

mental health AIDS

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

Biopsychosocial Update

HIV Prevention News

About Men Who Have Sex With Men

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

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

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

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

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

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

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

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

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

In This Issue:

Biopsychosocial Update	
HIV Prevention News.....	1
HIV Assessment News.....	8
HIV Treatment News.....	13
Tool Boxes	
Resources.....	5
Positively Golden:	
Advances in Aging with HIV (Part 2).....	8
A Note on Content.....	19

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

About Men

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

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

Bogart and colleagues note that these findings

serve as a companion to prior

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

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

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

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

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

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

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

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

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

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

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

About Adolescents & Young Adults

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

Tool Box

Resources

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

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

"The purpose of this study was to de-

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

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

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

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

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

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

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

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

(Tool Box is continued on Page 6)

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

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

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

(Tool Box -- continued from Page 5)

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

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

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

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

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

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

About Women & Men

Noar, Crosby, Benac, Snow, and

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

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

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

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

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

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

Troutman (2011) applied an expanded version of “the attitude-social influence-efficacy (ASE) model²

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

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

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

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

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

– Compiled by
Abraham Feingold, Psy.D.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

uninfected partner.

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

HIV Assessment News

Psychiatric Assessment & Intervention

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

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

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

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

Bhatia and colleagues suggest that

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

Tool Box

Positively Golden: Advances in Aging with HIV (Part 2)

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

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

Positive Aging Strategies

According to Hill (2011),

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

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

In short,

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

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

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

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

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

mental health AIDS

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Biopsychosocial Update

HIV Prevention News

About Adolescents & Young Adults

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

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

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

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

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

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

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

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

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

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

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

Readers can now link to the newsletter and archives through SAMHSA's new Behavioral Health and HIV/AIDS Web page.

In This Issue:

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

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

Koenig and colleagues point out that

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

The investigators continue:

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

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

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

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

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

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

Kershaw and colleagues observe that

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

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

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

About Women & Men

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

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

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

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

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

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

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

With regard to intervention, Nöstlinger and colleagues urge clinicians to

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

Tool Box

HIV Prevention 2011: Hits, Misses, & Hopes

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

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

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

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

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

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

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

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

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

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

Think Local

The formulation and testing of pre-expo-

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

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

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

Not Quite There Yet

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

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

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

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

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

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

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

Golub and colleagues believe that these

findings . . . have several impor-

Tailored to Fit

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

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

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

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

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

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

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

Attending to Trending

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

(Tool Box is continued on Page 6)

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

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

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

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

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

(Tool Box -- continued from Page 5)

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

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

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

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

Peering into the Future

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

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

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

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

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

The developers acknowledged that

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

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

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

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

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

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

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

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

McKirnan and colleagues add that they

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

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

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

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

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

About Women

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

Teti and colleagues reason that

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

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

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

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

About Men Who Have Sex With Men

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

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

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

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

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

Importantly, Hallett and colleagues emphasize that

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

HIV Assessment News

HIV Counseling & Testing

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

Psychiatric Assessment

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

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