group work with Latinos conducted by

[1] Melendez and colleagues (2003) offered their study participants "non-confrontational guidelines for staying firm and being heard" when negotiating safer sex with a potentially abusive partner. "Specific guidelines included deciding beforehand where and when to ask for safer sex (making sure it happens before engaging in foreplay), being clear on strategy, and stating one's needs and feelings. Women also discussed different tactics for dealing with an angry or abusive partner when asking for safer sex, including using self-talk to stay calm and focused, trying to solve the problem jointly, showing empathy and assertiveness and finally, in order to avoid abuse, diverting the topic to something less provocative or removing oneself from the scene" (p. 509).

mental health professionals has been described in recent literature (e.g., Hancock & Siu, 2009; Morales-Campos, Casillas, & McCurdy, 2009) and awaits formal evaluation.

"When addressing risk for HIV among Hispanic women . . .
o Screening for IPV may be an effective way of identifying women at risk for HIV.
o When evaluating risk for HIV among women, it is not enough to only assess for STIs [sexually transmitted infections] and behaviors that may place them at risk. A woman's partner's risk behaviors must also be considered.
*o Promoting positive aspects of culturally ascribed ideals for men (*machismo*) and women (*marianismo*) . . . may help address gender inequities that propagate HIV, substance abuse, and IPV in this population."*
—— González-Guarda, Peragallo, Urrutia, Vasquez, & Mitrani, 2008, p. 264

Also evolving is pilot work by Rountree and Mulraney (2008), who conducted five focus groups for the purpose of informing the design of an HIV risk-reduction intervention for women who had experienced IPV. The investigators worked with "a convenience sample including African American women (*n* = 10), Mexican American women [monolingual (*n* = 15), bilingual (*n* = 10)], and Anglo women (*n* = 8)[, who] participated in the racially/ethnically stratified focus groups. . . . The sample consisted of 43 women who were currently living at [a domestic violence] shelter or the transitional living facility next to the shelter" (p. 3). Rountree and Mulraney report that "in all five focus groups, . . . [r]espondents felt that they knew of ways to protect themselves from [HIV] infection in non-abusive relationships; however, [they] acknowledged the difficulties of doing so given the context of their abusive relationships. Examining the racial/ethnic differences across focus groups showed that the language used by women [in describing their experiences of IPV] is quite variable. The ways in which survivors define rape, sexual abuse, and their own experiences are all unique; however, their actual experiences have many similarities" (p. 1).

Rountree and Mulraney assert that their focus group findings "suggest that sexual health and sexual safety planning are . . . immediate needs. Therefore, a more holistic view of health, one in which sexual health is as important as physical and mental health, is called for" (p. 7). The investigators center their discussion on the empowerment of women who have experienced IPV in the service of sexual safety planning. <u>One way to foster empowerment</u>

> <u>is through the use of therapeutic support groups</u>. The women from the focus groups [touted] the benefits of gathering together to discuss . . . HIV prevention, sexual safety planning, domestic violence, and personal growth and autonomy. There are many benefits to this type of group intervention. It . . . can be less intimidating to share in a group than in individual therapy. It also . . . validates the . . . feelings, thoughts, and experiences [of women who have experienced IPV], as they see they are not alone. Overall, the participants in this sample found the focus groups in themselves to be a means of both empowerment and encouragement. They realized that they had support systems in place and resources in reach, and they found a safe place to talk about their sexuality. (p. 8)

Rountree and Mulraney report that

> focus group data and feedback from [a] community advisory board [have] informed the development of <u>a six-week, 2-hour-per-session curriculum</u>. . . . *Module 1* will focus on capacity building that will cover areas such as self-perception, self-image, healthy relationships, and HIV/AIDS awareness. *Module 2* centers on sexual safety planning, including issues related to power and control, early warning signs versus immediate danger, and communication and negotiation skills. *Module 3* focuses on life skills, including assessment of [and linkage to] self-determined educational and employment goals, assessment of alcohol and drug abuse, and links to services and support. The next step of the research process entails the piloting of the intervention using . . . quasi-experimental/treatment and comparison groups of women who have experienced . . . [IPV].[2] (p. 9)

Moreno (2007) speaks to the importance of support groups for Latinas in observing that the women participating in her study were not only abuse survivors, they were "resilient, and some were able to leave their abusive partners and start a new life. Many women attributed these changes to being HIV+ and the services, such as support groups, that they received at agencies that helped them to transform their lives. . . . The lesson learned here is that, <u>as women with HIV have a high incidence of abuse, HIV programs should include services for women who are survivors of trauma, and services for survivors of trauma should address HIV/STI risk reduction possibilities</u>" (p. 350).

Moreno also reminds us of the "big picture," pointing out that "IPV and HIV infection are not related strictly to the individual's risky conditions" and, for this reason, "behavioral interventions are not the only solution[;] we need to be able to intervene with structural factors. Considering that many Latinas are economically and socially dependent on men for support entails recognizing the conditions that these women live under, as well as how the socioeconomic, relational, political, and cultural conditions increase their risk for HIV and IPV" (p. 350).

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(Tool Box is continued on Page 8)

[2] Through a similar process, D'Amico, Barnes, Gilbert, Ryan, and Wenzel (2009) developed a "tripartite prevention program for impoverished young women transitioning to young adulthood" that addresses "substance use, HIV risk, and victimization by intimate partners" (p. 112). Of interest in this program, which awaits pilot testing, is a focus on motivational interviewing.

(Tool Box -- continued from Page 7)

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– Compiled by Abraham Feingold, Psy.D.

(Biopsychosocial Update -- continued from Page 5)

ships without determining each other's risk status. Second, it has been found that young adults often use partner selection (attractiveness of the person, appearance of health, etc.) rather than safer sexual practices to avoid disease. . . . Such superficial perceptions of risk judgment should be addressed. Third, the notion[s] of emotional safety and physical safety need . . . to be disentangled. . . . At times, those in main relationships appear to confuse emotional safety (i.e., intimacy) with physical safety (i.e., no risk of STDs). Interventions might more clearly communicate the idea that monogamy only means safety from disease if both partners have been tested and are sure they are free of STDs.

. . . [Additionally, interventions could highlight] the importance of protective behaviors in order to protect one's partner, to show concern for each other, and build trust by communicating about and practicing safe[r] behaviors. In [the] case of casual relationships, more risk appraisal should be encouraged to counter what has been called the "ultimate irony." . . . This is a situation in which young adults consider the discussion of each other's sexually transmitted infection status too serious a topic to be discussed in casual sexual encounters and often engage in unsafe sex.

