

MODULE FOUR

Intervention Strategies

A. New & Emerging Themes in Psychotherapeutic Intervention

- HIV rates have increased rapidly among disenfranchised ethnic minorities and women. Today, those infected are more often from communities of poverty (i.e., intravenous drug users and their sexual partners, persons who are incarcerated, individuals with serious mental illness, people who are homeless, the foreign-born, and those in the sex trade). As a result of these epidemic trends, those being infected with HIV are more likely to have a vast array of long-standing and complex problems that require an enormous amount of case management and practical help.
- For many from these traditionally disenfranchised communities, living with HIV is just one more thing to deal with in the daily struggle for survival that includes crushing poverty, drugs, violence, and other health problems. In fact, HIV-related issues may, out of necessity, simply not be one of their top priorities. Thus, the mental health provider is increasingly being called upon to assist with prioritizing therapeutic goals that may not involve HIV and to assist with the therapeutic objectives related to case management.
- For still others, contracting HIV/AIDS may have brought about positive developments in their life by enabling them to gain access to specialized and integrated care service systems otherwise unavailable to them. Additionally, some people have found that HIV/AIDS has been a positive force in their life because it served as a wake-up call for addressing drug use or other self-destructive behaviors; it provided them with a sense of identity that helped to organize their activities, and it provided them with access to support groups and others mechanisms for connecting with people who are in the same boat and struggling to improve their lives. Thus, HIV/AIDS may serve as a toehold for the mental health provider to assist in successfully addressing long-standing problems that had heretofore been intractable.
- HIV has increasingly become a multigenerational family disease. HIV-infected parents may be caring for children, some of whom are infected and some of whom are not.
- Many HIV-infected women are struggling to care for their children and their HIV-infected partners while finding little time to care for their own needs. Many women living with HIV are struggling with the post-traumatic effects of rape and sexual abuse.

- Because many of those infected with HIV have long-standing problems with mental illness and substance abuse, their lives may be quite chaotic and their capacity to relate and establish relationships impaired. This means that the mental health provider may need to focus on one-shot interventions and strategies for promoting engagement.
- Although not everyone responds to highly active antiretroviral therapies (HAART), and the long-term benefits remain uncertain, for many persons, previous expectations of dying are still supplanted by ongoing hope that HIV disease can be managed as a chronic condition.
- Although medical treatments have dramatically improved in recent years, people living with HIV are faced with more uncertainty about medical treatment. New drugs and new combinations of drugs are regularly released but no one knows how long their efficacy will last. Many people living with HIV disease wonder if their physicians are keeping up with the latest information and thus they worry that they are not taking the newest or best combination. Many worry that treatment decisions in the early days of AZT turned out to be wrong (e.g., high doses late in the progression of HIV) and thus they worry that the medical establishment may be wrong again. People living with HIV/AIDS worry about starting medications too early in the disease process, thus possibly diminishing treatment options or potentially causing drug-related physical problems in the future. They also worry about starting too late and thus letting HIV progress too far.
- Many people living with HIV disease experience internal conflicts expressed as a mixture of optimism and uneasiness because of uncertainties about HAART. Thus it is important for mental health providers to explore knowledge of potential HAART benefits and risks, expectations or fantasies about HAART, and emotional reactions to treatment success or failure.
- Uncertainty about the meaning and importance of “undetectable viral load” causes some to experience a great deal of anxiety. Many patients and providers are obsessed with achieving undetectable viral loads and thus want to switch drug combinations quickly if viral levels don't drop quickly after initiation of treatment or if “blip” in viral load occurs. Other patients and other providers are less concerned about lower levels of detectable virus and thus are reluctant to switch medication too quickly. The patient and/or the provider may feel like the patient has “a rhythm” with a particular medication regimen or the patient and/or the provider may be concerned that too many switches will reduce options later thus choosing a short term wait-and-see approach.
- In the face of uncertainty about medical treatments, people living with HIV/AIDS often make judgements about what they will and will not take based on considerations that they may or may not share with medical professionals. For example, decisions may be based on:

1. What they hear from friends on the street (e.g., “I used to take that stuff and it made me feel miserable and then my doc put me on this stuff and now I feel great”; “You are crazy to switch now; you just got used to what you have been taking”; etc.);
 2. What they remember from the past (e.g., “They told my friend to take AZT and he got sick and died”).
 3. What they believe about the potential for cross-resistance (e.g., “I don’t want to take any drugs until I finish having all my kids because I don’t want to develop a resistant strain and pass it on to my kids”; “Now that I have reached undetectable levels maybe I’ll cut my dose in half to minimize the possibility of my meds losing their effectiveness down the road”).
 4. Unexpressed anger at the medical team who may be blamed for not listening or attending to patient concerns or issues as a result of cultural differences, power differences, or the hectic time demands on providers.
 5. What they feel like they can deal with (e.g., “I have so many pills that I can’t deal with them all – I’ll take the antiretrovirals but right now I just can’t deal with the anti-depressants too”).
- Those who were infected with HIV before the development of combination therapies, who thought they were going to die, and who are now faced with the possibility of a second life may be faced with an identity crisis. Unexpected renewed health may activate a reconsidering of life choices, priorities, aspirations, and goals. Regrets about specific paths not chosen and feelings of loss related to missed opportunities may emerge (e.g., abandoning specific educational or occupational pursuits or choosing to avoid romantic involvement in anticipation that there is no future or to stay in a troubled relationship out of fear of being alone). Ambivalence about assuming the responsibilities and expectations inherent in reattaching to life and planning for the future may be present. People living with HIV may be struggling with questions such as the following:
 1. Can I really start planning for living for a long time after previously planning for only one-year, two-year, or five-year windows of time?
 2. How do I pick up my life again when I have been living it as though I was going to die soon (e.g., “I spent all my money”, “I quit working”, etc.)?
 3. Do I want to return to work and if I do what will happen to my benefits? Do I want to go back to what I was doing before or do I need to do something different because my life has changed so much since I quit work?
 4. Do I or should I feel guilty because I wasted time during the period I was expecting to die?
 5. Do I or should I feel guilty about fully re-engaging my life given how many friends I lost to HIV/AIDS?
 6. How can I help my friends relate to me better? When I was sick they knew what to say and do but now that I am feeling better we never talk about HIV

despite the fact that it is still hard to live with all the medications, the doctor visits, the lipid belly, and the uncertainty.

- In light of post-exposure prophylaxis, new treatments, and the reality of living with undetectable viral loads, people with and without HIV are struggling with whether they need to be as concerned about HIV transmission as they once were. People wonder – “If one’s viral load is undetectable does that mean the chances of transmission are substantially reduced or eliminated?” Unfortunately, no one has the definitive answer and thus people are once again faced with the disquieting truth of uncertainty. Careful attention should be paid to attitudes about the dangerousness of HIV disease given recent treatment advances as well as perceptions of social norms about risk in the wake of HAART availability.
- Many people living with HIV have lived long enough to have moved into a new developmental phase. Children infected through perinatal transmission are now adolescents dealing with the normal desire to have sex. Sometimes these children don’t know their HIV status, sometimes these children know their HIV status but don’t want to tell their peers because of fears of rejection, and sometimes the parents of HIV-infected children don’t want to acknowledge the reality that their child is struggling with the desire for sex. Men who have sex with men who were infected in their young and middle adult years are now moving into middle age or retirement years without role models to chart their developmental path.
- In light of new combination therapies, the use of AZT to prevent perinatal transmission, heterosexual couples are increasingly inclined to have children despite the continued stigma attached to such decisions. As the number of HIV-infected parents with children increases, the need for permanency planning also increases.

B. Other Common Themes Psychotherapeutic Intervention

1. Existential Issues

- What matters?
- How should I spend my time?
- How can I improve my relationships and which ones are worth investing in?
- Taking care of old business with family and friends.
- Exploring one's sense of spirituality.
- Developing an awareness of the dialectic between hope and despair.

2. Empowerment and Control

- Initiating and/or maintaining sobriety.
- Learning skills to deal with health care, insurance, disability, and social service systems.

- Learning how to shift from independence to dependence and back again with dignity.
- Setting concrete goals associated with what matters and with what can be controlled.
- Obtaining emotion-focused support and arranging distractions for things that cannot be controlled.

3. Gathering Information

- About conventional medical treatments.
- About experimental treatments.
- About non-conventional or alternative treatments.
- About health care and social services.
- About legal issues and services.
- About political and social activism.

