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Engaging, Retaining, and Providing Transdiagnostic CBT/MI for Underserved People with HIV

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Abstract

People with HIV experience elevated levels of co-occurring psychosocial concerns, which can interfere with HIV-related self-care behaviors, such as medication adherence. We recently developed a transdiagnostic, integrated cognitive-behavioral therapy (CBT) and motivational interviewing (MI) psychotherapy to address interrelated psychosocial problems (syndemics) that can interfere with medication adherence and self-care among people with uncontrolled HIV (i.e., a detectable viral load). Through completion of a field trial that included development, clinical supervision, treatment, and administrative coordination of this project, we identified recommendations for engaging, retaining, and delivering transdiagnostic CBT/MI to individuals with HIV and experiencing psychosocial and structural barriers to mental and physical health. We describe these recommendations, which include: (1) build the relationship, (2) address HIV in the context of syndemics, (3) attend to the impact of stigma on health, (4) be flexible in delivering the treatment, (5) manage emergent crises with relevant skill material, (6) tailor the treatment to education, language, and sociocultural context, (7) implement problem solving skills for structural barriers, (8) schedule flexibly and follow up (9) co-locate mental health services and coordinate among providers, and (10) provide a comfortable and affirming physical space. In addition to

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describing these recommendations, we provide clinical examples and highlight empirical research to illustrate and support using these recommendations.

Keywords

Transdiagnostic; cognitive-behavioral therapy; motivational interviewing HIV; engagement in care

People with HIV (PWH) experience high rates of mental health and substance use concerns (Bing et al., 2001; O'Cleirigh, Magidson, Skeer, Mayer, & Safren, 2015) and structural barriers that impact their health (Wawrzyniak et al., 2015). The co-occurrence of HIV, behavioral health, and structural problems is referred to as a syndemic, or, multiple, synergistic epidemics (Singer & Clair, 2003). Syndemics can worsen HIV-related health outcomes, including treatment and medication adherence (Blashill et al., 2015; Harkness et al., 2018). Therefore, it is important to engage, retain, and provide evidence-based treatment to PWH and interfering syndemic conditions.

The goal of this article is to describe recommendations for engaging, retaining, and delivering a transdiagnostic integrated cognitive-behavioral therapy and motivational interviewing (CBT/MI) psychotherapy (Naar & Safren, 2017) to PWH and uncontrolled viral load. Our recommendations are informed by our work with 27 individuals with unsuppressed virus (despite being in HIV care) who participated in a field trial of this psychotherapy. Typically, for those in care, viral load becomes suppressed or reduced by adhering to a daily regimen of antiretroviral treatment (ART), reducing the risk of complications due to HIV or depletion of CD4 cells (Gardner, McLees, Steiner, Del Rio, & Burman, 2011). Individuals in this trial were affected by multiple psychosocial (e.g., depression, trauma, substance use), interpersonal (e.g., intimate partner violence, HIV stigma), and structural syndemics (e.g., limited educational and work opportunities, living below the poverty line). The majority of clients identified as non-Hispanic Black and nearly a third as sexual minority individuals. Our recommendations include strategies for implementing CBT/MI intervention modules within this population and practices for engaging and retaining this population in CBT/MI treatment.

This manuscript is intended for clinicians who provide psychotherapy to underserved PWH in HIV clinics, hospitals, and community mental health clinics. However, it is possible that clinicians with other areas of focus or expertise who treat clients affected by HIV or from underserved backgrounds may find our recommendations helpful. To facilitate their implementation in practice, we organized these recommendations from individual clinician level to organizational/structural. We also include clinical exchanges that are based on a conglomeration of several clients, illustrating therapists' use of the treatment without revealing identifying information about clients. Additional clinical examples are provided, with client demographics altered for confidentiality.

Brief Description of Transdiagnostic CBT/MI Treatment

All clients began treatment with a Life Steps medication adherence counseling session (Safren, Otto, & Worth, 1999), a CBT/MI skills building approach to improve adherence.