The findings . . . also emphasize the importance of sensitizing males to the risk of contracting STD/HIV in sexual relationships, as their risk perceptions tend to be lower than those of females in risky sexual situations. . . . [G]ender-specific risk appraisals of main and casual sexual relationships need to be considered in tailored and targeted safer sex interventions. The same considerations may need to be extended in designing interventions keeping in mind racial differences in appraisals of risky sexual situations in relationships. Indeed, recent empirical evidence from meta-analyses of HIV prevention interventions has suggested that . . . gender- and race-specific issues surrounding risk perception will likely be better dealt with in single-gender and single-race interventions rather than those targeting more heterogeneous groups.

Finally, . . . sensation seeking and impulsive decision making were found to be strongly related to risk perception of contracting both STDs and HIV in the bivariate analyses. Given that high sensation seekers actually seek out risky behaviors and situations because they feel rewarded by the "thrill" of such experiences . . ., and impulsive individuals appear to make (often bad) decisions in the "heat of the moment" . . ., these characteristics may at times be important targeting variables. (pp. 50-51)

About Men Who Have Sex With Men

Serovich, Craft, McDowell, Grafsky, and Andrist (2009) interviewed 57 men who have sex with men (MSM) living

with HIV to identify **methods used** by these men **to initiate safer sex with casual sex partners**. The investigators identified four categories of strategies:

> having a nonnegotiable safer sex policy, behaviorally controlling the interaction, being verbally direct, and hinting. . . . Strategies varied by degree of explicitness and partner involvement. Men in this study often employed multiple strategies if their partner was not initially receptive to engaging in safer sex behaviors. These data suggest that HIV prevention programs should prepare MSM to handle difficult sexual encounters successfully without surrendering. In fact, because resistance from partners frequently occurs[,] HIV prevention programs should consider normalizing such interactions and educate men on how to negotiate safer sex. Perhaps a personalized continuum of strategies could be developed. This repertoire could then be practiced until an acceptable level of implementation comfort is achieved.
>
> The results also revealed that men are not only using multiple strategies to negotiate safer sex, but they are using varying strategies with different partners. Men often described engaging in certain safer sex strategies or choosing not to engage in strategies depending on a partner's assumed or known serostatus, perceived risk of violent retribution, where the encounter was going to take place, or where the partner was encountered. If a partner was known to be HIV-positive, then verbally direct and partner [-]involved strategies could be more easily employed. When a partner's status was not known[,] hinting strategies or ones with low partner involvement seemed preferred. Participants also discussed utilizing strategies based on personal safety and chose less confrontational strategies when they sensed the possibility of danger from a partner, did not want to risk sexual rejection, or believed that emotional intimacy with the partner . . . could develop. In contrast, more confrontational strategies were employed when they felt physically safe or when the availability and accessibility of other partners decreased the repercussion of rejection. . . . HIV prevention interventionists working to increase safer sex among HIV-positive men might consider helping MSM choose strategies based on such information and settings. (p. 11)

Serovich and colleagues suggest that, "rather than stressing condom usage as the only means of safer sex, . . . assist men with developing a safer sex identity that embraces multiple behaviors. . . . Offering numerous safer sex options . . . and taking into account men's motivations for sexual relationships may . . . be more beneficial to those living with HIV" (p. 12).

Two recent qualitative studies focus on **motivation and meaning in connection with the use of methamphetamine** (meth) **and other club drugs** among MSM. To examine motivations for the use of club drugs – "specifically, [meth], methylenedioxymethamphetamine (MDMA), ketamine, gamma hydroxy butyrate (GHB), and powdered cocaine" (p. 432) – Jerome, Halkitis, and Siconolfi (2009) conducted qualitative interviews with 16 MSM "who entered . . . [a] longitudinal study on club drug use and sexual behavior believing they were HIV negative or HIV unknown, yet who were, in fact, tested and confirmed to be HIV positive. These 16 seroconverted participants were subsequently matched with 16 participants who were confirmed as HIV negative for a total sample size of 32 participants" (p. 433). Participants, living in all parts of New York City, were matched for race/ethnicity, educational level, and most-frequently used substance. Qualitative analysis of the narratives

> revealed seven recurring, motivational subthemes that were considered central for understanding the role that club drug use plays in gay and bisexual men's lives. These motivations were enhanced physical sensation, facilitation of sex, emotional enhancement, emotional equivalence, emotional escape, facilitation of social interaction, and ability to overcome social inhibitions. Descriptions of these seven motivations appeared to fall within three larger domains, namely a physical, an emotional/mental, and a social domain. In the *physical domain*, participants reported that drug use gave them a physical rush, stamina, made sex more intense and pleasurable, as well as alleviated sexual inhibition, thus allowing them to have gay sex. In the *emotional/mental domain*, participants recounted that drug use enhanced emotions, helped them to be on the same wavelength as their peers, as well as allowed them to emotionally escape from traumatic experiences and life stresses. In the *social domain*, participants articulated that drug use enhanced their social interactions with men, that is, it gave them courage to approach and look beautiful to men, feel accepted by them, as well as allowed them to overcome social inhibitions associated with talking to men. Also, in the *social domain*, the men viewed drug use as a tool for obtaining sex and companionship through the promise of peer drug use. (pp. 436-437)

Jerome and colleagues contend that

"findings in all three domains provide support to the theory that men come with preexisting mental states (vulnerabilities) into a sexual and drug-taking event that may cause them to disengage through drug use and engage in unsafe sex" (p. 442). According to the investigators, these findings "strongly indicate a need for interventions aimed at diagnosing and treating affective disorders both behaviorally and with psychotropic medication, when necessary" (p. 443). For this reason, "approaches to treatment for drug addiction among gay and bisexual men must delve into mental health factors in order to disentangle associations between use and undesired psychological states, rather than simply dealing with the drug-using behavior in isolation" (p. 443).

Similarly, in the San Francisco Bay area, Chartier et al. (2009) examined "the impact of [meth] use on the lives and relationships of [22] HIV-positive MSM who had struggled with [meth] dependence or use, with a specific focus on identifying and describing personal values and meaning related to use" (p. 506). Among the findings of this investigation, many study participants used meth "to take a break from living with HIV/AIDS, being on disability, and often from debilitating mental health problems like depression. . . . Almost all participants acknowledged that this was only a momentary fix, but it remained important as one of the only identified resources that could provide momentary respite from carrying the burden of their life problems. Several men referred to this as self-medicating, particularly in relation to depression and anxiety" (p. 513).