4. Working Through Grief and Loss

- Loss of others.
- Loss of one's sense of self as a person without significant health problems.
- Anticipatory loss of capacity if combination treatments fail.

5. Managing Pain, Suffering, and Affective Responses

- Learning pain management skills.
- Learning cognitive strategies of managing depression, anxiety, and fear.
- Learning to make appropriate use of psychotropic medication.

C. Common Psychotherapeutic Tasks Associated With Physical Symptoms & Medical Treatments

- *Listening attentively to the client's presentation of symptoms, diagnostic procedures, and current medical treatments.* Health care providers are often too busy to listen. Friends, partners, and family may be disinterested, overwhelmed, or too quick to encourage the client to talk about other things.
- *Assisting with adherence to medical regimens.*
- *Exploring how changes in medications and physical status affect daily living.* Such explorations usually have implications for modifying routine ways of doing things. Such explorations typically lead to new observations about medications and about changes in health status and to the formulation of questions that need to be posed to the primary care provider.

- *Restoring a sense of control by assisting the client with gathering information about standard medical, experimental, ancillary, and alternative treatment options.*
- *Assisting the client in weighing various options in consultation with primary care providers, various conventional and non-conventional specialists, friends, family, and partners.*
- *Discussing fears, loss, and symbolic significance associated with symptoms, diagnostic procedures, medications, and treatments. Offering emotional support and transforming such discussion into strategies for concrete action whenever possible.*
- *Empowering the client to improve communication and collaboration with his or her physician and other health care providers.*
- *Assisting the client in coping with the roller coaster of constitutional symptoms and reactions to drugs (e.g., fatigue, diarrhea, eating problems, pain, sleeping problems...)*
- *Assisting clients' discovery of what they can do to increase their physical and psychological comfort.*
- *Teaching relaxation and pain management techniques.*
- *Preparing clients for scary or painful diagnostic procedures.*
- *Educating clients and significant others about neuropsychological complications and strategies for managing them.*

D. Common Issues to be Addressed in Psychotherapy Across the Course of HIV Disease

1. HIV Antibody Testing

a. Considering Client's Risk Behavior

- Assess risk behavior in explicit terms
- Explore the impact of alcohol and drugs on risk-taking
- Assess ability to say no to risky behavior

b. Contemplating Testing

- Assess the sense of vulnerability, safety, control, and social support
- Explore ambivalence about knowledge of HIV status

- Explore issues of confidentiality and disclosure
 - Become informed about testing procedures and early medical intervention
 - Examine beliefs about the anticipated effects of positive and negative test results
- c. Taking the HIV Test
- Containing anxiety
 - Summon courage to face the results
 - Deciding who, how, when, and where to tell
 - Organizing social support

2. Psychosocial Issues of Early HIVD

- a. Coping With Test Results
- Confronting life with a chronic illness and fears about death
 - Sorting through and containing affective responses and crisis intervention when necessary
 - Short-term planning
 - Confronting and coping with current and anticipated stigma
 - Who, how, when, and where of disclosure
 - Organizing social support
 - Assessing impact of results on substance use and recovery
- b. Accessing Health Care
- Assess concerns about accessing health care
 - Assess health care resources
 - Assess potential barriers to accessing health care
 - Make personal assessment of critical ingredients for quality relationships with health care providers
 - Collaborate with physician to develop action plan for health
- c. Wondering/Worrying/Planning
- Contain anxiety and hypervigilance for symptoms
 - Explore the possibility of redefinition of self and goals
 - Improve quality of social support
 - Strengthening relationships with health care team
 - Becoming informed about traditional, experimental, and alternative treatments
 - Make decisions about sex, disclosure, and safer sex

3. Coping with Early Symptoms, Decline in T-Cells, or Increased Viral Load

- Become informed about symptoms, medication effects, and psychological reactions
- Grieve the loss of the sense of oneself as a person without health concerns
- Consider treatment options
- Adjust to treatment side effects and the demands of adherence
- Manage fears of dependency
- Adapt to the impact of symptoms and medication regimens on work, family, and social lives

4. Psychosocial Issues of Later Stages of HIV Disease

a. Coping with Life As A Person with AIDS

- Cope with cognitive changes or the threat of them
- Cope with regression and vulnerability during periods when T-Cells drop, viral loads increase, or symptoms appear

b. Managing Chronic Health Problems

- Assessing depression and neuropsychological symptoms and the need for intervention
- Educating and organizing family, friends, and partners about one's changing needs
- Learning to set flexible goals to accommodate changes in energy and health status

c. Dealing with Repeated Treatment Failures

- Cope with feelings of disappointment, failure, and rage resulting from the fact that others are doing well but you are not
- Confront death in a more personal way
- Reevaluate level of support needed
- Organize support services
- Reconsider previous decisions about disclosure
- Confront impairment, retirement, and disability

d. Preparing to Die If Treatments Fail Altogether

- Making plans for children left behind

- Legal planning
- Weighing medical treatment needs with quality of life issues
- Dealing with anticipatory grief in self and others
- Determining what is worth the effort and what is not
- Managing dementia and/or delirium
- Coping with limitations of the therapist's time and commitment
- Taking care of unfinished business
- Coping with conflicts between biological and chosen families
- Making decisions about the quality of dying -- home, pain, hospice, etc.
- Saying goodbye
- Exploring spiritual sensations and thoughts

E. Interventions for Mood Disorders

- Transient sadness and anxiety are a normal part of living with the stresses of HIV disease. Mood symptoms that are severe and persistent and affect daily functioning are *much less common*.
- Psychotherapy and psychopharmacology are often used together to treat the more persistent symptoms of depression and anxiety. For many clients these two modes of treatment work synergistically. Symptoms that don't respond to one modality may respond to the other.
- Numerous studies have shown that treatment with HAART and the associated medical improvement is associated with a reduction in HIV-associated depressive symptoms (Bartoli et al., 2002).
- There is an ever-expanding selection of antidepressant medications such as tricyclics, selective serotonin reuptake inhibitors (SSRIs) (e.g., Prozac, Zoloft, Paxil, Luvox), bupropion (Wellbutrin), trazadone (Desyrel), venlafaxine (Effexor), nefazodone (Serzone), and mirtazapine (Remeron) that are effective in treating depression. Adjuvant treatments or medications that can be added to help boost the effect of the antidepressant medications include psychostimulants and hormonal treatments (thyroid, testosterone and DHEA)
- The co-administration of protease inhibitors and certain psychotropic medications may alter the metabolism of one or both agents, thereby lowering the therapeutic effectiveness of one or both agents. Of particular concern are those psychotropic medications that may be lethal in extremely high concentrations (e.g., tricyclic antidepressants, sedatives, opiates).
- Protease inhibitors, ritonavir (Norvir) in particular, are powerful inhibitors of the various P450 isoenzymes that metabolize antidepressants, benzodiazepines, and neuroleptics.

- Although clients with asymptomatic HIV disease who are not taking protease inhibitors may be treated with the same dosages as seronegative patients, those with more advanced disease should be treated initially with half the usual starting doses, raising dosage only after it is clear the client is tolerating the medication. It should be noted that bupropion and certain benzodiazepines (i.e., Valium, Klonopin, Halcion, and Dalmane) are contraindicated with ritonavir.
- St. John's Wort (*hypericum perforatum*), the popular herb sold as a dietary supplement for the treatment of depression and anxiety, can affect the protease inhibitor (PI) indinavir (Crixivan[®]), causing blood levels of that medication to drop by an average of 57%; this drop could allow HIV to strengthen or develop resistance (Piscitelli, Burstein, Chaitt, Alfaro, & Falloon, 2000). Scientists believe that this decline in indinavir's blood concentration occurs because St. John's Wort increases the activity of liver enzymes that break down and help to eliminate many drugs from the system. For this reason, it is possible that St. John's Wort may significantly decrease blood levels of protease inhibitors (PI) and, possibly, non-nucleoside reverse transcriptase inhibitors (NNRTI). In response, the Food and Drug Administration (FDA, 2000) issued a public health advisory warning against the concurrent use of St. John's Wort and PIs or NNRTIs.
- The antidepressant nefazodone (Serozone[®]) appears to cause palinopsia (i.e., the continuance or reoccurrence of a recent visual image) in HIV-positive men taking PIs; the antidepressant appears to interact with PIs, particularly ritonavir (Norvir[™]), potentiating their effect (Mosberian, Leung, Hollander, & Remick, 1999).
- Dextroamphetamine (a psychostimulant) appears to improve both mood and energy in men with advanced HIV disease who experience depression (particularly dysthymic disorder) accompanied by debilitating fatigue. No evidence of tolerance, abuse, or dependence was observed (Wagner & Rabkin, 2000).
- In people with advanced AIDS and with apathetic withdrawal as the most prominent depressive symptom, the psychomotor stimulant methylphenidate (Ritalin) may improve functioning or mood.
- Suicidality may be a symptom of a treatable depression or a pain syndrome. Most commonly, thoughts of suicide help clients maintain a sense of control, a sense that there is a means to an end to their suffering if necessary. Usually these feelings remain theoretical, in the distance. Imminent suicidal feelings, especially if a client has made concrete plans, require immediate assessment and intervention.
- Treatment of mania in patients with co-morbid HIV infection is complicated due to the increased incidence of medication side effects and the potential for drug-drug interactions. Medications can include antipsychotics at lower doses, benzodiazepines, mood stabilizers (lithium carbonate) and anticonvulsants

