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# FOCUS

## A Guide to AIDS Research and Counseling

### Report from the XVI International AIDS Conference

## The Evidence-Based Conundrum

Pamela DeCarlo



*\*Most citations throughout this article refer to conference presentations and are in brackets. The numbering system distinguishes among: the different days of the conference—MO, TU, WE, and TH; the different types of presentations—Oral Presentation (A), Poster Discussion (PD), Poster Exhibition (PE), Special Sessions (SS), Controversy and Common Ground (CC), Bridging Session (BS), Symposia (SY); and Plenary (PL); and, in some cases, the different tracks—Biology and Pathogenesis of HIV (A), Clinical Research, Treatment and Care (B), Epidemiology, Prevention and Prevention Research (C), Social, Behavioural and Economic Science (D), and Policy (E). Citations end with the presentation number.*

“Evidence-based practice,” the idea that service delivery must be based on science, was the mantra repeated at the August 2006 Toronto International AIDS Conference, with daily sessions on what works in prevention and almost every plenary speaker mentioning the need for science-based programs. While the message was consistent, the content was not.

There are several different variations on what is considered “proven,” according to the Centers for Disease Control and Prevention (CDC), prevention scientists, community-based organizations and politicians. For example, the CDC is currently promoting the Diffusion of Effective Behavioral Interventions (DEBI), which provides a dozen proven effective prevention interventions for community-based organizations to replicate and adapt across the United States. Most of these interventions were not evaluated through randomized clinical trials, which some prevention scientists see as the only way to measure the true effectiveness of interventions. Yet another approach, dubbed “ABC” (Abstain, Be faithful, use Condoms), has been credited with turning around HIV epidemics in Africa and has been heralded by the Bush administration as the answer to HIV prevention. It was clear at the conference that in many ways, “evidence” is in the eye of the beholder.

In Toronto, unlike in the United States, there was very little criticism of prevention policies, either of the DEBI program or the Bush administration. The most vocal exception was a protest that occurred during a speech by Anthony Fauci, head of the U.S. National Institute of Allergy and Infectious Diseases and advisor to the U.S. secretary of Health and Human Services. While Fauci

spoke during a special plenary “25 Years of AIDS – Reflecting Back and Looking Forward,” protesters chanted “Tony tell George, evidence can’t be ignored.”

One innovative program that directly addressed the Bush administration policies was presented during a session titled “Prevention Controversy.” Françoise Girard described how the Open Society Institute (OSI) sued the US government to override the Bush administration’s funding restriction in the 2003 Global AIDS Act [TUCC0203].\* The act prohibited U.S. funding of any foreign programs that were not anti-prostitution, and many of the OSI’s successful programs include sex workers. Two courts agreed with OSI’s lawsuit, and they granted an injunction, whose effect was to override the act’s restriction on programs for sex workers.

The general lack of criticism and the one isolated chant against Fauci, however, brought up the larger unasked and unanswered question: what is the evidence base regarding HIV prevention? Presentations on how prevention works were diverse and sometimes contradictory. For example, at the same plenary where protesters chanted against Fauci, referring to the Bush administration’s insistence on the ABC approach, Elizabeth Madraa of Uganda presented good news about the early response to the epidemic in her country, where the ABC approach was used effectively. HIV rates in Uganda have remained steady at 6.5 percent for the past three years, while rates have increased in other African nations. Madraa noted that the ABC approach alone is not enough, and that Uganda still has much work to do to fight complacency and continue to lower HIV rates.

### Where is the Greatest Need?

Somewhere in this call for evidence-based prevention lie other questions: do we always have proven interventions to offer? And if not, why not? The biggest buzz regarding HIV in the United States

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was the disproportionate burden of HIV on African Americans. Ron Stall looked at the re-emerging epidemics in the United States among men who have sex with men [THBS0202]. Stall found that men who have sex with men become infected at a rate of 1.9 percent to 2.9 percent, and that these numbers mean we can expect half of the population of young men who have sex with men to be HIV-positive by the time they are 50.