Life Steps involves psychoeducation, medication reminder strategies, problem-solving transportation issues to pick up medication and attend appointments, and managing side effects. Following Life Steps, therapists flexibly delivered the transdiagnostic CBT/MI treatment modules relevant to clients' goals and presenting concerns and reviewed Life Steps skills at each session. CBT/MI modules available for therapists to use included (1) CBT and MI psychoeducation, (2) behavioral activation, (3) cognitive restructuring to build flexible thinking and challenge unhelpful thoughts about medication and stressors, (4) problem solving barriers to HIV self-care and well-being, (5) substance use management and relapse prevention, (6) cognitive therapy focused on coping with trauma (using cognitive-processing therapy as a point of departure), (7) relaxation skills to manage side effects and stressors, and (8) a final relapse prevention session reviewing the modules addressed in treatment. Modules were developed from a variety of CBT- and MI-based protocols that have been shown to be effective in addressing adherence difficulties and the syndemic problems we were addressing, including our prior work on addressing HIV medication adherence and depression (Safren et al., 2012) and others' interventions for adherence and substance use among PWH (Parsons, Rosof, Punzalan, & Maria, 2005), behavioral activation to prevent acquisition of HIV among men who have sex with men who use stimulants (Mimiaga et al., 2012), cognitive processing therapy to address PTSD (Resick, Monson, & Chard, 2016), and the general style of integrating MI with CBT (Naar & Safren, 2017). Further information regarding the development of the intervention and outcomes is available elsewhere (MASKED FOR REVIEW). Training resources on the CBT and MI protocols from which the modules for the current CBT/MI intervention were developed are available in this article's online supplemental materials.

Therapists were supervised by two licensed providers, both CBT and health psychology experts and one an expert in PTSD treatment. A true "unified" protocol, whereby all clients received one standardized intervention, was not feasible in the context of clients' numerous and varied syndemic problems. Therefore, a modular approach was used to select intervention components through supervision, clinical judgment, and treatment planning. Modules were flexibly delivered, such that they could be split across multiple sessions or covered multiple times as clinically indicated. Clients could receive up to 14 sessions with up to 4 booster sessions.

Recommendations

1. Build the Relationship

Individuals with multiple marginalized identities have historically and personally experienced stigma related to HIV, race/ethnicity, sexual orientation, socioeconomic status, mental health, or substance use. These individuals are less likely to engage and be retained in treatment (Santiago, Kaltman, & Miranda, 2013). Deficits in therapeutic alliance (Vasquez, 2007) and concerns about medical experimentation, harm, and medical mistrust, particularly among African-Americans, given the history of racism in health care (Suite, La Bril, Primm, & Harrison-Ross, 2007), are potential sources of underutilization of services and can lead to lower ART adherence (Bogart et al., 2016).

For these reasons, it was especially important for therapists to be attentive to the therapeutic relationship, taking a collaborative treatment approach, directly addressing clients' experiences with stigma, and acknowledging client-therapist power differentials. When issues arose, therapists responded with openness rather than defensiveness. Drawing from a client-centered MI approach, therapists demonstrated genuine, unconditional positive regard and worked to allay clients' ‘ fears of judgment when disclosing issues related to sex, substance use, mental health, or other sensitive topics. For many, this approach was in contrast to prior encounters with healthcare professionals, in which they reported feeling judged, dismissed, or disempowered.

Therapists used the CBT/MI approach to build the alliance and engagement (Naar & Safren, 2017), as in prior HIV adherence trials (Naar-King et al., 2009; Parsons et al., 2005). The approach was collaborative, guided by clients' treatment goals elicited in the first session:

Therapist: Before we move on, I would like to ask you to think about why taking your HIV medication is important to you.

Client: Because my doctor wants me to.

Therapist: Okay, so your doctor wants you to take your medication. What is *your* number one reason for taking your medication? Another way to think of it is to ask yourself, “What will taking my medication allow me to do or feel?”

Client: Well, I guess I want to live long enough to be around to see my grandson grow up. He's pretty good at football, and I think he has a real chance of getting a scholarship someday. He's a smart kid, too, he could go to college on that.