(valproate). Carbamazepine is an alternative treatment but may cause significant side-effects and drug interactions.

E. Interventions for Anxiety Disorders

- The anxious client can learn to cope more effectively with illness-related stressors, often through brief psychotherapeutic interventions involving the identification of overt and covert stressors, the enhancement of coping and communication skills, and relaxation techniques.
- Nonpharmacologic therapies to reduce anxiety include: muscle relaxation, meditation techniques, individual psychotherapy, psychoeducation, aerobic exercise, electromyographic biofeedback, behavioral techniques, acupuncture, self-hypnosis and guided imagery, cognitive behavioral therapy, supportive group therapy and the establishment of social networks. Integrating care can also help to prevent or relieve anxiety.
- For treatment of short-term anxiety, psychiatrists and other physicians may prescribe benzodiazapines, starting with lower doses, and bearing in mind that they can induce relapse of substance use disorders. For generalized anxiety disorder, it is common to start treatment with buspirone (BuSpar). For panic disorder antidepressants are effective treatment. SSRI's are most commonly used. Benzodiazapines may also be prescribed as needed for breakthrough anxiety for the period before antidepressant become effective.
- Anxiety disorders are common during specific points in the process of HIV disease progression. Diagnosing anxiety among patients with HIV infection requires a comprehensive differential diagnosis in order to rule out underlying medical etiologies. HIV-related anxiety disorders are treatable, both with nonpharmacologic and pharmacologic treatment strategies, or a combination of the two.

F. Interventions for Psychotic Symptoms

- Antipsychotics are very effective for treating HIV+ severely mentally ill patients with primary psychotic disorders. In general, for HIV patients with psychosis, the rule is to start with lower doses and increase the doses more slowly than usual. Stabilization of psychosis prior to beginning an antiretroviral regimen is essential in order for adherence to be maintained.

G. Interventions for Bereavement and Multiple Loss

- Despite new treatments that prolong the lives of people with HIV disease, deaths continue to occur and friends, families, and other loved ones continue to grieve. Furthermore, mourners who lost loved ones in the past few years may experience a

very specific kind of dismay at the idea that their loved ones may have just missed the opportunity to extend their lives.

- Many people mourning HIV-related losses experience grief symptoms similar to those faced by other bereaved individuals (e.g., numbness, sadness, denial, preoccupation with the deceased, etc.). However, the unfortunate reality of multiple losses as well as stigma associated with AIDS, homosexuality, and substance abuse increase the likelihood that people suffering AIDS-related bereavement will experience prolonged or complicated grief reactions.
- Worden (1982) identified four tasks that must be accomplished before mourning is complete. These four tasks are as follows: (1) to accept the reality of the loss; (2) to experience the pain of grief; (3) to adjust to an environment in which the deceased is missing; and, (4) to withdraw emotional energy and reinvest it in other relationships or other pursuits. Mental health providers can perform a critical role in assisting AIDS mourners to work through these tasks by providing information, support, and encouragement.
- Pathological or complicated mourning is best understood as an exaggeration or distortion of the normal process of mourning. Three variants of complicated mourning are widely discussed in the clinical literature: absent mourning, delayed mourning, and chronic mourning.
- Absent or delayed mourning refers to the lack of grief symptoms. This absence of grief may have to do with primitive defenses of denial and repression; it may have to do with the fact that there are so many things going on or so many recent losses that the mourner cannot create the “psychological space” to feel; or, it may have to do with the mourner’s perception that they will be overwhelmed by grief or by fears of their own death and dying.
- Chronic mourning involves the undesired persistence of grief reactions, including shock, yearning, searching disorganization, and despair over a prolonged period of time. Even after an extended period of time, the loss continues to feel fresh and painful memories and thoughts may intrude into consciousness and disrupt occupational and social functioning.
- Although depression, anxiety, and stress are normal reactions to grief and often can be addressed through existing social support, professional intervention is necessary when grief reactions result in major depression, serious anxiety disorders such as post-traumatic stress disorder, or substance abuse. It is important to note that contrary to clinical lore suggesting that early intense grief is the normal and healthy response to loss, Zisook and Shuchter (1991) found that early intense grief reactions are associated with complicated mourning.
- The burden of grieving is often increased for many people because they think their reactions are not normal and because well-intentioned friends and family often act

to shut down expressions of grief. Mental health providers can accomplish a great deal by offering bereavement education – emphasizing the typical course and reactions to bereavement. This process of normalizing grief reactions and providing a supportive arena for expression of grief is extraordinarily helpful to most people.

- Those experiencing multiple loss often feel like they cannot access their feelings of grief because if they do they will be overwhelmed by a flooding of feelings associated with all of their losses. It is often helpful to assist others in developing skills in compartmentalizing and closing down feelings of grief as they deal with their feelings a little bit at a time in the safety of a psychotherapeutic hour. Paradoxically, helping mourners feel confident that they can shut down their feelings enables them to feel more confident about accessing their feelings without being overwhelmed. It is important to note that those who have suffered multiple losses may need assistance in separating and organizing their losses so each one can be fully grieved.
- Mourners with post-traumatic reactions to grief often need to revisit traumatic memories associated with those who have died. Traumatic memories and images (e.g., a partner who was blue as they struggled for oxygen, a gaunt friend who was shriveled and had soiled himself; a child who was scared and calling for help; etc.) are often jumbled, disconnected from affect, or split off from the rest of one's experience. Therapists can assist in slowly assessing these images, making sense of them, and integrating them into the client's current sense of self.
- Mental health providers should be sensitive to religious and cultural differences among mourners and should encourage mourners to draw upon their own religious, cultural, or personal traditions to engage in activities and rituals of meaning that will facilitate the grief process. A grief ritual is a formal activity that provides a time and a place to honor an important loss.
- Community-wide rituals (e.g., memorials services, viewing of the AIDS Memorial Quilt, candlelight parades, etc.) can reduce the isolation of mourners and offset the sense that those who have died have been devalued or forgotten.
- Support groups for those who are grieving can be very helpful, especially when groups are fairly homogeneous in nature in terms of levels of distress and the length of time since the person with AIDS died. Generally, support groups are less effective when they are convened soon after the loss of a loved one (Goldblum and Erickson, 1998).
- The use of psychotropic medication in the clinical management of bereavement is an area of great debate. Given the historic misuse of medications to “calm” mourners, there is a general mistrust about this approach among bereavement experts who sometimes express concern that medications can be used to mask the necessary pain of grief. However, judicious use of medications to assist clients

who are overwhelmed by bereavement symptoms is likely to be helpful as the client continues to engage Worden's four tasks of grief.