The rates are worse for Black men who have sex with men, with incidence rates from 4 percent to 15 percent. Using the lowest estimate, this means that half of all young Black men who have sex with men will become infected by the time they are 35. Stall noted that we have known for at least 20 years that Black men who have sex with men and substance-using men who have sex with men are at greatest risk for HIV, and he cites racism, homophobia, and AIDS-related stigma as reasons why there are

still no proven effective interventions for these men.

#### Randomized Controlled Trials

Even within the context of proven or evaluated interventions, researchers disagree on measures of effectiveness.

Is it enough to note that participants change their unsafe behaviors after an intervention, or must we show that participants did not seroconvert to HIV (which can only be done in a randomized controlled trial)? At a session titled "What is Working (or not) for HIV Prevention Among MSM?" Kenneth Jones described an adaptation of the "popular opinion leader" intervention for young Black men who have sex with men in North Carolina [MOAC0103]. The program trained 224 young men to talk to their peers about safer behaviors. The evaluation showed decreases in unprotected receptive anal intercourse over 12 months. During questioning, however, it became clear that the researchers had not measured participant seroconversion rates. An outside researcher noted that such outcomes were critical to understanding the true effectiveness of the intervention, since even programs that reduce risk behaviors do not always result in reduced HIV transmission.

It is not easy to conduct a randomized controlled trial that shows reductions in HIV seroconversion rates, as King Holmes discussed in a session titled "Scientific Challenges to More Effective HIV Prevention" [TUSY0801]. Looking at scientific reviews of effective interventions, he questioned the reliance on randomized controlled trials, noting that there were 45 published trials that measured reductions in sexually transmitted diseases, and only 2 that showed significant reductions in HIV infection.

## Clearinghouse: AIDS Conferences

January 25–28, 2007, Charlotte, North Carolina: 2007 National African American MSM Leadership Conference on HIV/AIDS. To contact organizers, phone or write: Patrick Kelly, The National AIDS Education and Services for Minorities, Inc., 2140 Martin Luther King, Jr. Drive, Atlanta, GA 30310; 404-691-8880 (phone); info@naesmonline.org (e-mail); <http://naesmonline.org> (web site).

February 1–3, 2007, Salt Lake City: Science and Response: 2nd National Conference on Methamphetamine, HIV and Hepatitis. To contact organizers, phone or write: Amanda Whipple, Harm Reduction Project, 155 South 300 West, Suite 101, Salt Lake City, UT 84101; 801-355-0234 (phone); methconference2007@harmredux.org (e-mail); <http://www.methconference.org> (web site).

February 17–19, 2007, Oakland, California: 14th Annual Ryan White National Youth Conference on HIV and AIDS. To contact organizers, phone or write: National Association of People with AIDS, 8401 Colesville Road, Suite 750, Silver Spring, MD 20910; 240-247-0880 (phone); info@napwa.org (e-mail); <http://www.napwa.org> (web site).

February 25–28, 2007, Los Angeles: The 14th Conference on Retroviruses and Opportunistic Infections. To contact organizers, phone or write: Conference Secretariat, Conference on Retroviruses and Opportunistic Infections, 115 South Saint Asaph Street, Alexandria, VA 22314; 703-535-6862 (phone); info@retroconference.org (e-mail); <http://www.retroconference.org> (web site).

May 20–23, 2007, New Orleans: 2007 HIV Prevention Leadership

Summit. To contact organizers, phone or write: Terrence Calhoun, The National Minority AIDS Council, 1931 13th Street NW, Washington, DC 20009; 202-483-6622 (phone); info@nmac.org (e-mail); <http://www.nmac.org> (web site).

June 5–8, 2007, Durban, South Africa: 3rd South African AIDS Conference. To contact organizers, phone or write: 3rd South African AIDS Conference, 27-12-345 3457 (phone); sec@sa-aidsconference.com (e-mail); <http://www.sa-aidsconference.com> (web site).

July 22–25, 2007, Sydney, Australia: 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention. To contact organizers, phone or write: Conference Secretariat, International AIDS Society (IAS), Ch. de l'Avanchet 33, PO Box 20, CH-1216 Cointrin, Geneva, Switzerland; 41-(0)22-7-100-800 (phone); info@ias2007.org (e-mail); <http://www.ias2007.org> (web site).