Regarding the use of meth to enhance or to increase the frequency of sex, "although some identified that as an important reason – and often the only reason they used – they were not the majority. Participants identified several additional reasons for using [meth]. Many described that their HIV infection brought chronic pain and fatigue, preventing them from accomplishing activities of daily living. With the energy boost from [meth], they were able to clean their places of residence, do laundry, go to the store, and sometimes even work for extra money" (p. 513).

Even through nearly all study participants recognized the negative effect of meth use on their lives, "the majority . . . described many more factors motivating and facilitating their use than discouraging it, and found the former to generally be more compelling" (p. 513). Several of the men attributed their use of meth "to their worsening depression and suicidality, anxiety, isolation, paranoia, and a general deterioration in their ability to cope with life stressors" (p. 513). Among some of those taking meth primarily in connection with sex,

> paralleling th[e] . . . drive for increasingly pleasurable and more frequent sex was also the search for a long-term partner. This felt at odds with connecting only around sex while high. For those in relationships in which [meth] was involved there was often violence and emotional abuse. The estrangement of family and friends because of [meth] use was common, especially with prolonged use. Some kept themselves away when they were using because they did not want to do more damage in those relationships, and for others family and friends had pulled away because of their use. (p. 514)

With regard to having meaning in their lives,

> not . . . working left many participants feeling useless, listless, and with significant amounts of unscheduled time. Many felt they would be able to work, but were wary of looking for or contracting for work because they did not want to jeopardize their disability status. Several men were then in the situation of having considerable free time, a source of money coming in on a regular basis, and a slowly deteriorating sense of life meaning and purpose. This, as some described, was a perfect recipe for developing a drug addiction, even if one had not existed before in their lives. (p. 514)

Additionally, "being embedded within a mainstream cultural paradigm that designates partnership, children, and family as important indicators of life meaning, particularly as one ages, was identified as contributing to lacking a sense of purpose. Combined with not working, having a debilitating, chronic disease, and coping deficit, many men turned to [meth] use and sex. For those who discussed this issue, insight did not provide sufficient motivation to deter them from continued engagement in these high-risk behaviors" (p. 514).

Not unlike Jerome and colleagues, Chartier and colleagues believe that treatment

> must not only focus on addressing problematic behavior, but could also include understanding the context from which such behavior was derived, incorporating what a person values and finds meaningful in his or her life into altering behavioral choices. With an eye to reconnecting an individual with a valued and meaningful life from which more functional decisions can be made, altering the person's relationship to the context in which they are currently functioning . . . can provide a useful roadmap for modifying the treatment of [meth] addiction. Acceptance-based therapies, such as acceptance and commitment therapy (ACT), tar-

get these areas specifically and might aid in this process. . . .

A suggestion echoed by many of the participants was that treatment should occur in a nonjudgmental environment. . . . Gay affirmative therapy might be helpful in its advocacy that therapists . . . should . . . help clients develop gay identity in a safe and esteem-building environment. . . .

In addition to increasing awareness of the need for sensitivity about sexuality, there are issues specific to living with HIV/AIDS that bear consideration in the treatment of [meth] addiction. For example, people living with HIV/AIDS often complain of debilitating fatigue, which can come in part from physical (i.e., anemia, low CD4 count, impaired liver or thyroid function, abnormalities in cortisol) or psychological causes such as depression. . . . With the alternative being self-medication with a dangerous and highly addictive drug like [meth], if there are available pharmacologic agents to address comorbid and debilitating physical symptoms like fatigue, they should be considered. (pp. 515-516)

HIV Assessment News

HIV Counseling & Testing

Sheon and Lee (2009) "used conversation analysis to examine recordings of HIV-test counseling sessions in order to understand **how counselors and clients conceptualize and discuss sex partners' disclosure of HIV status**. Of 50 test sessions [with MSM] audio-recorded in four publicly funded sites in Northern California, 47 sessions included a discussion about sexual partners' serostatus disclosure" (p. 133). The investigators "identified three major patterns in the ways that counselors and clients discussed sex partners' serostatus disclosure. First, in the majority of the sessions (91.5%), counselors and clients avoided directly asserting partners' serostatus. Second, they treated both positive and negative serostatus disclosure as uncertain and untrustworthy. Third, counselors and clients collaborated with one another in constructing a shared understanding about the uncertainty, unknowability and untrustworthiness of HIV disclosure from partners" (p. 137). The results of this study

> have significant implications for HIV prevention and serostatus disclosure as a prevention method. First, given the participants' skepticism about serostatus disclosure from sex partners, . . . [these] data suggest that serostatus disclosure may not be an effective HIV-prevention strategy, at least among seronegative populations. . . . [T]he current emphasis on serostatus disclosure as a prevention strategy should be reconsidered. [MSM] often avoid directly disclosing their status. . . . When they do disclose, the disclosure may be dismissed as unreliable or it may not necessarily lead to safer sex behaviors.
>
> Second, the results of this study suggest that clients may receive incoherent HIV-prevention messages about serostatus disclosure. . . . Although the counselors in . . . [this study advised] clients to talk with their partners about their status before having sex, serostatus disclosure from partners was generally perceived as an unreliable indicator of actual serostatus. Indeed, quite a few counselors . . . advised clients not to rely on partners' disclosure in making safer sex decisions. These paradoxical messages may lead clients to disregard prevention messages more generally.
>
> . . . Third, if . . . [these] data reflect widely shared views on disclosure, it appears that HIV-prevention strategies advocating sero-sorting are primarily relevant for seropositive populations. . . . In 1985, HIV antibody screening divided the population into two categories: HIV-positive and HIV-negative. However, these two categories differ fundamentally in their permanence. An HIV-positive person remains so forever – although combination therapies have produced a category of positives with undetectable HIV. A sexually-active, HIV-negative person, on the other hand, could potentially test HIV-positive at any moment given the perennial uncertainties surrounding the antibody window period and routes of transmission. This fundamental difference in permanence between HIV-positive and HIV-negative categories means that it may be more useful to think of HIV status as dichotomized between HIV-positive and HIV-"unknown" because the status of HIV negative, particularly among high risk populations such as MSM, is subject to a high degree of uncertainty. . . . The instability of HIV-negative status may contribute to the perception that HIV serostatus disclosure and sero-sorting is an unreliable prevention strategy for MSM without an HIV-positive diagnosis. (pp. 137-138)