H. Interventions for Neuropsychological Impairment

1. General considerations

- Numerous studies have shown that treatment with HAART has a significant impact in improving the course of HIV-associated cognitive disorders (Sacktor et al., 1999; Tozzi et al., 1999; Cohen et al., 2001; Stankoff et al., 2001; Suarez et al., 2001). Nevertheless, a substantial proportion of HIV+ patients on HAART continue to display cognitive impairment (Bartoli et al., 2002).
- Cognitive and motor slowing makes it difficult for impaired clients to function in situations that are: (1) noisy, full of multiple sources of stimulation, and chaotic (e.g., a busy mall full of commotion, a crowded train station, a packed restaurant in a small space, etc); (2) unfamiliar environments; and, (3) situations that require quick decisions and action.
- It is often the case that clients with cognitive impairment do not recognize that these types of situations are the source of substantial agitation and anxiety. Many clients find it very helpful when mental health providers point out the types of situations that create tension, how to prepare for unfamiliar environments, how to avoid tension-producing situations, and how to arrange to participate in activities when environments are less chaotic.
- Clients with HIV-associated dementia may lack the necessary initiative to begin an activity even if they are motivated to undertake it. Mental health providers can educate family and friends about their crucial role in providing impetus for starting a desired activity.
- It is critical for mental health providers to educate friends, family, and partners about the realistic implications of cognitive impairment for the client with HIV. Education can do a lot to reduce fears and correct myths and misattribution. For example, upon hearing the term dementia, many people imagine the most severe clinical characteristics such as complete memory loss and a vegetative state. Additionally, friends, family members, and partners may attribute a client's forgetfulness to willful stubbornness or manipulation.
- As Van Gorp, Dilley, and Buckingham (1998) point out, "therapy can assist clients in sorting out the activities they can continue and those they cannot, and in setting limits for activities that may create potential problems. Such planning may make the difference between success and

failure in adapting to and coping with cognitive changes and may prevent further assaults on self-esteem of clients already beset by limitations, frustrations, and feelings of failure on many fronts. Finally, therapy can offer clients emotional support to handle these assaults and the opportunity to express their frustrations about declining capacities”(p. 307).

2. Practical Recommendations

- Several practical recommendations can assist clients in the struggle to adapt to cognitive changes. Van Gorp, Dilley, and Buckingham (1998) provide the following list of recommendations for mental health providers to suggest to clients and caretakers:
 1. Place a large calendar near the bedside or prominently in the living space.
 2. Use notes, reminders, lists, and appointment books to cue recognition. Maintain a telephone log and a medication log.
 3. Use a tape recorder to dictate thoughts and questions.
 4. To respond to motor and gait disturbances, alter living arrangements as much as possible to avoid stairs.
 5. Limit the number of different caretakers and distractions.
 6. Avoid crowds or having more than one visitor at a time.
 7. Allow more time for conversations.
 8. Keep instructions as simple as possible and give one instruction at a time. Break large tasks into smaller ones, and keep a log for complex projects.
 9. Keep to a routine; for example, go to bed and get up at roughly the same time each day.
 10. If able to drive, plan routes in advance, allow plenty of time, and take a friend along. Don't drive in heavy traffic.

3. Pharmacological Treatment

- Several studies (Chang et al., 1999; Martin, Pitrak, Novak, Pursell, & Mullane, 1999; Stankoff et al., 2001) have found that antiretrovirals partially reverse both clinical and metabolic changes associated with mild HIV-related neurocognitive impairment. Zidovudine (AZT, Retrovir®), in and of itself, appears to offer some neuroprotective effects, even during the early stages of infection (Pereda et al., 2000).
- When selecting an antiretroviral regimen, many people living with HIV try to include at least one drug that is able to cross from the bloodstream into the cerebral spinal fluid (CSF), the protective liquid surrounding the brain and spinal cord. By doing so, they hope to control levels of HIV in the brain and to guard against HIV-Associated Dementia (HAD). With the exception of indinavir (Crixivan®), however, levels of protease inhibitors (PIs) in the CSF are usually very low.

- While HAART can improve subcortical cognitive functions, its impact appears to vary by dysfunction. Individuals may demonstrate continual improvement on psychomotor tests, but performance on memory tests may plateau, suggesting distinct neuropathological mechanisms underlying these two types of dysfunction (Suarez et al., 2001).
- Another pharmacological approach is to treat the slowing nervous system with stimulants, although this strategy has been shown to have only short-term effects (Buckingham & Van Gorp, 1998).
- The primary goal in managing delirium is to identify and treat the underlying factor or cause (pneumonia, urinary tract infection, cerebral lesion) when possible. Recommended management, besides treating the cause, includes treating the confusion, perceptual abnormalities, and agitation, so that the patient is better able to cooperate with interventions necessary for diagnosing and treating the underlying medical disorder. Recommended treatment includes antipsychotic medications in low doses to help reduce the confusion and calm the patient.
- Delirium is frightening to the patient as well as family and friends. Every effort should be made to repeatedly reassure and re-orient the patient by explaining the procedures and establishing a calm and constant environment. Changes in environment worsen the situation.
- Following recovery all patients who have experienced delirium should be educated about the apparent cause of their delirium, if identified, so that the patient, family, and subsequent physicians can be made aware of risk factors that may lead to delirium in the future. Psychotherapy focused on working through the experience of the delirium may, at times, be necessary to resolve anxiety, guilt, anger, depression, or other emotional states.

I. Interventions for Substance Abuse

1. Tasks of Recovery

- According to Zweben (1998), the tasks of recovery can be summarized as follows: (1) becoming motivated to change; (2) discontinuing alcohol and drug use; (3) achieving and consolidating abstinence; (4) changing life patterns to support recovery (e.g., employment, recreation, and interpersonal relationships); and, (5) addressing the individual and interpersonal issues that emerge
- Although many therapists have been trained to believe that addiction must be addressed primarily through work on the “underlying” problems, there is little if any evidence from systematic studies to support this view.

- Most addiction counselors hold the view that abstinence is the foundation of therapeutic progress and that work on coexisting issues must take into account a client's stage of recovery. In fact, some addiction counselors believe that no other issues, including HIV-related ones, should be tackled until abstinence is secure. In general, substance use is best viewed as an independent behavior or disorder requiring specific intervention, concurrent with or subsequent to working on other issues.

2. **Prioritizing Treatment Goals**

- In working with an HIV-infected client with both substance abuse and psychiatric disorders, the mental health clinician must prioritize treatment and integrate interventions to address all three disorders.
- Factors that affect safety should be tackled first (e.g., acute medical problems, psychotic symptoms, abusive relationships, housing problems, etc.). In other words, the clinician must ask, Where is the best place to start if the goal is to keep my client safe and set the stage for future change?
- After clinicians have addressed any immediate crisis, they can consider other factors relevant to stabilizing the client. Important strategies for stabilizing the client include assembling the elements of the client's support system; defining constructive participation of family, friends, and partners; connecting the client to a case manager who can link him or her to available benefits and services; and putting together a long-term plan to maximize improvement.
- In the maintenance phase of care, it is important to monitor activities that sustain the gains achieved. For example, when patients who have responded well to twelve-step programs begin to reduce their participation without discussing how they made their decisions, it may signal an impending relapse. Becoming careless about sleep, nutrition, or exercise can also destabilize a client. Warning signals are often best detected in mundane details the client may not report unless specifically asked, so it is important that clinicians routinely review areas known to be sensitive indicators.
- The greatest threat to effective treatment of triply diagnosed clients is the potential for fragmentation among the agencies, disciplines, and individual providers necessary for appropriate care. It is likely that at one time or another the client will be involved with social service, mental health, addiction treatment systems, and criminal justice. Each system has its own set of resources and expectations and thus it is critical to involve a case manager and team treatment planning whenever possible.

3. Abstinence Versus Harm Reduction

- Most of the addiction treatment system in the United States focuses on achieving abstinence. This position is derived from the disease model tenet that a person who crossed the line to uncontrolled use cannot return to controlled use. Although abstinence is the ultimate goal of most addiction counselors, there is an increasing acceptance of relapse as part of the process of change.
- Most addiction treatment programs in the United States also stress the goal of abstinence from all intoxicants, not just an individual's primary drug of choice. There are three reasons for this stance. First, most substance abusers will substitute one drug for another. Second, many people relapse to their substance of choice following use of another substance. Third, the process of relapse also encompasses the state of mind -- the longing to get high-that precedes the actual behavior. Hence, rationalizing the use of another intoxicant is a precursor to actual relapse behavior.
- Harm reduction approaches to drug treatment have largely developed in response to the HIV/AIDS epidemic. It assumes that a using addict can make positive changes in his or her life despite continued drug use. Harm reductionists point out that people use substances for a reason (e.g., a way to cope with intrusive thoughts, depression, poverty, racism, abuse, etc.). According to proponents, change must begin with understanding and acceptance of an individual in relationship to his or her substance use behavior, helping the individual identify the harm that results from that behavior, and working with him or her to make small, incremental changes in the behavior in order to decrease that harm.
- In general, harm reductionists assert that users may ultimately benefit most from abstinence but that, given the opportunity (through respectful, clinical engagement and the experience of improved quality of life) many active users have the ability to mitigate both HIV-related and substance-related harm without achieving abstinence.