Therapist: Okay, so it's important for you to take your medication so you can stay around and see your grandson grow up. That sounds like a really important reason.

Client: Yes, it is. He's my world. He's my everything.

Therapist: Great, so let's write that down here as a reason to take your medication. *Live long enough to see grandson grow up.* What might be another reason to take your medicine?

Client: I'm not sure, but I think when I'm taking it all the time, I actually feel better. I mean, I don't like having to do it, but sometimes I feel better. And, getting sick less often.

Therapist: You might be right. Taking your medication can make me feel better and get sick less often. Could we add that to the list?

Client: Yeah! Let's add it.

Therapist: Okay, here it is, *To feel better and get sick less often*. What else do you think could be better by taking your medication?

Client: I'll feel good about myself.

Therapist: Yeah, tell me about that. What do you mean by that?

Client: I'll feel good about myself, because, like, I know I'm supposed to. And, so, if I do, I might feel good. I feel bad when my levels are high, so I would feel good if they were low again like they used to be.

Therapist: So yeah, to you, there's something that makes you feel good, or even proud, when you take your medicine and take care of yourself, would you say that?

Client: Yes, absolutely.

Therapist: And, it sounds like when your viral load is low, or undetectable, you feel some pride in that, too.

Client: Yeah, my doctor is happy and telling me I'm doing a good job. That feels good.

Therapist: Okay, that's great, so let's make your final reason *To feel proud of yourself for taking your medicine and having low, or what we call, undetectable viral load*. Is that good?

Client: Yes, that's it.

Therapist: What else?

Client: That's good. I think those are my reasons.

2. Address HIV in the Context of Syndemics

Informed by our prior work with PWH and co-occurring depression (Safren et al., 2012), therapists worked with clients to identify how their psychosocial (e.g., depression, anxiety, substance use) and interpersonal/structural (e.g., transportation difficulties, family rejection based on HIV status, financial problems) syndemic problems impacted their well-being and HIV-related self-care. Due to the prominence of syndemic problems in the lives of underserved PWH, it was essential to address HIV self-care by addressing these interfering problems. Thus, we deployed CBT/MI skills to address syndemics and HIV-related self-care simultaneously.

One client, an African-American heterosexual woman in her late 40s with longstanding depression and who was unable to find work due to an incarceration history, found it difficult to see any benefits of taking medicine. The therapist validated the challenging circumstances she was facing and implemented CBT/MI skills to work toward improving both the syndemic problems and their impact on her health. The behavioral activation module was used to identify opportunities to stay engaged in activities that enhanced her sense of mastery and pleasure despite her barriers to working. For instance, she identified having a coffee as an enjoyable and realistic activity that she could schedule into her morning routine. She also used this daily enjoyable activity as a reminder to take her medication. Her therapist also helped her identify and challenge unhelpful thoughts to improve HIV self-care:

Client: There's no point in taking medication, it's not like it's going to make any difference in my life anyway. I'm never going to find a job or get back on track.

Therapist: You mentioned your viral load was undetectable a few years ago, what was that like?

Client: I guess I was more hopeful then. I wasn't as depressed and I felt like I could take care of myself because I got to be undetectable.

3. Attend to the Impact of Stigma on Mental and Physical Health

Due to the disproportionate impact of HIV on marginalized social groups, it was important to utilize the CBT/MI skills to address stigma. Clients described stigma-related barriers to medication adherence such as not wanting to take medication in front of people to whom they had not disclosed their HIV status and discomfort with a medication alarm due to anticipated stigma. Therapists addressed these stigma-related barriers using a variety of CBT/MI strategies. Using the problem solving module, clients developed creative solutions to work around or address the impact of stigma on their adherence. One client, an African-American heterosexual woman in her early 20s, set a generic daily calendar event related to her personal interests which she knew was a medication reminder, but others would not be able to identify as such. Another client (late 40s Caribbean Black heterosexual man), who feared stigmatizing reactions from others if he took his medication at work developed a plan to take his medicine in his car with a prepared meal, before entering his workplace.