Psychiatric Assessment

Kapetanovic et al. (2009) analyzed medical records data from a cohort of 273 women living with HIV who had received perinatal care and found that the overall prevalence of **maternal perinatal depression** (PND) was 30.8%.[4] Furthermore, "PND was sig-

[4] "Since antenatal and postpartum depression frequently overlap, the more inclusive term perinatal depression (PND) has been increasingly used in the literature as more clinically relevant" (Kapetanovic et al., 2009, p. 101).

nificantly associated with substance abuse during pregnancy . . . and past history of psychiatric illness. . . . Compared to mothers with CD4 nadir greater than 500 cells/mm^3, mothers with a CD4 nadir during pregnancy $\leq$ 200 cells/mm^3 were 3.1 times more likely to experience PND. . . . Women who had antiretroviral (ARV) medications adherence problems during pregnancy were more likely to experience PND than women who were adherent" (p. 101). Although preliminary, these results suggest that

> HIV-infected pregnant women are at high risk for depression, both during pregnancy and postpartum. . . . Clinicians caring for HIV-infected women should be aware of this risk, and consider screening the women routinely for depression, both antenatally and postpartum, preferably with one of the standard validated screening tools (e.g., Edinburgh Postnatal Depression Scale[; Cox, Holden, & Sagovsky, 1987]). . . .
>
> For HIV-infected women with a past history of mental illness, substance use during pregnancy, significant social stressors and CD4$^+$ count 200 cells/mm^3 or less at any point during pregnancy, . . . such screening is strongly indicated. It also seems reasonable to suggest that CD4$^+$ count 200 cells/mm^3 or less should be considered as a clinical marker of the PND risk in HIV-infected pregnant women. (pp. 106-107)

Neuropsychological Assessment

Skinner, Adewale, DeBlock, Gill, and Power (2009) "analysed the relative performance of the HIV Dementia Scale (HDS), International HIV Dementia Scale (IHDS) and the Mini-Mental Status Exam (MMSE) together with neuropsychological [(NP)] tests (Symbol-Digit, Grooved Pegboard and Trail Making) in HIV-1-seronegative subjects (HIV-; *n* = 13) and in HIV-1-seropositive subjects with HAND [HIV-associated neurocognitive disorder] (HIV + HAND; *n* = 13) and other neurological disorders (HIV + OND; *n* = 20)" (p. 246) to determine the **capacity of NP screening tools to detect HAND in persons** attending HIV primary care clinics who had been **exposed to or** are **actively receiving HAART** (highly active ARV therapy). Skinner and colleagues found that the conventional NP tests "consistently showed significantly poorer performance by HIV + HAND subjects compared with the other two groups. Similarly, the mean HDS and IHDS scores were lower in the HIV + HAND group compared with the other two groups . . . while the mean MMSE score did not show significant differences between the HIV + HAND and HIV + OND groups" (p. 246). The investigators conclude that "the MMSE is a weak tool for diagnosing HAND in this group of patients but the HDS and IHDS demonstrate better efficiencies, although cut-off values for the HDS require reassessment in the era of effective [ARV] therapy" (p. 246).

HIV Treatment News

Medical Care

The **integration of mental health and HIV primary care services** is the subject of two recently published studies that examined different aspects of care and reached varying conclusions regarding service integration.

Hoang et al. (2009) measured and ranked integrated HIV care (IHC) at five Veterans Affairs (VA) healthcare facilities and evaluated the effect of IHC on **HIV viral suppression** among 1,018 veterans receiving combination ARV therapy. The investigators "defined IHC to be a care model in which specialists from multiple disciplines collaborate within a geographically and temporally constrained clinic environment to provide HIV-infected patients with onsite primary care, HIV specialty services, and other services such as treatment for hepatitis C, mental health, substance abuse, social services, etc." (p. 561). Hoang and colleagues found that

> patients who visited HIV clinics with more integrated specialty services were more likely to achieve viral suppression. In particular, patients visiting clinics which offered hepatitis, psychiatric, psychologic, and social services in addition to primary care and HIV specialty services were 3 times more likely to achieve viral suppression than patients visiting clinics which offered only primary care and HIV specialty services. This effect had been adjusted for patients' access to [ARV] medication and demographic and clinical factors. (p. 565)

Moreover, the investigators "believe that . . . [these] results are generalizable to care settings beyond the VA" (p. 565). Having found that "frequency of visits was a strong predictor for viral suppression," Hoang and colleagues "suggest not only that resources should be allocated to integrate subspecialty services into HIV primary care clinics but also that providers should channel patients toward these clinics and retain them in care. Future studies should examine which specific elements of IHC are most associated with viral control and what role provider experience plays in this association" (p. 566).

Are integrated care services for persons living with HIV, as well as diagnosed mental health and substance-related disorders, **cost effective**? Weaver et al. (2009) conducted the first randomized controlled trial to address this question regarding the care of "triply diagnosed" patients. Study participants from four study locations (Chicago, Detroit, St. Louis,

and Seattle) were randomly assigned to the intervention group (*n* = 232), which received integrated HIV primary care, mental health, and substance abuse services; or the control group (*n* = 199), which received care-as-usual. During the 12 months of the trial, "the 6% and 8% . . . decline in total average monthly cost of health services for the intervention and control groups[,] respectively, was not significant. . . . For the sample as a whole, two out of three measures of the **quality of life** decreased during the trial; . . . [u]nfortunately, the results failed to demonstrate that the interventions to integrate care significantly affected the cost of health services or quality of life" (p. 41).

Although these results "did not demonstrate that the integrated interventions significantly affected the health service costs or quality of life of triply diagnosed patients," (p. 33), Weaver and colleagues speculate that "future trials with lower baseline levels of integration, longer duration and larger sample sizes may show improvement or slow the decline in quality of life" (p. 42). In the interim, health service professionals "could pursue coordination or integration of care guided by the evidence that it does not increase the cost of care. The results do not[,] however, provide an imperative to introduce multidisciplinary care teams, adherence counseling, or personalized nursing services as implemented in this study" (p. 33).