4. General Categories of Treatment Programs

National Institute on Drug Abuse (NIDA) research studies on drug addiction treatment have typically classified treatment programs into several general types or modalities, which are described in the following text. Treatment approaches and individual programs continue to evolve, and many programs in existence today do not fit neatly into traditionally drug addiction treatment classifications.

a) Agonist Maintenance Treatment

- Agonist Maintenance Treatment for opiate addicts is usually conducted in outpatient settings often called methadone treatment programs. These programs use a long-acting synthetic opiate medication, usually methadone or LAAM, administered orally for a sustained period at a dosage sufficient to prevent opiate withdrawal, block the effects of illicit opiate use, and decrease opiate craving.
- Patients stabilized on adequate, sustained dosages of methadone or levo-alpha-acetylmethadol (LAAM) can function normally. They can hold jobs, avoid the crime and violence of the street culture, and reduce their exposure to HIV by stopping or decreasing injection drug and drug-related high-risk sexual behavior. Patients stabilized on opiate agonists can engage more readily in counseling and other behavioral interventions essential to recovery and rehabilitation.

b) Narcotic Antagonist Treatment Using Naltrexone

- Narcotic Antagonist Treatment Using Naltrexone for opiate addicts usually is conducted in outpatient settings although initiation of the medication often begins after medical detoxification in a residential setting. Naltrexone is a long-acting synthetic opiate antagonist with few side effects. It is taken orally either daily or three times a week for a sustained period of time. Individuals must be medically detoxified and opiate-free for several days before naltrexone can be taken to prevent precipitating an opiate abstinence syndrome. When used this way, all the effects of self-administered opiates, including euphoria are completely blocked. The theory behind this treatment is that the repeated lack of the desired opiate effects, as well as the perceived futility of using the opiate, will gradually, over time, result in breaking the habit of opiate addiction. Naltrexone itself has no subjective effects or potential for abuse and is not addicting.
- Patient noncompliance is a common problem. Therefore, a favorable treatment outcome requires that there also be a positive therapeutic relationship, effective counseling or therapy, careful monitoring of medication compliance. Many experienced clinicians have found naltrexone most useful for highly motivated, recently detoxified patients who desire total abstinence because of external circumstances, including impaired professionals, parolees, probationers, and prisoners in work-release status. Patients stabilized on naltrexone can function normally.

c) Outpatient Drug-Free Treatment

- Outpatient Drug Free Treatment varies in the types and intensity of services offered. Such treatment costs less than residential or inpatient treatment and often is more suitable for individuals who are employed or

who have extensive social supports. Low-intensity programs may offer little more than drug education and admonition. Other outpatient models, such as intensive day treatment can be comparable to residential programs in services and effectiveness, depending on the individual patient's characteristics and needs. In many outpatient programs, group counseling of emphasized. Some outpatient programs are designed to treat who have medical or mental health problems in addition to their drug disorder.

d) Long-Term Residential Treatment

- Long-term Residential Treatment provides care 24 hours per day, generally in non-hospital settings. The best-known residential treatment model is the therapeutic community (TC), but residential treatment may also employ other models, such as cognitive-behavioral therapy.
- TCs are residential programs with planned lengths of stay of 6 to 12 months. TCs focus on the "resocialization" of the individual and use the program's entire "community," including other residents, staff, and the social context, as active components of treatment. Addiction is viewed in the context of an individual's social and psychological deficits, and treatment focuses on developing personal accountability and responsibility and socially productive lives. Treatment is highly structured and can at times be confrontational, with activities designed to help residents examine damaging beliefs, self-concepts, and patterns of behavior and to adopt new, more harmonious and constructive ways to interact with others.
- Many TCs are quite comprehensive and can include employment training and other support services on site. Compared with patients in other forms of drug treatment, the typical TC resident has more severe problems and more criminal involvement.

e) Short-Term Residential Treatment

- Short-term Residential Treatment Programs provide intensive but relatively brief residential treatment based on a modified 12-step approach. These programs were originally designed to treat alcohol problems, but during the cocaine epidemic of the mid-1980's many began to treat illicit drug abuse addiction. The original residential treatment model consisted of a 3 to 6-week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as Alcoholics Anonymous. Reduced health care coverage for substance treatment has resulted in a diminished number of these programs, and the average length of stay under managed care review is much shorter than in early programs.

f) Medical Detoxification

- Medical Detoxification is a process whereby individuals are systematically withdrawn from addicting drugs in an inpatient or outpatient setting, typically under the care of a physician. Detoxification is sometimes called a distinct treatment modality but is more appropriately considered a precursor of treatment, because it is designed to treat the acute physiological effects of stopping drug use. Medications are available for detoxification from opiates, nicotine, benzodiazepines, alcohol, barbiturates, and other sedatives. In some cases, particularly for the last three types of drugs, detoxification may be a medical necessity, and untreated withdrawal may be medically dangerous or even fatal.

g) Treating Criminal-Justice Involved Drug Abusers

- Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug use and related crime. Individuals under legal coercion tend to stay in treatment for a longer period of time and do as well or better than others *not* under legal pressure. Often, drug abusers come into contact with the criminal justice system earlier than other health or social service systems. Criminal justice system intervention to engage the individual in treatment may help interrupt and shorten a career of drug use. Treatment for the criminal justice-involved drug abuser may be delivered prior to, during, after, or in lieu of incarceration.

5. Scientifically Based Approaches to Drug Addiction Treatment

The following section presents several examples of treatment approaches and components that have been developed and tested for efficacy through research supported by the National Institute on Drug Abuse (NIDA) (NIDA Publication No. 994180).

a) Relapse Prevention

- Relapse prevention is a cognitive-behavioral therapy developed for the treatment of problem drinking and adapted later for cocaine addicts. Cognitive-behavioral strategies are based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Individuals learn to identify and correct problematic behaviors. Relapse prevention encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.

- The relapse prevention approach to the treatment of cocaine addiction consists of a collection of strategies intended to enhance self-control. Specific techniques include exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. A central element of this treatment is anticipating the problems patients are likely to meet and helping them develop effective coping strategies.

b) Supportive-Expressive Psychotherapy

- Supportive-Expressive Psychotherapy is a time-limited, focused psychotherapy that has been adapted for heroin- and cocaine-addicted individuals. The therapy has two main components: (1) supportive techniques to help patients feel comfortable in discussing their personal experiences; and, (2) expressive techniques to help patients identify and work through interpersonal relationship issues. Special attention is paid to the role of drugs in relation to problem feelings and behaviors, and how problems may be solved without recourse to drugs.

c) Individualized Drug Counseling

- Individualized Drug Counseling typically focuses directly on reducing or stopping the addict's illicit drug use. It also addresses related areas of impaired functioning- such as employment status, illegal activity, family/social relations - as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence. The addiction counselor encourages 12-step participation and makes referrals for needed supplemental medical, psychiatric, employment, and other services. Individuals are encouraged to attend sessions one or two times per week.

d) Motivational Enhancement Therapy

- Motivational Enhancement Therapy is a client-centered counseling approach for initiating behavior change by helping clients to resolve ambivalence about engaging in treatment and stopping drug use. This approach employs strategies to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist.