HIV stigma also affected clients' lives more broadly, especially with respect to real or anticipated rejection based on HIV status. One client, a mid 50s Latino heterosexual man, was rejected by his family based on his HIV status and became socially isolated and depressed due to anticipating that others would also reject him. Another client (mid 40s heterosexual African-American woman), chose to stay with a partner with whom she was unsatisfied because he accepted her HIV status and she feared not finding another partner. Mastery and social support can offset the relationship between stigma and depression among PWH, improving both adherence and mental health (Rueda et al., 2012). Therefore, therapists utilized behavioral activation and problem-solving to increase clients' engagement in enjoyable and mastery activities and build non-stigmatizing social support. One client (late 40s African-American heterosexual man) was a father who had not disclosed his HIV status to his adult son, feared disclosure due to anticipated rejection. Using problem solving, the client identified strategies for having this conversation and then used these to disclose to his son. Through this disclosure, he learned that his son was also HIV-positive and they developed a new, stronger relationship with bidirectional support in managing their HIV-related self-care.

4. Be Flexible in Delivering the Treatment

Despite the CBT/MI intervention being a treatment protocol, flexibility in the sequence and specific focus of session content was essential. Therapists tailored the protocol by deploying the specific modules that were most relevant to the clients' specific syndemic problems. Balanced with careful treatment planning, therapists could make in-session decisions about changing, repeating, or extending across several sessions, those modules that were relevant to clients' most pressing needs. This approach allowed therapists to be adherent to the core principles of the CBT/MI protocol to ensure clients gained generalizable skills, with a

balance toward keeping sessions relevant to the issues clients were most motivated to work on in a particular session. This responsiveness was essential for engaging clients in psychotherapy.

For example, a client (mid 40s African-American heterosexual man) with PTSD, stimulant use, and pervasive difficulties with interpersonal conflict in most areas of his life presented during one session with distress regarding housing. He was staying with a friend who was using substances, a trigger for his own stimulant use, which he wanted to avoid due to fear of becoming incarcerated again. The therapist had previously conducted the problem solving module with the client and was planning to introduce the relaxation module for the current session. However, the problem solving module was more relevant to his immediate stressor and treatment goal of reducing stimulant use. Thus, it was an opportunity to solidify the problem solving skill in the context of an immediate stressor that he was highly motivated to address. Guided by the flexibility of the CBT/MI protocol, the therapist returned to problem solving, delivering the relaxation module in a later session when it was more relevant.

As another example, therapists were attentive to variability in clients' abilities to engage with treatment material across sessions. Among those coping with longstanding substance use problems, the uptake of treatment material and its perceived relevance was limited when sessions occurred in the weeks following termination of substance use. Clients showed markedly different facility with complex materials over time, and therapists adjusted implementation of the CBT/MI protocol accordingly. For instance, behavioral activation and relaxation were more concrete than cognitive restructuring. As such, these were more implementable at certain times in treatment.

5. Manage Emergent Crises with Relevant Skill Material

It was not uncommon for clients to present to sessions with an acute crisis, such as pending legal issues, acute suicidal ideation and planning, or family health crises that required immediate clinical attention. Therapists utilized the CBT/MI modules to manage these crises, with the primary exception of suicidality that required standardized suicide risk assessment.

One client (late 50s African-American heterosexual man) presented to a session highly emotionally dysregulated due to his wife being suddenly hospitalized for a life threatening condition. Responding to this crisis, the therapist utilized the relaxation and emotion-focused coping skills modules to manage his acute distress. The therapist worked with him to identify barriers to medication adherence during this acutely stressful time and his motivations for remaining adherent despite this crisis. Another client (mid 50s Latino heterosexual man) had extreme abdominal swelling and untreated Hepatitis C, but could not access treatment through his insurance. Using problem solving, he and his therapist identified ways he could find treatment options and ultimately enrolled in a clinical trial for treatment. In each case, deploying a CBT/MI module that was relevant to an acute crisis helped clients develop generalizable skills to manage inevitable future threats to HIV self-care.