Psychiatric/Psychological/ Psychosocial/Spiritual Care

Adherence to Treatment

Kremer, Ironson, and Porr (2009) "examined **spiritual/mind-body beliefs** related to treatment decision-making and adherence in 79 HIV-positive people (35% female, 41% African American, 22% Latino, 24% White) who had been offered [ARV] treatment by their physicians" (p. 127). The investigators found that

> decision-making was influenced by health-related spiritual beliefs (e.g., calling on God/Higher Power for help/protection, God/ Higher Power controls health) and mind-body beliefs (e.g., mind controls body, body tells when medication is needed). Participants believing God/Higher Power controls health were 4.75 times more likely to refuse, and participants with mind-body beliefs related to decision-making were 5.31 times more likely to defer [ARVs] than those without those beliefs. Participants believing spirituality helps coping with side effects reported significantly better adherence and fewer symptoms/side effects. Fewer symptoms/side effects were significantly associated with the beliefs mind controls body, calling on God/Higher Power for help/ protection, and spirituality helps adherence. (p. 127)

On the basis of these findings, Kremer and colleagues conclude that

> spiritual/mind-body beliefs may serve as both barriers and motivators to treatment decision-making and adherence. . . . [M]ind-body beliefs . . . may encourage individuals to postpone [ARVs] . . . until they are ready to take them and enhance adherence, once the individual is prepared to take treatment. Unless initiation of treatment is . . . deferred beyond a critical point, awaiting treatment readiness may be the superior choice that prevents the development of treatment resistance due to nonadherence. . . .
>
> Furthermore, the belief that spirituality helps coping with side effects is not only related to better adherence but also to fewer symptoms/side effects. Fewer symptoms/side effects are also reported in those calling on God/ Higher Power for help and protection and those believing that spirituality helps adherence. In summary, the importance of spiritual/ mind-body beliefs in treatment decision-making and adherence should be acknowledged since not taking or not adhering to treatment may affect survival and quality of life of people with HIV. (pp. 132-133)

Mellins et al. (2009) examined "factors associated with adherence to . . . ARVs . . . in an HIV-infected population at high risk for non-adherence: **individuals living with psychiatric and substance abuse disorders**" (p. 168). Data were derived from a multisite convenience sample of 1,138 adults living with HIV, psychiatric, and substance-related disorders. Among study participants,

> 62% were prescribed ARVs at baseline (*n* = 542) and 45% of those on ARVs reported skipping medications in the past three days. Reports of non-adherence were significantly associated with having a detectable viral load. . . . The factors associated with non-adherence were current drug and alcohol abuse, increased psychological distress, less attendance at medical appointments, non-adherence to psychiatric medications and lower self-reported spirituality. Increased psychological distress was significantly associated with non-adherence, independent of substance abuse. (p. 168)

Mellins and colleagues point out that "those patients at the greatest risk for ARV non-adherence in this study were those who reported current alcohol, marijuana or crack use and psychological distress. . . . These findings suggest that brief, focused screening measures targeting current substance use, use of specific drugs and psychological distress, should be utilized to identify those at highest risk for non-adherence, thus fa-

cilitating more effective treatment planning" (p. 174). In addition, these data

> suggest that there are adults coping with HIV, mental illness and substance use who can adhere to ARV medications and, thus, considerations about initiating ARV treatment should not be based on presence of substance abuse or mental illness alone. However, the data also suggest that HIV-infected patients coping with mental illness and substance abuse are at heightened risk for sub-optimal adherence, particularly in the context of current substance use and psychological distress. Several studies of HIV-infected adults document an association between psychological distress, particularly depression and poor health outcomes . . ., highlighting the need for therapeutic interventions. (p. 175)

Malee et al. (2009) assessed the relationship between **cognitive functioning** and ARV medication adherence among 1,429 **children and adolescents with perinatally acquired HIV infection** who were between the ages of 3 and 18 years and living across the U.S. The investigators found that

> the mean score of the children in this cohort was within the low-average range of cognitive functioning, and their performance in most areas, including verbal, memory, and perceptual organization, was below expectations for the general population. Sixteen percent of children in this cohort were cognitively impaired. . . . This finding is consistent with recent studies that describe a decrement in rates of progressive HIV encephalopathy but not elimination of significant neurocognitive impairment among children with HIV during the HAART era. (p. 170)

Despite impairments, "cognitive status was not associated with adherence to full medication regimens; however, children with borderline/low average cognitive functioning (IQ 70-84) had increased odds of nonadherence to the protease inhibitor class of [ARV] therapy. Recent stressful life events and child health characteristics, such as HIV RNA [viral load] detectability, were significantly associated with nonadherence" (p. 164). These findings point to "the presence of adequate caregiver vigilance and active participation in the process of adherence with these children" (p. 170). Additionally,

> higher caregiver education and the nature of the child-caregiver relationship, appeared to be protective and reduced the risk for medication nonadherence in children with HIV infection. Children whose medications were administered by caregivers such as relatives (e.g., aunts, grandparents) or nonrelative adults (e.g., foster/adoptive parents) demon-

Tool Box

Books & Articles

Alfonso, V., Toulson, A., Bermbach, N., Erskine, Y., & Montaner, J. (2009). Psychosocial issues influencing treatment adherence in patients on multidrug rescue therapy: Perspectives from patients and their health care providers. *AIDS Patient Care & STDs, 23*(2), 119-126.
"Multidrug rescue therapy (MDRT) is often used for the treatment of highly experienced patients who harbor HIV variants with decreased susceptibility to multiple antiretrovirals [(ARVs)]. Patients on MDRT typically have limited treatment options, and without treatment, their prognosis can be poor. . . . [A]dherence to MDRT demands a substantial behavior change . . . [and a]llocating the time to make a commitment to treatment can optimize adherence. It is therefore crucial that patients be provided with time to make informed decisions, explore and resolve their willingness and readiness to commit to treatment, and maintain supportive relationships with their [health care providers], all of which can optimize adherence to MDRT" (p. 119).

Allen, J., Hamilton, A., Nunn, R., Crock, L., Frecker, J., & Burk, N. (2009). Evaluation of a community-based mental health drug and alcohol nurse in the care of people living with HIV/AIDS. *Journal of Psychiatric & Mental Health Nursing, 16*(2), 129-136.
"This study evaluated a community-based mental health drug and alcohol nurse role caring for people living with HIV/AIDS (Mental Health D&A Nurse) in a large not-for-profit district nursing organization providing care to people living with HIV/AIDS in an Australian city. . . . [P]ositive findings support continuing implementation of the role within this community setting and indicate that even greater benefits will ensue as the role develops further. Findings are of interest to clinicians and policy makers seeking to implement similar roles in community-based HIV/AIDS care" (p. 129).

Cavanaugh, C.E., & Classen, C.C. (2009). Intergenerational pathways linking childhood sexual abuse to HIV risk among women. *Journal of Trauma & Dissociation, 10*(2), 151-169.
"This article reviews and links . . . two bodies of literature to indicate how mothers' histories of childhood sexual abuse may compromise their parenting practices, which may in turn impact daughters' HIV risk. We also . . . present a model indicating potential intergenerational pathways between childhood sexual abuse and HIV risk among women. The literature supporting this model and gaps in the literature are described" (p. 151).