- The first treatment session focuses on providing feedback generated from the initial assessment battery to stimulate discussion regarding personal substance use and to elicit self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk situations are suggested and discussed with the client. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Clients are sometimes encouraged to bring a significant other to sessions. This approach has been used successfully with alcoholics and with marijuana-dependent individuals.

e) Behavioral Therapy for Adolescents

- Behavioral Therapy for Adolescents incorporates the principles that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward for incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, and recording and reviewing progress. Praise and privileges are given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control: stimulus control, urge control, and social control.
- **Stimulus Control** helps patients avoid situations associated with drug use and learn to spend more time in activities incompatible with drug use.
- **Urge Control:** helps patients recognize and change thoughts, feelings, plans that lead to drug use.
- **Social Control:** involves family members and other people important in helping patients avoid drugs. A parent or significant other attends treatment sessions when possible and assists with therapy assignments and reinforcing desired behavior.

f) Multidimensional Family Therapy for Adolescents

- Multidimensional Family Therapy (MDFT) for Adolescents is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

- During individual sessions, the therapist and adolescent work on important development tasks, such as developing decision-making, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child.

g) Multisystemic Therapy

- Multisystemic Therapy (MST) addresses the factors associated with serious antisocial behavior in children and adolescents who abuse drugs. These factors include characteristics of the adolescent (for example, favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood settings) mist youths and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Reduced numbers of incarcerations and out-of-home placements of juveniles offset the cost of providing this intensive service and maintaining the clinicians' low caseloads.

h) Community Reinforcement Approach Plus Vouchers

- Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24-week outpatient therapy for treatment of cocaine addiction. The treatment goals are twofold: (1) to achieve cocaine abstinence long enough for patients to learn new life skills that will help sustain abstinence; and, (2) to reduce alcohol consumption for patients whose drinking is associated with cocaine use.
- Patients attend one or two individual counseling sessions per week, where they focus on improving family relations, learning a variety counseling, and developing new recreational activities and social networks. Those who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy. Patients submit urine samples two or three times each week and receive vouchers for cocaine-negative samples.
- The value of vouchers increases with consecutive clean samples. Patients may exchange vouchers for retail goods that are consistent with a cocaine-free lifestyle. This approach facilitates patients' engagement in treatment and systematically aids them in gaining substantial periods of cocaine abstinence. The approach has been tested in urban and rural areas and used successfully in outpatient detoxification of opiate-addicted

adults and with inner-city methadone maintenance patients who have high rates of intravenous cocaine abuse.

i) Voucher-Based Reinforcement Therapy in Methadone Maintenance Treatment

- Voucher-Based Reinforcement Therapy in Methadone Maintenance Treatment helps patients achieve and maintain abstinence from illegal drugs by providing them with a voucher each time they provide a drug-free urine sample. The voucher has monetary value and can be exchanged for goods and services consistent with the goals of treatment. Initially, the voucher values are low, but their value increases with the number of consecutive drug-free urine specimens the individual provides. Cocaine- or heroin- positive urine specimens reset the value of the vouchers to the initial low value. The contingency of escalating incentives is designed specifically to reinforce periods of sustained drug abstinence.

j) Day Treatment with Abstinence Contingencies and Vouchers

- Day Treatment with Abstinence Contingencies and Vouchers was developed to treat homeless crack addicts. For the first 2 months, participants must spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual and group counseling, multiple psychoeducational groups (for example, didactic groups on community resources, housing, cocaine, and HIV/AIDS prevention; establishing and reviewing personal rehabilitation goals; relapse prevention; weekend planning), and patient-governed community meetings during which patients review contract goals and provide support and encouragement to each other.
- Individual counseling occurs once a week, and group therapy sessions are held three times a week. After 2 months of day treatment and at least 2 weeks of abstinence, participants graduate to a 4-month work component that pays wages that can be used to rent inexpensive, drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

k) The Matrix Model

- The Matrix Model provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Patients learn about issues critical from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction.

- The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention.
- Treatment materials draw heavily on other tested treatment approaches. Thus, this approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain work sheets for individual sessions; other components include family educational groups, early recovery skill groups, relapse prevention groups, conjoint sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

J. Enhancing Coping Skills

1. Hope, Meaning, Control & Coping

- According to Taylor's Cognitive Adaptation Theory (1983), successful adjustment to life-threatening illnesses involves developing a sense of meaning from one's illness experience, maintaining a sense of control over what one can control; and finding ways to enhance self-esteem in the face of multiple assaults and losses.
- People who maintain hope and cope well in the face of HIV tend to have a sense of control over their lives and the course of their illness as well as tend to engage more often in active, problem-focused coping strategies such as involvement in medical treatment, information seeking, life-style changes, and social activism (Remien, Rabkin, Williams, & Katoff, 1992).
- People who maintain hope and cope well in the face of HIV disease commonly experience personal growth as a result of confronting the prospect of death (e.g., Schwartzberg, 1993). For many, personal growth arises from the process of reprioritizing values and then examining one's activities, time commitments and relationships in terms of those reprioritized values. This process often leads to a new sense of meaning that provides direction and organization to future activities and goal-setting.
- Thus, it is important for mental health providers to assist clients in determining what is most important to them; in determining what is within their control; in prioritizing personal goals in light of what is important and controllable; and in organizing active, problem-focused strategies directed toward the accomplishment of their personal goals.

- Clients should be encouraged to set reasonable short-term and long-term goals in various arenas of their life (e.g., career, personal growth, relationship with partner, relationships with members of family of origin, relationships with friends or family of choice, health care, activism, spirituality, etc.).
- Clients can be assisted in deriving satisfaction from goal-directed behavior by instructing them in strategies of self-praise and self-encouragement as intermediate steps in the path toward a goal.
- Clients can be assisted in deriving a sense of meaning from the accomplishment of their personal goals by helping them develop greater awareness and appreciation for the ways in which their goal-directed activity relates to their core values.
- Mental health providers can help HIV-infected clients to act more consistently with their core values by encouraging them to articulate images or phrases that encapsulate their core values and then instructing them how to invoke those images and phrases at times when they are most vulnerable for relapse into less adaptive ways of behaving.
- People who maintain hope and cope well in the face of HIV disease tend to be effective in working through cycles of illness, loss, grief, and re-goaling when the progression of disease produces changes in capacities, function or role.
- People who maintain hope and cope well in the face of HIV disease typically demonstrate the abilities (1) to face losses rather than avoid them; (2) to mourn losses effectively and quickly; (3) to develop a new sense of self in response to the mourning process; (4) to identify attainable goals that are consistent with the new sense of self derived from the mourning process; (5) to infuse newly acquired goals with meaning and importance; and (6) to redirect positive energy to the pursuit of newly acquired goals.
- When people with HIV are confronted with realistic losses, mental health providers can foster hope by assisting their clients to engage the tasks of grief (e.g., (1) to accept the reality of the loss; (2) to work through to the pain of grief; (3) to adjust to an environment in which the things or people that were lost are missing; and (4) to emotionally relocate the loss and move on with life.
- Although people who maintain hope and cope well in the face of HIV tend to have a sense of control over their lives and engage more often in active, problem-focused coping strategies, they also demonstrate the capacity to give up control by switching to emotion-focused strategies of coping (e.g.,

denial, acceptance, avoidance, escape, distancing, distraction, obtaining emotion support from others, etc.) for periods of time in order to “recharge their batteries”, prevent themselves from becoming overwhelmed, garner emotional support from others, or deal with immediate situations that are inherently uncontrollable.

- In general, individuals who possess a broader range of coping strategies do better. Therefore, mental health providers should help HIV-infected clients develop a variety of both problem-focused and emotion-focused coping strategies as well as a better understanding of when to use what kind of strategy (i.e., problem-focused strategies for things that can be controlled and emotion-focused strategies for things that cannot be controlled).

2. Cognitive-Behavioral & Stress-Management Group Interventions

- Stress reduction and coping improvement interventions that are based on cognitive and behavioral theories and delivered to small groups have shown positive effects on the mental health of people living with HIV/AIDS.
- Kelly et al. (1993) reported one of the first randomized trials testing a coping and stress management intervention in a randomized controlled study design. Sixty-eight men experiencing moderate depression were randomized to one of three study conditions: (a) an eight-session coping and stress management intervention grounded in concepts derived from social-cognitive theory; (b) an eight-session social-support-group intervention modeled after closed support groups available in the community; or (c) an individual counseling on demand control condition. Results showed that both the cognitive-behavioral and social-support groups improved in their mental health adjustment compared with the individual therapy control condition. The social-support group, however, had the greatest overall improvement at a 3-month follow-up assessment.
- Coping effectiveness training (CET) is another cognitive-behavioral mental health intervention model tested with HIV-positive men (Chesney, Folkman, & Chambers, 1996). On the basis of Lazarus and Folkman’s (1984) stress and coping theory, coping effectiveness training emphasizes the use of emotion-focused and problem-focused coping strategies as they best fit stressors that are perceived as uncontrollable or controllable, respectively. Coping effectiveness training also includes instruction in the effectiveness use of social support, maintenance training, and workbook exercises.
- Coping effectiveness training was compared with a time-matched HIV education and waiting-list control group in a pretest-posttest design. The study found that men who received the coping efficacy training reported

less perceived stress, reduced emotional distress, less AIDS burnout, and improved coping efficacy compared with both of the control conditions.