He presented a *British Medical Journal* article that noted that parachutes have never been proven effective in clinical trials, yet are still widely used, demonstrating the value of common sense and field-tested approaches. As the article concluded, “We think that everyone might benefit if the most radical protagonists of evidence-based medicine organized and participated in a double blind, randomised, placebo controlled, crossover trial of the parachute.”

Only a few randomized controlled trials were featured during sessions regarding what works in prevention. At a session titled “What’s New? Innovations in HIV Prevention,” Ralph DiClemente presented a randomized controlled trial of an HIV risk reduction intervention for clinically depressed African American adolescent girls [WEAC0203]. He noted that African American girls have high rates of depression (47 percent in the study) and that depression is associated with sexual risk behavior. The small group intervention for girls was based at a community health center and was effective for all participants. The subset of girls who were depressed showed significant behavior change, including increased condom use, greater HIV knowledge and lower rates of pregnancy.

Two other randomized controlled trials were geared to drug users. In a session titled “Getting to the Point: New Challenges and Solutions for IDU’s,” Steffanie Strathdee presented STRIVE, a peer mentoring intervention for young injection drug users with hepatitis C [TUAC0305]. STRIVE used six small group workshops led by peer facilitators to impart information on hepatitis C transmission, build skills, and practice mentoring other injection drug users in the community. STRIVE helped injection drug users reduce sharing of syringes, cookers, cotton, and rinse water.

A session entitled “Prevention Works: What’s the Evidence?,” featured a randomized controlled trial of an intervention for heterosexual methamphetamine users. Again, Steffanie Strathdee described Life in the FASTLANE, a harm reduction-based program to reduce sexual risk behaviors

among current methamphetamine users [MOAC0205]. The trial compared two programs. Each consisted of four weekly 90-minute one-on-one counseling sessions, but the intervention program added four monthly booster sessions. The intervention was effective at increasing intentions for safer sex and actual protected sex acts, proving that active methamphetamine users can reduce their risk behaviors. However, adding the four booster sessions made no difference in risk reduction behaviors, and participants who used greater amounts of methamphetamine improved less than those who used smaller amounts.

### Circumcision and Other Biomedical Methods

In biomedical approaches to HIV prevention, of course, randomized controlled trials reign supreme. The Toronto Conference put great emphasis on biomedical interventions and women-controlled prevention mechanisms, and Bill and Melinda Gates set the tone by starting the conference with a call for more funding for microbicides and vaccines, and greater attention to oral prevention drugs (often known as PrEP or pre-exposure prevention). Biomedical approaches were often presented as being beyond evidence-based reproach, and the

one promising future for prevention. This idea permeated the conference, even though almost none of the approaches mentioned have actually been “proven” effective. Some (vaccines) have failed and are being reconfigured and retried, some (diaphragms, microbicides, PrEP) are still in trial and may take years before we are sure of their effectiveness, and some (circumcision, sexually transmitted disease control) have shown mixed results in developing countries but have not been evaluated in the US or other developed countries.

In her speech on microbicides and other prevention technologies, Gita Ramjee, Director of the South African Medical Research Council, called for an expansion of the alphabet of prevention beyond the ABC approach, using the letters C through I : C – circumcision; D – diaphragm; E – exposure prophylaxis (post-exposure prophylaxis

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[PEP] and PrEP); F – female-controlled microbicides, including vaginal rings; G – genital tract infection control; H – herpes simplex virus-2 (HSV-2) suppression treatment; and I – immunity (through vaccines).

Several speakers mentioned male circumcision as a promising intervention. In a session titled “Male Circumcision: Is it Time to Act?” researchers reported on findings from circumcision intervention trials in Africa. Robert Bailey from the United States discussed a randomized controlled trial in Kenya, where 1,334 18 to 24 year old men were circumcised [TUAC0201]. The trial is still in progress, but men in both groups had reduced risk behavior, and the overall incidence of new HIV infections was 1.8 percent, lower than what researchers had expected. This result prompted Bailey to say, “Soon we can add male circumcision to the very limited armament of HIV prevention methods.”