Copenhaver, M., Chowdhury, S., & Altice, F.L. (2009). Adaptation of an evidence-based intervention targeting HIV-infected prisoners transitioning to the community: The process and outcome of formative research for the Positive Living Using Safety (PLUS) intervention. *AIDS Patient Care & STDs, 23*(4), 277-287.
"This study outlines the process and outcome of formative research that we conducted in preparation to deploy Positive Living Using Safety (PLUS), a behavioral intervention, designed to

strated lower risk for nonadherence. . . . Parents with HIV disease may require increased social support to ensure medication success for their children, particularly if their current or chronic life stress is high. (p. 171)

Malee and colleagues recommend

target[ed] preventive, multilevel interventions to support children and families at highest risk for nonadherence, particularly when medication regimens are initiated. Developmentally appropriate education, deliberate practice of emerging and complex self-care routines, and ongoing monitoring of adherence are essential for all children, regardless of cognitive status, especially during early adolescence when caregivers and teens anticipate greater independence. Children and families who experience stressful life events, even if short-lived, may require additional psychosocial support and monitoring to enhance adherence. Stress management and problem-focused coping skills may be particularly useful for children and caregivers and could be facilitated in a primary care setting in which culturally sensitive mental health care and case management are available. (p. 172)

In a related study, Naar-King et al. (2009) surveyed 123 youth between the ages of 8 and 18 years, as well as their caregivers, in a "multisite study of family allocation of pediatric HIV management," with the

address the HIV risk behavior and HAART [highly active ARV therapy] adherence challenges faced by HIV-infected inmates as they transition back to the community" (p. 285).

Davey, M.P., Foster, J., Milton, K., & Duncan, T.M. (2009). Collaborative approaches to increasing family support for HIV positive youth. *Families, Systems, & Health, 27*(1), 39-52.
"The authors highlight the use of a common clinician-rated family support tool for medical and mental health staff to discuss patients and their families. . . . Through the use of a case example the authors elaborate on how this family support tool aided in building a collaborative relationship with a focus on garnering family support for youth coping with the diagnosis of HIV" (p. 39).

Dennis, M.K. (2009). Risk and protective factors for HIV/AIDS in Native Americans: Implications for preventive intervention. *Social Work, 54*(2), 145-154.
"This article examines historical, biological, social, and behavioral cofactors related to the spread of HIV/AIDS within the context of Native American culture. Special attention is given to vulnerable subgroups and to the need for culturally appropriate efforts at prevention and intervention that respect the unique needs of each group" (p. 145).

Froerer, A.S., Smock, S.A., & Seedall, R.B. (2009). Solution-focused group work: Collaborating with clients diagnosed with HIV/AIDS. *Journal of Family Psychotherapy, 20*(1), 13-27.
"Given that solution-focused brief therapy (SFBT) is strength-based, emphasizes resources, and focuses on solutions despite the presence of a problem, SFBT groups may be one unique resource available to combat the challenges encountered by persons living with HIV/AIDS. This article aims to set forth the value of adapting SFBT principles within the context of group therapy to best serve the mental health needs of the HIV/AIDS population" (p. 14).

Gilliam, P.P., & Straub, D.M. (2009). Prevention with positives: A review of published research, 1998-2008. *Journal of the Association of Nurses in AIDS Care, 20*(2), 92-109.
"This article provides a review of the scientific evidence within the prevention with positives domain from 1998 to 2008. A discussion is provided regarding early descriptive and formative studies as well as more recent and ongoing intervention trials specifically designed for persons living with HIV. A summary of current knowledge, a description of ongoing research, and gaps in knowledge are identified" (p. 92).

Marvel, F., Rowe, C.L., Colon-Perez, L., DiClemente, R.J., & Liddle, H.A. (2009). Multidimensional Family Therapy HIV/STD risk-reduction intervention: An integrative family-based model for drug-involved juvenile offenders. *Family Process, 48*(1), 69-84.
"We describe the development and implementation of the Multidimensional Family Therapy HIV/STD risk-reduction intervention (MDFT-HIV/STD). . . . MDFT-HIV/STD is the first model to address largely unmet HIV/STD prevention and sexual health needs of substance abusing juvenile offenders within the context of a family-oriented evidence-based intervention" (p. 70).

Nobles, W.W., Goddard, L.L., & Gilbert, D.J. (2009). Culturecology, women, and African-centered HIV prevention. *Journal of Black Psychology, 35*(2), 228-246.
"In this article, we discuss the Healer Women Fighting Disease Integrated Substance Abuse and HIV Prevention Program for African American women – an innovative project that tested the efficacy of the African-centered behavioral change model in the prevention of behavioral choices associated with HIV/AIDS" (p. 229).

O'Leary, A., & Wolitski, R.J. (2009). Moral agency and the sexual transmission of HIV. *Psychological Bulletin, 135*(3), 478-494.
"The present article reviews the literature on sexual transmission risk behavior within [a] theoretical framework of moral agency. The article first reviews evidence for the operation of moral agency in transmission risk behavior and HIV status disclosure. Next, suggestive evidence is presented for the operation of mechanisms of moral disengagement. . . . Finally, the article reviews a small number of interventions that have been shown to be effective in reducing transmission risk behavior, through the lens of moral agency, and make[s] recommendations for future intervention research" (p. 478).

(Tool Box is continued on Page 16)

(Tool Box -- continued from Page 15)

Pence, B.W. (2009). The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/AIDS. *Journal of Antimicrobial Chemotherapy, 63*(4), 636-640.
"Extensive research has demonstrated that the primary barriers to [ARV therapy] adherence include mental illness, especially depression and substance abuse, as well as histories of traumatic experiences such as childhood sexual and physical abuse. . . . The efficacy of standard mental health interventions, such as antidepressant treatment and psychotherapy, has been well-defined, and a small but growing body of research demonstrates the potential for such interventions to improve [ARV therapy] adherence and reduce sexual risk behaviours. . . . Challenges to the provision of mental healthcare . . . in HIV clinical settings include time and resource constraints, lack of expertise in psychiatric diagnosis and treatment, and lack of available mental health referral services" (p. 636).