- In another trial, Eller (1995) examined the effects of two brief and focused cognitive and behavioral stress-reduction techniques; guided imagery and progressive muscle relaxation. Compared with a standard-of-care control group, both treatment conditions demonstrated reductions in depression.
- Lutgendorf et al. (1997) tested a 10-session cognitive-behavioral stress management (CBSM) intervention that included didactic components to educating group participants about stress and the benefits of relation, cognitive restructuring, coping skills training, assertiveness training, anger management, and identification of social supports in comparison with a waiting-list control group. Gay men who received the CBSM treatment demonstrated reductions in anxiety and dysphoria relative to the control group at the post-intervention assessment. The declines in distress occurred in the context of already low levels of distress at baseline; reductions in depressed mood occurred most often in men who were not clinically depressed.
- Similar results have been reported in other studies of CBSM interventions for people living with HIV infection (Crusess et al., 2000; Lutgendorf et al., 1998) in each case, CBSM group interventions have had positive effects on the emotional health of individuals exposed to the intervention relative to a waiting-lost control group assessed from pre-intervention to post-intervention.

K. Social Support Interventions

1. Functions of Social Support

- There is an abundance of scientific literature that indicates social support can prevent and alleviate the emotional distress associated with chronic and life-threatening illness. Social support refers to the number and types of contacts a person has, the functional aspects of the relationships, and the perceived quality or adequacy of the support.
- In general, a person is likely to be most satisfied with his or her social support when he or she has several persons in their support system who together can provide adequate support in each of three functional areas of support: emotional, informational, and instrumental support.
- Emotional support, like emotion-focused coping, does not directly address concrete matters. Instead, emotionally supportive behaviors such as expressing concern, providing encouragement, and serving as a confidant, provide an overall sense of comfort and hope. A specific need

for emotional support that is repeatedly expressed by people with HIV/AIDS is the need for physical contact. When touch is avoided it clearly communicates fear and distance. For many, touch symbolizes acceptance and understanding.

- Informational support refers to the type of support associated with obtaining accurate information about health care and treatment options, social service resources, insurance coverage, strategies for coping with and adjusting to life with HIV disease, etc. Seeking information promotes a sense of control and helps people interpret, comprehend, and cope with HIV infection.
- Instrumental support refers to practical assistance with everyday needs (e.g., transportation, shopping, housework, etc.)
- The mental health provider can be of substantial assistance by helping the client in assess and develop his or her support system in terms of emotional, informational, and instrumental sources of support.
- It is also helpful for the mental health provider to convene meetings with the client and members of his or her support system. These meetings can be used to clarify and explain the needs of the client, identify the realistic availability and resources of various members of the support system, apportion and assign tasks among the various members of the support system, and explore potential conflicts associated with roles and responsibilities.

2. Support Groups

- Support groups for people living with HIV/AIDS are often organized through AIDS service organizations and they have been generally successful in responding to people's needs for both emotional and informational support.
- Mathews and Bowes (1989) identified five dimensions of HIV-related support groups: (1) sharing common experiences; (2) providing group cohesiveness; (3) reinforcing hope; (4) helping others; and (5) learning from others' experiences. Additionally, support groups are often places where people can exchange both practical and emerging scientific information as well as places where people can engage in shared problem-solving about commonly experienced issues and problems.
- Support groups can be structured in a myriad of ways. They can be open or closed groups, time-limited or ongoing, and heterogeneous or homogeneous with respect to stage of the illness, gender, sexual orientation, and modes of having contracted the virus. There are pros and

cons to each type of arrangement and obviously the structure of the group dramatically impacts the types of issues that arise in group sessions.

3. Volunteer Support

- Many AIDS service organizations provide support to people living with HIV/AIDS through volunteer programs that are often referred to as buddy programs. Buddy volunteer programs offer both companionship and physical assistance.
- Many people who volunteer as buddies are living with HIV themselves. Volunteer experiences can provide a source of support as well as increase self-esteem, perceived internal control, and a sense of personal self-worth.

4. Supporting the Caregiver

- Many disease-related problems are managed at home, where the primary caregiver has a critical role in helping the person with AIDS deal with the disease and its psychological sequelae. The role of the informal caregiver is likely to become even more significant in the coming years as the health care system shifts increasingly towards home-based care. It is critical to support caregivers in order for caregivers to continue to support people living with HIV/AIDS.
- The University of California, San Francisco (UCSF) Coping Project, conducted by Susan Folkman, PhD, and her colleagues Margaret Chesney, PhD, Molly Cooke, MD, Alicia Boccellari, PhD, and Anne Christopher-Richards, MA, at the Center for AIDS Prevention Studies (CAPS) at UCSF followed a cohort of 253 gay men who were the primary caregivers of partners ill with AIDS. Although this study dealt exclusively with gay men as caregivers, key findings are likely to be illustrative of the needs and coping styles of other caregivers.
- Data from semi-structured interviews and questionnaires suggest a number of coping strategies that these men use to sustain psychological well-being in the midst of their incredibly difficult circumstances. Three strategies stood out: (1) focusing on discrete instrumental tasks, (2) finding positive meaning in caregiving, and (3) noting and remembering ordinary events that have positive meaning.
- Focusing on small instrumental acts. A number of participants report that they counter the feelings of helplessness by focusing on discrete, instrumental acts of caregiving that they can carry out successfully. A participant put it this way: "In many ways tasks associated with caregiving, such as learning to administer IV's, have helped me. You

can't stop the disease yet, but I found that there are things that you can do ... to overcome that sense of helplessness." Identifying instrumental acts of caregiving that can be successfully achieved, such as changing bed linens, preparing a favorite meal, or giving a massage permits feelings of efficacy and mastery. Findings indicate that the more advanced the ill partner's disease, the more effective this problem-focused strategy is in maintaining the caregiver's positive mood.

- Finding positive meaning. A second strategy is to find positive meaning in caregiving by tapping into underlying values. Participants report, for example, that caregiving makes them feel needed, shows their love for their partner, brings them closer to their partner, makes them feel competent, and causes them to grow as a person. Seeing caregiving as an opportunity to show love is particularly meaningful.
- Noting positive events. Early in this study participants commented to the investigators that they wanted to talk about positive events in their lives in addition to the stressful events they were asked to describe. The participants said that the researchers would be getting only part of the picture of how the participants coped with caregiving and bereavement if they asked only about stressful events. Because this feedback occurred very early in the study, the researchers were able to add a question to the interview that asked participants to describe a "positive meaningful event that helped you get through the day." Only rarely were participants unable to describe a positive meaningful event from the previous week, suggesting that people not only have the capacity, but perhaps even the need to note and remember positive events when they are in the midst of events that are highly stressful.
- Practitioners can help caregivers understand that they can experience both positive and negative moods during caregiving and bereavement. Depressive mood is a normal response to having a partner become increasingly sick with AIDS. What may be critical is for practitioners to help caregivers become aware of ways of promoting positive feelings in the midst of their distress. Effective coping strategies reported by participants in the UCSF Coping Project include: (1) focusing on discrete, manageable tasks during caregiving; (2) focusing on valued, meaningful consequences of their caregiving; and (3) noting and remembering small positive events such as a peaceful moment with a good cup of coffee and a newspaper, or hearing words of affection and appreciation, which elicit positive feelings such as humor, contentment, caring, or tenderness.