Many audience members reacted strongly to the circumcision session, decrying the ethics of this approach and the fact that most presenters were Western and White. They felt that circumcision was an intervention developed outside of Africa to tell Black African men what to do with their bodies. Male circumcision has never been proven effective in the United States, although there is an ongoing trial. This highlighted another issue regarding evidence-based interventions. The scientific community presents male circumcision as an innovative, relatively easy and low-cost approach to prevention, yet if acceptance among service providers and the general public is mixed, it may not be widely used. How does the call to rely on scientifically proven prevention programs take into account popular opinion and acceptance? Is science the only criteria used to decide about prevention programs?

With so much talk about microbicides, empowering women and the need for women-controlled technologies, there was, once again, very little discussion on the role of heterosexual men. One innovative session titled “Engaging Men in Gender Equity and HIV/AIDS,” outlined the evidence base of prevention programs directed to men who have sex with women [THLP0102]. The overall message was that programs that had a gender-based perspective and focused on transformation were effective. Gary Barker outlined effective elements of men’s programs: explicit discussion about men and masculinity, an enabling environment with peer support, alliance building, and focus on men’s vulnerabilities. In discussion after the presentations, many del-

egates noted that the conference had been silent about the need for programs for men and boys, and this omission was especially harmful in discussions around preventing mother-to-child transmission, in which fathers were almost universally absent. An African delegate noted that in South Africa, 80 percent of HIV testing is among women, and programs need to encourage men to test as well. Barker commented that gender work with men could be the “social circumcision,” that is, a way to focus on men to help reduce HIV infections in a manner that doesn’t involve medical procedures.

### The Evidence-Based Conundrum

Overall, the future of evidence-based prevention seemed mixed at the Toronto conference. While everyone agreed that this gold standard should be used when implementing programs, there was little agreement as to the definition of “proven” effective programs and even less talk about how to best implement evidence-based interventions.

We need to be careful when we talk about evidence-based programs, because proving that behavioral interventions work is a very difficult task, particularly in the area of prevention. If the only mark of an effective intervention is demonstrated reductions in new HIV infections, then the field of prevention is in trouble. This may be part of the reason why there was so much emphasis on biomedical interventions for prevention at the conference, even though there is still scant scientific evidence that they work. While microbicides were touted as one possible answer to prevention for women, nobody talked about the fact that once they’re developed, women will still have to change their behavior to use them consistently and correctly, just like condoms. Even with microbicides, vaccines, male circumcision, or PrEP, we will still need behavioral interventions to increase use and change peer norms.

### Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to [rmarks@itsa.ucsf.edu](mailto:rmarks@itsa.ucsf.edu) or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

### Authors

*Pamela DeCarlo is the Dissemination Manager at the Center for AIDS Prevention Studies (CAPS), UCSF, where she writes and edits HIV Prevention Fact Sheets, manuals and newsletters, and manages the CAPS website (<http://www.caps.ucsf.edu>).*

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# Prevention: The Search for a Common Language

Andrew Joseph, MA, MFT

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Kalichman SC, ed. *Positive Prevention: Reducing HIV Transmission among People Living with HIV/AIDS*. New York: Springer, 2006. (Cloth; 281 pages; \$59.95.)

Public health researchers and community health service providers usually speak different languages. To providers, the language of empirical research can sound and feel abstract, out of touch with actual experience. Researchers may feel dissatisfied with the vague language providers use to describe their practice. They look for ways to ground public health practice in science.

*Positive Prevention* reviews the current state of empirical research in the area known as “prevention for positives.” It details what we know about the sexual and needle-sharing behavior of people living with HIV, and the interventions that have proved effective in changing these behaviors. While it speaks the abstract language of research, the book clarifies the whys and the hows of prevention work in a way front-line care providers should find compelling and useful.