Due to the frequency and intensity of syndemic problems in the lives of underserved PWH, it was critical to thoroughly train and supervise therapists on determining when to utilize the CBT/MI modules to address crises and when to transition to standardized risk assessment. In one case, a client (early 30s African-American heterosexual woman) with a history of intimate partner violence and current PTSD and depression experienced a major, acute traumatic event during treatment, leading to high levels of suicidal ideation. This situation required the therapist to transition from the planned treatment module to the suicide assessment protocol, ultimately linking the client to be evauated for inpatient hospitalization.

6. Tailor the Treatment to Education, Language, and Sociocultural Context

PWH and not engaged or retained in care often experience barriers to care that are rooted in social, cultural, and economic inequalities (Pellowski, Kalichman, Matthews, & Adler, 2013). Our trial served this population, and as such, many clients had less formal education and English fluency than typically seen in CBT treatment trials: nearly half had not completed high school and some were recent U.S. immigrants with limited English fluency. Thus, treatment modules were thoroughly reviewed and modified to be at a 4^{th}-6^{th} grade reading level, consistent with recommendations for working with other medical populations with lower health literacy or limited literacy (Kuhajda, Thorn, Gaskins, Day, & Cabbil, 2011). Additionally, we used visual tools (e.g., graphs, images of virus, shapes) to explain abstract concepts related to HIV adherence, such as viral load, viral suppression, uncontrolled virus, and medication resistance. In response to a common criticism regarding the complexity of CBT language, therapists were trained to use language that was more concrete and familiar (e.g., “thinking traps” vs. “cognitive distortions”).

Overall, we implemented CBT in a less traditional format, mindful of the economic and educational barriers to care faced by many underserved PWH. For example, home practice was often related to planned behaviors rather than worksheets. This modification enhanced home practice for participants with different levels of literacy and comfort with written assignments and for whom stigma, unstable housing, and limited privacy interfered with written home practice. Clients could be asked to “pay attention to thinking traps” (cognitive appraisal) or “do a daily enjoyable activity” (behavioral activation), planning specific circumstances that would serve as reminders for home practice.

With regard to sociocultural context, several examples from the manualized treatments from which our CBT/MI modules were developed did not fit clients’ lived experiences. For example, several activities on an existing pleasant activities list for behavioral activation required spending money or engaging in activities that were impractical. We used an iterative adaptation process based on feedback from clients, changing “getting a massage” to “getting a backrub from a partner or friend” and “going to the gym” to “taking a walk.” These modifications allowed clients to fully engage in treatment, without feeling alienated or fracturing rapport by recommending activities that were disconnected from clients’ realities.

7. Implement Problem Solving Skills for Structural Barriers

Clients were affected by numerous structural barriers to engaging in treatment, completing home practice, and adhering to medication. For example, Miami’s extremely limited public

transporation system, on which many clients were reliant, was a treatment barrier. Clients also faced structural barriers to medication adherence, such as difficulty picking up medications due to the limited hours at the pharmacy that offered medication pickup through the AIDS Drug-Assistance Program (ADAP). Although the CBT/MI protocol was not designed to fix these structural issues, we focused on helping clients learn and implement problem solving skills to navigate structural barriers. Clients generated solutions such as scheduling therapy and medical visits on the same day to reduce their total commute, obtaining a bus pass at a reduced cost, and storing "back up" medication. Building clients' problem solving skills became a generalized skill that also increased attendance at medical and case management appointments.

8. Schedule Flexibly and Follow Up

Many clients faced barriers to attending appointments at regular dates or times due to difficulties with public transportation, unexpected life events, or competing family demands. To address these barriers, therapists worked with clients in session to identify strategies to attend scheduled appointments, including therapy and medical care. Administrative staff developed positive working relationships with clients, problem solving barriers to session attendance and following up repeatedly after missed sessions. Although these strategies are consistent with recommendations for engaging and retaining low income racial and ethnic minorities in treatment (Santiago et al., 2013), we found that one of the most effective means to facilitate retention in treatment was scheduling flexibly. For example, therapists made every attempt to work the client into their schedule on the frequent occurrences when clients came to our office at a non-scheduled day or time. In one case, a client (early 40s African-American gay man) with ongoing substance use and difficulty anticipating his availability worked out an ad-hoc visit schedule with the therapist, calling when he was near the office, and the therapist would see him if possible.