Reisner, S.L., Mimiaga, M.J., Skeer, M., Perkovich, B., Johnson, C.V., & Safren, S.A. (2009). A review of HIV antiretroviral adherence and intervention studies among HIV-infected youth. *Topics in HIV Medicine, 17*(1), 14-25.
"This article reviews published adherence studies on HIV-infected youth (ages 13 to 24 years), focusing on rates of adherence to [ARV] regimens and interventions designed to enhance adherence. Included are possible directions for future research and suggestions for intervention development to improve [ARV] adherence among HIV-infected youth" (pp. 14-15).

Stevens, P.E., & Hildebrandt, E. (2009). Pill taking from the perspective of HIV-infected women who are vulnerable to antiretroviral treatment failure. *Qualitative Health Research, 19*(5), 593-604.
"In this article we focus on the medication experiences of . . . 14 women who persistently had difficulties taking ARVs as prescribed, detailing their descriptions and evaluations of pill taking. Results suggest that rather than judging themselves harshly for non-adherence, they perceived their at-odds pill taking to be personally meaningful and accomplished for good purpose. Their rationales provide insights for more nuanced, empowerment-based interventions for individuals who are vulnerable to ARV treatment failure" (p. 593).

Stoff, D.M., Forsyth, A., Marquez, E.D., & McClure, S. (Eds.). (2009, April). Mentoring for diversity in the mental health of HIV/AIDS. *American Journal of Public Health, 99*(1 Suppl.), S4-S91.
"The articles in this supplement describe and critically analyze new mentoring programs that provide unique opportunities to diversify the workforce addressing mental health and HIV/AIDS" (p. S11).

Vlassova, N., Angelino, A.F., & Treisman, G.J. (2009). Update on mental health issues in patients with HIV infection. *Current Infectious Disease Reports, 11*(2), 163-169.
"The evidence supporting the need for optimal provision of mental health care in HIV clinics is mounting, along with evidence that these disorders can be treated successfully. Disorders of mental life include brain diseases (e.g., depression, bipolar disorder, schizophrenia, and dementia), personality disorders, addictions, and psychologic disruptions, which contribute to the spread of the virus through their influence on behavior. However, although evidence exists that successful treatment of co-occurring mental disorders leads to improved HIV outcomes, integrated mental health care in HIV clinics remains grossly suboptimal" (p. 163).

Werth, J.L., Jr., & Crow, L. (2009). End-of-life care: An overview for professional counselors. *Journal of Counseling & Development, 87*(2), 194-203.
"The purpose of this article is to provide professional counselors with an overview of [end-of-life] issues, including ethical and legal concerns, practice considerations, and recommendations for the field" (p. 194).

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purpose of describing "the level of youth and caregiver responsibility across a range of illness-management tasks and to assess the relationship of medication adherence to **responsibility for medication-related tasks**" (p. 191) in families of children and teens who were perinatally infected with HIV. The investigators found that "approximately one-fourth of the youth reported being fully responsible for taking medications. A smaller percentage of caregivers reported full youth responsibility. Older youth and caregivers of older youth reported higher degree of youth responsibility for medication-related tasks, though age was unrelated to adherence. Caregiver report of greater responsibility for medications was associated with better adherence" (p. 187). In short, caregivers in this study were "likely to transition responsibility for HIV care to older youth but this transition was not always successful as evidenced by poor medication adherence" (p. 187). Naar-King and colleagues also point out that

> caregivers reported being fully responsible for tasks unrelated to medications such as explaining school absences, but [were] more likely to decrease their responsibility for medication-related tasks critical to maintain ing good health outcomes. . . . Consequently, <u>interventions are necessary to increase parental oversight of medication tasks with careful transition to shared responsibility with older adolescents</u>. . . . However, <u>other illness-management tasks, such as making health care appointments, may be helpful for practicing youth responsibility in a way with less detrimental impact upon health if the transition is difficult</u>. Furthermore, learning to successfully accomplish these other illness-management tasks will be necessary for successful transition into adult care. (pp. 191-192)

Coping, Social Support, & Quality of Life

Butler et al. (2009) conducted a longitudinal study of 395 perinatally HIV-infected children and youth from across the U.S. to "examine the impact of **HIV disclosure** on pediatric quality of life and to describe the distribution of age at disclosure **in a perinatally infected pediatric population**" (p. 935). The investigators found that "disclosure did not significantly affect [quality of life]" in this cohort. "Although primary caregivers reported lower [quality of life] scores after disclosure for all of the domains except social/role functioning, these differences were not significant, even after adjustment for demographic and clinical factors" (p. 940). Butler and colleagues conclude that "diagnostic disclosure to children with HIV should not be delayed because of fear of a negative impact on [quality of life]. Disclosure is occurring at younger ages [(median age in this study was 11 years)], which may suggest a decline in the stigma and fear surrounding an HIV diagnosis. Additional work is needed to describe important factors that are related to optimal strategies in disclosing an HIV diagnosis. Such knowledge may offer critical guidance to pediatric providers in counseling caregivers of HIV-infected children and adolescents" (p. 941).

Continuing the analysis of data derived from a study highlighted in the Fall 2006 issue of *mental health* **AIDS**, Bormann and Carrico (2009) examined "whether increases in positive reappraisal coping or distancing coping mediated the sustained decreases in anger found following a **group-based mantram intervention** that was designed to train attention and promote awareness of internal experiences" (p. 74). Mantram repetition is defined as "silently repeating a spiritual word or phrase frequently throughout the day" (p. 74). The investigators randomly assigned 93 study participants to either a mantram (n = 46) or attention-matched control group (n = 47). Measurements were taken at baseline, week 5, week 10 (at the conclusion of the intervention), and week 22.

According to Bormann and Carrico, "participants in the mantram intervention reported significant increases in positive reappraisal coping over the 5-week intervention period, whereas the control group reported decreases. Increases in positive reappraisal coping during the 5-week intervention period appear to mediate the effect of mantram on decreased anger at 22-week follow-up" (p. 74). In other words, "the mantram intervention appears to reduce trait-anger by decreasing the likelihood that individuals respond reflexively with anger to a given stressor" (p. 78).

Bormann and Carrico conclude that these results "provide preliminary support for the efficacy of the mantram intervention and highlight that it may reduce anger by increasing the utilization of cognitive coping skills" (p. 79). "By learning to more effectively manage feelings of anger, mantram may assist HIV-positive individuals with increasing and maintaining supportive social relationships as well as meeting important treatment-related goals such as achieving adequate levels of adherence to [ARV] therapy" (p. 78). In addition, the use of a "mantram may assist individuals in managing reactivity in order to derive the maximum benefit from other cognitive-behavioral and coping skills training elements of multi-modal stress management interventions designed for HIV-positive persons" (p. 78).