## A New Prevention Agenda

*Positive Prevention* springs from the Centers for Disease Control and Prevention’s national agenda, presented in 2001 and refined in 2003, which prioritizes prevention interventions that target the behaviors of HIV-positive people. Put simply: any new HIV infection requires interaction with someone who is already infected—therefore, people living with HIV can have the greatest impact on reducing its spread. Multiple studies indicate that a significant number of HIV-diagnosed men and women acknowledge acting in ways that can lead to further transmission. The public health community can significantly limit the spread of the epidemic by: encouraging people living with HIV to become aware of their serostatus through testing; improving access to quality health care; initiating HIV antiviral treatment when indicated; sustaining medication adherence; and adopting and maintaining risk-reducing behavioral habits.

The contributors to this book address, in particular, the final one of these areas: the challenge of adopting and maintaining behavior change. Since effective interventions must be tailored to the characteristics of target populations, individual chapters

examine the behavioral trends and needs of significant subgroups, including gay and bisexual men, injection drug users, young people, and residents of India, South Africa, the United Kingdom, Switzerland, and Australia.

## Challenging Assumptions

Jane Simoni and David Pantalone of the University of Washington challenge a common assertion that the key to prevention is disclosing one’s HIV status to sex partners. Analyzing 22 published studies that have included data on both the disclosure and the sexual risk behavior of HIV-positive people, the authors deny that any association between these two variables has been empirically established. They highlight how commonly “informed exposure” occurs, as when an HIV-negative man pressures his HIV-positive girlfriend to have unprotected intercourse despite his knowledge of her serostatus. At the same time, “uninformed protection” also happens, as when a gay man consistently uses condoms with anonymous partners, yet neither discloses his own status nor asks his partners’ status. Therefore, the authors conclude, the assertion that disclosure equals increased safety is simplistic and often incorrect.

Jeffrey Parsons of Hunter College and the City University of New York explores how unique social and cultural factors condition the risk behavior of gay and bisexual men. These include the phenomenon of “barebacking,” which denotes not simply a failure to use condoms, but a conscious decision, implicitly supported by an ideology of sexual liberty, for men to connect skin-to-skin. They also explore the prevalence of “sexually charged environments,” such as bathhouses, sex clubs, internet websites, parks, highway rest stops, and circuit parties. Men commonly enter these environments feeling little personal concern for their anonymous partners, preferring to negotiate sex with gestures, but not words, and having used drugs or alcohol beforehand. Parsons’ illustrations and explanations serve the training needs of providers working with men who have sex with men, but who may be unfamiliar with critical aspects of their clients’ everyday experiences.

## Empowering Primary Care Providers

Susan Kiene, of the University of Connecticut, and colleagues focus on the impact primary medical providers can make. Doctors, nurse practitioners, and physicians’ assistants have intensive and repeated

contact with people living with HIV. When they build trusting relationships, they are uniquely positioned to influence patients' health-related behavior.

Research shows that HIV doctors commonly talk with their patients about topics such as medication adherence, emotional well-being, and cigarette smoking, but talk much less about sexual risk behavior. Research also demonstrates, however, that with modest training, medical providers can increase their comfort in talking about sex and learn to facilitate brief, productive conversations during routine follow-up visits. How can a clinician make a difference within such tight time constraints? As with many of the demonstration programs described in *Positive Prevention*, interventions intended for medical personnel make use of motivational interviewing techniques. Based on the "stages of change" construct, this method meshes well with the familiar harm reduction dictum, "meet the client where they're at."

### Ethical Gaps

Contributors grant that addressing prevention with HIV-positive people can be a "sensitive" project, while national discussion on this strategy has represented "a political minefield," since it suggests to some the notion of blaming people with HIV for the epidemic. The book neglects to address directly, however, the ethical challenges bound up in the whole enterprise of trying to influence other people's sexual behavior. It is one thing to encourage a person living with HIV to take steps to protect his or her own health; it is another to address how he or she is—or is not—taking responsibility for the health of others.

I work in an HIV-focused mental health clinic where many clients prioritize their own material and emotional survival above preventing transmission of HIV to others. How do I work to balance their *individual* priorities with my own commitment to the *community* priority of prevention? *Positive Prevention* addresses neither the ethical nor the practical complexities of this task.