In clinics with high no-show rates, one feasible strategy for implementing flexible scheduling might be overbooking clinician's schedules (e.g., in a clinic with a 50% attendance rate, overbooking can facilitate effective use of clinician time). Clinics and hospitals that serve this population could also implement structural changes such as creating an "on-call" day for unscheduled clients, allowing for "walk-in" visits, restructuring clinic hours for evening or weekend appointments, or allotting staff time for intensive outreach and re-engagement. Although there are cost issues, our experiences suggest flexibility may help to engage and retain those at highest risk of falling off the HIV care cascade, with downstream cost implications.

9. Co-Locate Mental Health Services and Coordinate among Providers

Clients were primarily referred to us by providers and case managers at the local HIV clinic (within walking distance of our office) who were having difficulty engaging their patients in regular appointments or whose viral loads were not suppressed. Medical providers in this system often have large patient loads and many of their patients are complex and highly underserved. Thus, it is important for these providers to utilize complementary resources to address the syndemic problems that interfere with their patients' health. As such, we found that explaining to providers that this resource was available to their patients with adherence

difficulties was a feasible strategy for engaging this population in mental health treatment and also eased the workload for the medical team. Therapy then could be utilized as a point of re-engagement in HIV care. Consistent with recent evidence showing the impact of co-located mental health services within HIV clinics on viral suppression (Aggarwal, Pham, Dillingham, & McManus, 2019), we recommend the structural shift toward co-locating and enhancing communication between HIV care providers and mental health teams. In this field trial, therapists often communicated with clients' HIV care providers and case managers (with client consent) to inform them of progress or concerns (e.g., adherence to medication without corresponding decline in viral load potentially indicative of resistance). This communication was facilitated by being located in a common health system.

10. Provide a Comfortable and Affirming Physical Space

Clients did not have consistent access to safe, comfortable, and affirming physical spaces, and in fact, some of their past difficulties with engagement in care related to feeling stigmatized, disrespected, or poorly treated in healthcare environments. Therefore, we made concerted efforts to ensure clients felt respected and affirmed in our office, with the goal of the therapy visit being a "high point" of each client's day. To show appreciation and creating a welcoming environment for clients, we provided small snacks, juice, water, and coffee to clients during sessions and decorated therapy rooms with indicators of respect, diversity, and inclusion of racial and ethnic minorities, sexual and gender minorities, and PWH. This approach is consistent with recommendations for building identity-based inclusion in healthcare environments (McClain, Hawkins, & Yehia, 2016). Additionally, if clients arrived early to sessions or were waiting for public transportation after sessions, they were invited to use our waiting room, restrooms, power outlets, air-conditioned seating, and snacks and drinks. The therapy setting was a space to take care of their needs and be respected in a way that was often not the case in the context of clients' lives outside of treatment. This type of adaptation likely requires an organizational commitment in terms of time, space, and resources. In our experience, clients responded to these adaptations positively, justifying the effort to enhance treatment engagement and retention.

Conclusions

Because the majority of PWH and uncontrolled viral load are underserved and affected by syndemic issues, it is especially important to identify and utilize strategies to engage, retain, and provide care to this population. The majority of behavioral trials for PWH have arguably reached those with greater access to resources than clients in this trial, and thus, may not necessarily address the needs of this subpopulation most affected by syndemics. This article includes our recommendations for reaching this underserved subpopulation, based on our field trial of a CBT/MI treatment. Our goal is to highlight strategies that can be feasibly implemented in "real world" settings to address the syndemic problems that worsen health for underserved populations with HIV. Individual, organizational, and structural efforts will be needed to meet the U.S. "Ending the HIV Epidemic" goals (Fauci, Redfield, Sigounas, Weahkee, & Giroir, 2019), particularly for people who lack resources and may be most likely to fall off of the HIV care continuum. We hope that our approach will be a useful

guide to clinicians and practice settings providing services to underserved individuals with HIV.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Clinical Impact Statement

Question:

What strategies can therapists use to engage, retain, and provide transdiagnostic, integrated cognitive-behavioral therapy and motivational interviewing to underserved clients with HIV?