Mavandadi, Zanjani, Ten Have, and Oslin (2009) compared data from two diverse samples of men and women living with HIV: 74 "younger" adults between the ages of 21 and 54 years, and 35 "older" adults 55 years of age or older. 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)

"Although prior work has demonstrated that older adults with HIV/AIDS may be particularly susceptible to social isolation, smaller social networks and declines in psychological well-being" (p. 96), Mavandadi and colleagues conclude that "more attention should be paid to the social environment of individuals diagnosed with HIV as the quality of social relationships may be particularly important for successful psychological adaptation to HIV" (p. 91).

Continuing the focus on social context, Knowlton, Curry, Hua, and Wissow (2009) interviewed 156 dyads to examine **supporter relationship factors associated with depressive symptoms** among "disadvantaged, HIV-seropositive, injection drug-using individuals" (p. 534) and their main informal supporters. The investigators found that

> among this sample of support recipients, depressive symptoms . . . were associated with a 3.6 times higher odds of their main supporter's higher depressive symptoms and a 2.5 times higher odds of their supporter being a peer (versus partner or older or

> younger generation kin). The support recipient's financial reliance on her main supporter was associated with a 3.7 times higher odds of high depressive symptoms. Moreover, each 1-point increase in supporter-recipient conflict was associated with a 29% higher likelihood of the support recipient's probable depression, and each 1-point improvement in supporter-recipient communication was associated with a 24% lower likelihood of depression. The final model explained over half (52%) of the statistical deviance in the sample's depressive symptoms. Furthermore, supporter-recipient relationship factors attenuated the effects of individual-level factors (i.e.[,] female sex and current drug use) on the support recipient's depressive symptoms. (p. 535)

Knowlton and colleagues conclude that

> clinical assessment and treatment of depression is merited of not only persons living with HIV/AIDS but also their main supportive ties.
>
> Study results suggest that interventions to promote this population's psychological well-being ought to address interpersonal support dynamics. Specifically, results suggest that interventions promoting interpersonal communication and conflict resolution skills and reciprocity of social support from friends and siblings may facilitate less stressful negotiation of social support among this population. . . . [I]ntervention approaches promoting the support recipient's reciprocity of support may potentially improve the willingness of others to provide informal care. Interventions also need to address the financial costs of HIV-related support and informal caregiving and possible resultant strains of financial support exchange.
>
> Results also suggest that . . . interventions targeting both main supporters and the support recipients will likely be more efficacious compared with those that target either group alone. . . . Such intervention approaches may not only alleviate depressive symptoms among those living with or affected by HIV/AIDS, but they may also improve the likelihood of main supporters assuming and sustaining informal HIV caregiving as illness progresses. (p. 538)

Bottonari and Steplemen (2009) conducted a chart review to identify **factors associated with longevity of outpatient psychotherapy** among persons living with HIV. The investigators reviewed the records of 87 clients – "33.3% female, 52.9% ethnic minority, 57% sexual minority, middle-aged (42.0 years ± 9.6 years)" (p. 109) – served in a Ryan White-funded clinic and found that

> mental health treatment is acceptable to many [people living with HIV] and that previous consumers of care will likely reengage in the future. . . . [A]lmost three quarters of . . . [study] participants returned for care after their initial intake session, suggesting that they perceived initial benefit from their evaluation appointment and were willing to return for further treatment. . . . However, only one third of . . . [the] sample remained in treatment for six sessions or more. . . . Hence, it appears appropriate . . . [to] examine what factors are associated with longevity in care among HIV-positive patients. (p. 114)

On this question, Bottonari and Steplemen found that "the presence of cohabitating social support distinguished between those who continued or terminated after the intake session, with social support being associated with continuation after intake. Furthermore, shorter distance from clinic, history of previous psychotherapy, concurrent pharmacotherapy, comorbid personality disorder diagnosis, and having an ethnic minority provider were associated with greater longevity in treatment" (p. 109). Although these findings must be considered preliminary, they alert clinicians to "factors that are associated with early termination in outpatient psychotherapy among [people living with HIV]. Previous research has demonstrated that therapists believe that [people living with HIV] may need to continue in therapy longer than HIV-negative individuals. . . . As such, treatment providers could utilize . . . [these] findings to pay attention to their patients with these characteristics in order to improve patient retention" (p. 115).

End-of-Life Care

To assess congruence in adolescent/surrogate preferences for end-of-life (EoL) care, Lyon et al. (2009) randomly assigned 38 dyads consisting of medically stable adolescents living with HIV/AIDS and receiving hospital-based outpatient treatment, and their guardians/surrogates, to one of two conditions. Dyads in the intervention condition were offered a three-session "**model of family/adolescent-centered advance care planning** [(ACP)] for adolescents living with HIV and their families for increasing congruence and quality of communication while decreasing decisional conflict" (p. e199).[5] Dyads in the control con-

[5] In session 1, a family-centered ACP survey "was administered via an interview to determine whether and when the adolescent wanted to be involved in decision-making about EoL care and to identify values, beliefs, and experiences with illness." In session 2, "trained facilitators elicited the patient's representation of illness, stimulating adolescent and guardian/surrogate conversations about ACP to provide an oppor-

dition gave a nonmedical developmental history, received health promotion counseling, and conversed about future plans. Lyons and colleagues found that "family-centered advance care planning by trained facilitators increased congruence in adolescent/surrogate preferences for [EoL] care, decreased decisional conflict, and enhanced communication quality. Families acknowledged a life-threatening condition and were willing to initiate [EoL] conversations when their adolescents were medically stable" (p. e199).

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tunity to express fears, values, goals, and experiences with regard to death and dying and to prepare the guardian/surrogate to fully represent the adolescent's wishes. Misinformation was corrected and questions for the physician listed. The adolescent completed the Statement of Treatment Preferences . . . in session 2. Immediately after session 2, a revised Statement of Treatment Preferences was completed via interview with the guardian/surrogate, eliciting responses to, 'My child . . .' for the 3 situations." In session 3, the "adolescent completed . . . a legal directive that documented how he or she would want to be treated if unable to speak for himself or herself. These documents were placed in the adolescent's medical chart, with a copy to the family and physician" (Lyon et al., 2009, p. e200).

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Tool Box

A Note on Content

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

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

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

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

mental health **AIDS** is available online!
Go to: http://mentalhealthAIDS.samhsa.gov