Another conspicuous gap in the presentation is the absence of any chapter focusing on U.S. communities of color. Given what we know about the disproportionate numbers of new infections among Black and Latino women and men, research on risk behavior and behavior change in these populations should be a federal priority. This racial gap mirrors the general lack of research and intervention in all of the non-White, postcolonial world. The chapter on "International Perspectives" reminds us how for years HIV testing has not been encouraged in South Africa, for example, because HIV antiviral treatment has generally not been available. In India, little epidemiological data have been gathered at all, and HIV-positive people are widely shunned and denied medical treatment.

### Conclusion

While not a clinical handbook, *Positive Prevention* translates state-of-the-science behavioral research into terms providers can understand and appreciate. Its review of today's most demonstrably effective intervention programs will both sharpen and deepen readers' understanding of the complex project of influencing others' risk behaviors.

### Authors

Andrew Joseph, MFT, is a psychotherapist with the UCSF AIDS Health Project. He has worked in the areas of HIV, mental health, and substance abuse for the past fifteen years.

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# Psychiatry in the Age of Improved HIV Treatment

George Harrison, MD

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Citron K, Brouillette MJ, Beckett A, eds. *HIV and Psychiatry: A Training and Resource Manual*. Cambridge, U.K.: Cambridge University Press, 2005. (Paper; 360 pages; \$65.00.)

The editors of *HIV and Psychiatry* set out their intent to produce a case-based training tool to enhance the competence of mental health practitioners. In general, they were successful.

The audience for this book is as wide as the diverse group of people providing mental health services to the HIV community. Those in training to become mental health professionals will appreciate the way that basic information is conveyed through cases that drive home the instructional material. Established clinicians may use the text as either an introduction or a refresher regarding topics or populations they do not routinely serve. Supervisors can use this text to help supervisees understand specific aspects of the field. Because so many topics are covered, practitioners will reach for this book again and again.

## A Helpful Structure

The structure and organization of the book serve the reader well. In each section, the authors provide a case vignette and an overview of the topic. By alternating between further case information and related didactic information, the authors engage the reader's attention and then explore the complexities of the topic. Even the layout of the text assists the reader in learning the didactic material: the book uses a distinctive background and type face for the case vignettes. The effect is to create an easy reference for readers seeking quick access to a particular topic.

A medical overview chapter is followed by the book's 18 chapters, which are divided into four areas: psychiatric interventions, mental health disorders, subpopulations, and legal and ethical issues. The two intervention chapters cover psychopharmacologic and psychotherapeutic approaches for working with HIV-positive clients. The chapters on specific mental health disorders span cognitive disorders, mood and psychotic disorders, suicidal behaviors, and disorders of concern to an inpatient psychiatric consultation service. The chapters describing subpopulations include the chronically mentally ill, children, gay men, couples, women,

prisoners, and diverse ethnic groups. The final chapters deal with legal and ethical issues, and countertransference.

The primary purpose of publishing a new edition of *HIV and Psychiatry* was to accommodate all the changes in the epidemic since the advent of improved HIV treatment. These changes inform not only the medical chapters but also chapters on psychotherapeutic approaches, and the experiences of both clients and providers. The chapters that offer a medical overview are extremely useful, and the psychopharmacology chapters are filled with concise summaries that highlight antiviral interventions. These are amply supplemented with useful charts and tables, such as the table summarizing interactions between HIV antiviral treatments and psychotropic medications.

The book's last chapter, on the experience of provider fatigue, is particularly valuable and describes the challenges of managing the mental health issues of a population that has changed considerably over the years. The authors review some of the hallmarks of burnout and then direct clinicians to interventions that can revitalize their practice with clients and allow a sustainable work life.

## Breadth versus Depth

One of the strengths of the text is that the authors and editors were able to organize the entire field of HIV psychiatry into a readable, accessible, and concise text at a little over 300 pages. At the same time, the degree to which these vast topics have been condensed sometimes limits their utility.

While the book covers substantial ground, some topics would benefit from greater attention, among them the role of spirituality and the needs of older adults, heterosexual men, Asian Americans, and stimulant users. Perhaps because HIV is a life-threatening illness, the spiritual life of the client is often intertwined with coping and well-being, so the inclusion of more material on the interrelationship between HIV, mental health, and spirituality might have given providers additional, much-needed tools.