L. Interventions for Sexual Risk Reduction

1. Predictors of Risk Among People Living with HIV/AIDS

- Across several studies with diverse populations, as many as half of men and women living with HIV infection report practicing unprotected sexual behaviors that pose high risk for HIV transmission (Kalichman, 1998).
- Assessment of sexual risk taking involves examining a number of factors that have been associated with risk among seropositive men and women such as: relationship factors, economic conditions, emotional states, substance use, psychological control and behavioral inhibition, and willingness to disclose HIV status.
- Several studies suggest that unsafe sex is more frequent in primary relationships than in casual relationships (Doll et al., 1992).
- HIV seropositive men and women may engage in unprotected sex for money, drugs, or to meet other survival needs (Kalichman, Belcher, et al., 1998).
- Depression, anxiety, hostility, and fewer behavioral coping strategies all correlate with high-risk sexual practices among HIV-positive men and women (Kalichman, 1998)
- Alcohol and drug abuse are commonly associated with unprotected sexual behaviors among people living with HIV/AIDS (Kalichman, Kelly, et al., 1997)
- Impulsivity, high needs for sensation, excessive sexual-erotic ideation, manic episodes, and serious personality disorders all associated with high risk behavior among people living with HIV (Kalichman, Carey, & Carey, 1996).
- In the case of casual sexual partners, unsafe sex is more likely to occur with partners who are unaware that their partner is HIV infected, whereas condoms are used more frequently when a sex partner is known to be HIV infected (Wenger, Kusseling, Beck, & Shapiro, 1994)
- In many cases, unprotected sex occurs with another seropositive partner, posing no risk for new or primary HIV infections. However, the risks in such cases are significant for re-infection with a different, more virulent, or drug resistant variant of HIV. In addition, risks of co-infection with

other sexually transmitted pathogens must be considered given the potential synergistic effects of viral infections in activating HIV.

2. Risk Reduction Interventions for People Living with HIV/AIDS

- According to Kalichman (1998) research thus far suggests that risk reduction interventions for people living with HIV/AIDS should include elements to reduce stress, normalize sexuality, boost self-esteem, improve relationships, and build self-efficacy for safer sex and serostatus disclosure.
- It is important to note that many people living with HIV (and many people in general) do not know how to use a condom correctly. It is important that the mental health provider be prepared to explain the correct way to unroll, apply, or remove a condom as well as the importance of water-based lubricants.
- Additional targets for intervention cited by Silven (1998) include skill development in the following areas: (1) negotiating safer sex; (2) engaging in safer sex activities; (3) identifying and dealing with high risk situations; (4) identifying ways to disengage or alter the chain of events that lead to risk behavior.
- It is important for mental health providers to remember that clients may possess the information and skills necessary to change their risk behavior and yet fail to change because: (1) they question the legitimacy of warnings against the dangers of re-infection, especially with HIV positive individuals with undetectable viral loads; (2) they believe that others in their peer network are less concerned about safe sex in the light of new treatment; (3) they have not practiced new skills sufficiently to feel confident about performing them; (4) they are subjected to physical coercion from their sexual partners; (5) they need to engage in unsafe sex for economic survival; or, (6) they lack the internal motivation to deal with the demands of change.
- Before intervening, mental health providers should first attempt to identify the obstacles to change that are specific to each individual. Simply providing general information, persuasion, and a limited amount of practice with generic behaviors (such as using condoms) may fail to address these specific obstacles.

3. Harm Reduction & Stages of Change

- Harm reduction is a client-centered, morally neutral approach to supporting clients living with HIV who continue to engage in unsafe sex

and/or substances use. Harm reduction aims at meeting clients where they are and empowering them to make central decisions about change in their life. It recognizes that there are stages of change and that clients can be helped to move through the changes by a variety of means, including outreach, peer education, community forums, and treatment education.

- The stages of changes utilized in most harm reduction interventions are those developed by Prochaska and DiClemente (1982): (1) Pre-contemplation; (2) Contemplation; (3) Preparation; (4) Action; and (5) Maintenance. Progress through these stages may take time and may not be linear; clients may remain at or revisit some stages.
- The counselor's role is to provide support and information, exercising patience and active listening skills throughout the process. Treatment planned in accordance with harm reduction of tailored to the client's stage of change and should be modified as client behavior changes. Harm reduction also recognizes that there will be lapses.
- In the pre-contemplation stage, clients have slight awareness of life problems; annoyance at complaints by others; no connection of problems to drug use; they are in search for ways to continue their behavior without consequences; and they display unrealistic problem-solving methods, magical thinking; mood swings.
- In the pre-contemplation stage, counselors should provide sensitive, safe, supportive atmosphere for client self-expression, foster links between unsafe sex, drugs and consequences; introduce the possibility of, and elicits benefits of change; provide information and give feedback; create uncertainty and confusion; raise anxiety.
- In the contemplation stage, clients experience ambivalence and confusion; they are defensive about old behaviors; they are likely to experience fear, hopelessness and despair; there may be consideration that there might be a problem in behavior; and they are window-shopping for solutions.
- In the contemplation stage, the counselor understands and accepts ambivalence while reflecting and emphasizing client's thoughts and feelings that are change-oriented; helps clients assess costs/benefits of change vs. no change; strengthens hope; allows the client to grieve loss of lifestyle; and deals with the fear of change.
- In the preparation stage, the client accepts that a problem exists; they are in the midst of developing a plan for action, and they are in the process of strengthening their commitment.

- In the preparation stage, the counselor explores options for a change plan, helps the client choose the best course of action; works on obstacles to implementation; breaks plan down to small, achievable steps; reinforces benefits of change; helps create realistic expectations.
- In the action stage, the client actively engages in changed plan, disassociates from old cohorts, connects to new cohorts.
- In the action stage, the counselor supports action steps taken, fosters patience, watches for and makes client aware of impediments to continued change-oriented activity, and reinforces connections that support new and positive behaviors.
- In the maintenance stage, client's action steps become regular, consistent and ingrained; they develop an awareness of threats to the continued plan, and they are in the process of increasing comfort with their new reference group.
- In the maintenance stage, the counselor explores relapse triggers and helps client develop strategies to avoid relapse, helps client to develop adaptive coping skills to avoid relapse, fosters patience.

4. **Motivational Interviewing**

- Motivational interviewing (Miller & Rollnick, 1991) “is a particular way to help people recognize and do something about their present or potential problems. It is particularly useful with people who are reluctant to change and ambivalent about changing. It is intended to help resolve ambivalence and to get a person moving along a path to change. For some people, this is all they really need. Once they are unstuck, no longer immobilized by conflicting motivations, they have the skills and resources to change. All they need is a relatively brief motivational boost. For others, motivational interviewing is only a prelude to treatment. It creates an openness to change, which paves the way for further important therapeutic work” (p. 52).
- Motivational interviewing utilizes the stages of changes model developed by Prochaska and DiClemente (1982) along with the following key principles:
 1. **Express Empathy** - understand the client's feelings and perspectives without judging, criticizing or blaming. This is accomplished through skillful reflective listening. Accepting people as they are seems to free them to change. Acceptance and respect builds a therapeutic alliance and supports the client's self-esteem - an important condition for change. Accept ambivalence as a normal part of change.

2. **Develop Discrepancy** - create and amplify, in the client's mind, a discrepancy between present behavior and broader goals. (Where one is and where one wants to be.) Increase awareness of the costs of present behavior.
 3. **Avoid Argumentation** - arguments are counterproductive and evoke resistance. The more you tell someone "you can't", the more likely they respond "I will". Resistance is a signal to change strategies.
 4. **Roll with Resistance** - instead of fighting resistance, we reflect back or reframe their statements to create a new momentum to change.
 5. **Support Self-Efficacy** - conveying hope for change. Self-efficacy - refers to a person's belief in his or her ability to carry out and succeed with a specific task. A key element in motivation to change. "You can do it. You can succeed."
- Motivational interviewing typically uses open-ended questions to evoke self-motivational statements. Examples of statements to invoke problem recognition include:
 1. What things make you think that this is a problem?
 2. What difficulties have you had in relation to your sexual behavior or drug use?
 3. In what ways do you think you or other people have been harmed by your sexual behavior or drug use?
 4. In what ways has this been a problem for you?
 5. How has your use of sex or drugs stopped you from doing what you want to do?
 - Examples of statements to invoke concern include:
 1. What is there about your sexual behavior or drug use that you or other people might see as reasons for concern?
 2. What worries you about your sexual behavior or drug use?
 3. What can you imagine happening to you?
 4. How do you feel about your sexual behavior or drug use?
 5. How much does that concern you?
 6. In what ways does this concern you?
 7. What do you think will happen if you don't make a change?
 - Examples of statements to invoke intention to change include:
 1. The fact that you're here indicates that at least a part of you thinks it's time to do something.
 2. What are the reasons you see for making a change?
 3. What makes you think that you need to make a change?
 4. If you were 100% successful and things worked out exactly as you would like, what would be different?
 5. What things make you think that you should keep on the way you have been?

6. And what about the other side? What makes you think it's time for a change?
7. What are you thinking about your sexual behavior or drug use at this point?
8. What would be the advantages of making a change?
9. I can see that you're feeling stuck at the moment. What's going to have to change?