Findings:

For therapists working with underserved clients with HIV, there are strategies that may increase clients' likelihood of using and staying in transdiagnostic CBT/MI treatment and can help to ensure that treatment is useful and relevant to clients' lives.

Meaning:

Despite the psychosocial, interpersonal, and structural challenges facing underserved clients with HIV, a variety of strategies may improve engagement and delivery of evidence-based mental health services using the strategies identified may help to offset the impact of these challenges on clients' health and well-being.

Next Steps:

Future research might continue to explore the effects of using the strategies identified here on client outcomes, both in terms of mental health and HIV health, for example, through a randomized trial of this treatment.

Table 1

Summary of Recommendations and Applications for Delivering CBT/MI

Recommendation	Application for Using CBT/MI with Underserved People with HIV
1. Build the relationship	• Directly acknowledge any mistrust or reluctance the client may feel for engaging in treatment. • Acknowledge and validate any prior stigmatizing or discriminatory medical/healthcare experiences the client may have had in the past. • Use motivational interviewing to set treatment goals and session agendas to reduce client-therapist power differentials and establish a collaborative relationship.
2. Address HIV in the context of syndemics	• Collaborate with the client to identify how their syndemic problems (i.e., depression, family rejection, unemployment) are impacting their overall well-being and HIV-related self-care. • Implement CBT/MI skills to reduce the degree or impact of syndemic problems on clients' overall well-being and HIV-related self-care.
3. Attend to the impact of stigma on health	• Given the stigma associated with HIV and the social groups HIV disproportionately affects, it is essential to use CBT/MI skills to address stigma and its impact on well-being and HIV-related self care. • Example: use the problem solving module to identify non-stigmatizing medication reminders or to find affirming social support
4. Be flexible in delivering the treatment	• Capitalize on client's intrinsic motivation to address immediate stressors by utilizing the most relevant modules to these stressors, thereby addressing current concerns *and* developing generalizable CBT skills for future stressors • Example: switching a planned problem solving module for the substance use management and relapse prevention module when working with a client who presents to session having just lost his job and now feeling it is futile to take his medication or maintain his sobriety
5. Manage emergent crises with relevant skill material	• Due to the frequency and intensity of syndemic conditions affecting this population, it is likely that clients will present to sessions with emergent crises. • Emergent crises can largely be addressed through utilization of the most relevant CBT/MI modules, however, therapists need to be trained to determine when to transition to standardized risk assessment.
6. Tailor the treatment to education, language, and sociocultural context	• Use visual aids to deliver complex concepts, such as medication adherence or psychoeducation about CBT and MI to increase knowledge and motivation for taking medicine and engaging in therapy • Adapt home practice to be behavioral and accessible across literacy levels
7. Implement problem solving skills for structural barriers	• Rather than solving structural barriers on behalf of clients (i.e., case management), utilize the CBT/MI modules to teach skills that can be used to address the current, and inevitable future barriers, to care. • Example: use the problem solving module to address transportation problems that interfere with attending therapy and medical appointments.
8. Schedule flexibly and follow up	• When possible at an organizational level, allocate staff and resources for creative solutions to engaging underserved individuals living with HIV in treatment. • For example, resources could be used to extend clinic hours, create drop-in services, or conduct intensive outreach and follow up to re-engage clients.
9. Co-locate mental health services and coordinate among providers	• For therapists embedded in multidisciplinary settings, such as hospitals or HIV clinics, coordinate with clients' other providers to optimize HIV and mental health outcomes.

Recommendation	Application for Using CBT/MI with Underserved People with HIV
	• Use treatment modules to increase clients' motivation and skills in navigating the healthcare system to obtain other needed medical services.
10. Provide a comfortable and affirming physical space	• When possible, and especially for organizations in which underserved people with HIV represent a substantial portion of the patient population, dedicate organizational resources toward creating safe, affirming, respectful, and inclusive physical spaces in which treatment is delivered.

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