While a variety of subpopulations are discussed, an exploration of the challenges faced by older adults is missing, although the needs and mental health issues of an older HIV-positive population will be of ever increasing clinical concern. Similarly, heterosexual men are mentioned only in passing, yet these men face unique, complex issues that deserve to be addressed in a separate section. As it stands, these concerns are lumped together with those

## Authors

George Harrison, MD, is a Health Science Associate Clinical Professor of Psychiatry at University of California San Francisco and Medical Director of the UCSF AIDS Health Project.

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of men who have sex with men or are addressed solely through the lens of substance addiction. This oversight, however, is not surprising, since it reflects the lack of effective HIV-related mental health interventions and programs for heterosexual men.

The chapter on ethnic diversity challenges the reader to consider the interaction between culture and HIV-related mental health. As an HIV psychiatrist practicing in San Francisco, I found myself wishing more material had been included on Asian Americans, although they represent a disproportionately smaller group of those living with HIV in the United States.

Surprisingly, despite its relationship to sexuality, gay culture, and hepatitis C transmission, stimulant abuse was barely addressed in the substance disorder chapter, which focused primarily on heroin and alcohol abuse. Again, my sense that this

was a critical omission reflects my experience as a practitioner on the West Coast of the United States, where the escalating stimulant abuse epidemic is a crucial driver of new HIV infections. While some of this material is applicable to work with amphetamine or cocaine dependency issues, it has been my clinical experience that a client's use of stimulants complicates HIV treatment in a way that heroin or alcohol does not.

## Conclusion

*HIV and Psychiatry* brings together a massive amount of information and presents it in a highly organized and accessible manner. Despite its shortcomings, the book will have great utility in many settings. The new edition incorporates key changes in the field and retires the first edition as a time capsule regarding practice in the days before more effective treatments for HIV emerged.

## Barebacking in Context

Marshall Feldman, LCSW

Shernoff M, *Without Condoms: Unprotected Sex, Gay Men and Barebacking*. New York: Routledge, 2006. (Paper; 371 pages: \$31.95.)

*Without Condoms* by Michael Shernoff is a clear, well-written account of the psychological, emotional, political and historical issues surrounding gay men and unprotected sex. While mental health care professionals are the primary audience, the book is also aimed at gay men and those who love them, professors and students of human sexuality, and health care professionals.

“Barebacking” refers exclusively to gay men and, thus, risks pathologizing them. This contrasts with the societal view of unprotected sex among heterosexuals—as an expression of intimacy and as “normal,” especially when pregnancy is the goal. The underlying message may be that gay men are not as responsible as their heterosexual counterparts.

Shernoff places the practice of unprotected sex among gay men within two contexts that are usually disregarded: the historical and political. He also explores the psychology of barebacking and how providers can address its occurrence in a way that affirms a client's gay identity. Shernoff explores several factors that play into the decision to engage in unprotected sex, including trust, commitment and negotiated safety in gay relationships, the rise of the internet, and the influence of substance use.

Perhaps the most useful aspect of *Without Condoms* is that Shernoff provides concrete examples of his work as a therapist. The case examples are just one way that the book provides a practical framework and gives the reader an opportunity to examine thoughts and feelings about unprotected sex. This is an important book.

## Author

*Marshall E. Feldman, LCSW, is a psychotherapist and Coordinator of Mental Health Services for the UCSF AIDS Health Project's REACH Program.*

## Next Issue

In the January issue of *FOCUS*, **Stephen Follansbee, MD** quotes a recently published article that estimates that 2.8 million years of life have been saved since 1989 in the United States alone due to HIV antiviral treatment. Follansbee, the Medical Director of HIV Services at Kaiser Medical Center San Francisco and Vice-Chair of the Bay Area Consortium of HIV Providers, updates the current state of the art of HIV treatment strategies, antiviral treatment, and medical issues for people with HIV.

Also in the January issue, **Michael Montgomery**, former Chief of the Office of AIDS of the California Department of Health Services, briefly reviews the almost-20-year experience of the U.S. AIDS Drug Assistance Program (ADAP) of broadly delivering these life-saving treatments.