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COGNITIVE-BEHAVIORAL INTERVENTIONS IN HEALTH CARE FOR PEOPLE WITH HIV WITH LOW ADHERENCE TO TREATMENT

INTERVENÇÕES COGNITIVO-COMPORTAMENTAIS NO CUIDADO À SAÚDE DE PESSOAS COM HIV COM BAIXA ADESÃO AO TRATAMENTO

INTERVENCIONES COGNITIVO-CONDUCTUAL EN LA ATENCIÓN SANITARIA DE PERSONAS CON VIH CON BAJA ADHERENCIA AL TRATAMIENTO

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ABSTRACT

This study aims to contribute to mental health care for People Living with HIV (PLHIV) who present low adherence to Antiretroviral Therapy (ART). Based on an integrative literature review, the challenges faced by this population are discussed, involving psychological, social, and relational aspects, often marked by stigma and psychological distress. In this context, Cognitive-Behavioral Therapy (CBT) stands out as an effective approach for clinical interventions aimed at promoting treatment adherence. Techniques such as cognitive restructuring—focused on identifying and modifying dysfunctional thoughts related to illness and treatment—emotional regulation—aimed at improving the management of uncomfortable emotions—and the integration of motivational interviewing, which contributes to overcoming ambivalence regarding the consistent use of medication and other treatment-related procedures, are explored. The study highlights the importance of qualified clinical listening and the personalization of psychological interventions, acknowledging the complexity of the ART adherence process. It is argued that mental health care, when guided by evidence-based approaches, can strengthen the therapeutic alliance and promote self-care, thus enhancing public health practices. In this scenario, CBT emerges as a strategic and flexible resource, capable of responding ethically, technically, and sensitively to the unique demands of PLHIV.

Keywords: Cognitive Behavioral Therapy. Mental Health Care. People Living with HIV. Low Adherence to Antiretroviral Treatment. Cognitive Distortions. Emotional Dysregulation.

RESUMO

Este trabalho tem como objetivo contribuir para o cuidado em saúde mental de Pessoas Vivendo com HIV (PVHIV) que apresentam baixa adesão ao Tratamento Antirretroviral (TARV). A partir de uma revisão integrativa da literatura, são discutidos os desafios enfrentados por essa população, que envolvem aspectos psicológicos, sociais e relacionais,

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frequentemente marcados por estigma e sofrimento. Nesse contexto, destaca-se a Terapia Cognitivo-Comportamental (TCC) como uma abordagem eficaz para intervenções clínicas voltadas à promoção da adesão terapêutica. São exploradas técnicas como a reestruturação cognitiva, voltada à identificação e modificação de pensamentos disfuncionais relacionados ao processo de adoecimento e tratamento; a regulação emocional, que busca melhorar o manejo das emoções desconfortáveis; e a integração da entrevista motivacional, que contribui para a superação da ambivalência quanto ao uso contínuo da medicação e demais procedimentos relacionados ao tratamento. O estudo evidencia a importância da escuta clínica qualificada e da personalização das intervenções psicológicas, reconhecendo a complexidade do processo de adesão ao TARV. Argumenta-se que a atenção em saúde mental, quando orientada por abordagens baseadas em evidências científicas, pode potencializar o vínculo terapêutico e promover o autocuidado, qualificando as práticas em saúde pública. A TCC, nesse cenário, se apresenta como um recurso estratégico e flexível, capaz de responder de forma ética, técnica e sensível às demandas singulares de PVHIV.

Palavras-chave: Terapia Cognitivo-Comportamental. Cuidado em Saúde Mental. Pessoas Vivendo com HIV. Baixa Adesão ao Tratamento Antirretroviral. Distorções Cognitivas. Desregulação Emocional.

RESUMEN
Este trabajo tiene como objetivo contribuir al cuidado de la salud mental de Personas que Viven con VIH (PVVIH) que presentan baja adherencia al Tratamiento Antirretroviral (TAR). A partir de una revisión integradora de la literatura, se discuten los desafíos enfrentados por esta población, que involucran aspectos psicológicos, sociales y relacionales, frecuentemente marcados por el estigma y el sufrimiento psíquico. En este contexto, se destaca la Terapia Cognitivo-Conductual (TCC) como un enfoque eficaz para intervenciones clínicas orientadas a la promoción de la adherencia terapéutica. Se exploran técnicas como la reestructuración cognitiva, dirigida a la identificación y modificación de pensamientos disfuncionales relacionados con el proceso de enfermedad y tratamiento; la regulación emocional, que busca mejorar el manejo de emociones incómodas; y la integración de la entrevista motivacional, que contribuye a superar la ambivalencia respecto al uso continuo de la medicación y otros procedimientos relacionados con el tratamiento. El estudio pone de relieve la importancia de una escucha clínica cualificada y de la personalización de las intervenciones psicológicas, reconociendo la complejidad del proceso de adherencia al TAR. Se argumenta que la atención en salud mental, cuando está guiada por enfoques basados en evidencias científicas, puede fortalecer el vínculo terapéutico y promover el autocuidado, mejorando así las prácticas en salud pública. En este escenario, la TCC se presenta como un recurso estratégico y flexible, capaz de responder de manera ética, técnica y sensible a las demandas singulares de las PVVIH.

Palabras clave: Terapia Cognitivo-Conductual. Atención de Salud Mental. Personas que Viven con VIH. Baja Adherencia al Tratamiento Antiretroviral. Distorsiones Cognitivas. Desregulación Emocional.

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1 INTRODUCTION

HIV continues to be a serious public health problem. Approximately 38 million people are living with HIV (PLHIV), 28 million of whom are on Antiretroviral Treatment (ART). In 2021, there were 1.5 million new infections and 680 thousand deaths from AIDS-related illnesses. Although there is still no cure, advances in ART have improved patient quality of life (UNAIDS, 2021; WHO, 2022). In Brazil, Law No. 9,313/1996 guarantees free access to HIV and AIDS treatments and medicines in the SUS (BRASIL, 1996). Adherence to treatment is a dynamic and multifactorial process, involving physical, psychological, social, cultural, and behavioral aspects, requiring joint decisions between the patient and the health team. Non-adherence is characterized by non-compliance with prescriptions and abandonment of treatment. Adherence to treatment is a major challenge for health services and professionals (MINISTRY OF HEALTH, 2008).

Since the 1980s, HIV and AIDS have been studied, including their impacts on mental health, due to the emotional overload and psychic vulnerability associated with the diagnosis (MALBERGIER, 2000). PLHIV can face psychological changes such as denial, anxiety, depression, guilt, shame, social isolation, and fear. These changes may arise when the patient considers the possibility of infection due to risk behaviors (REMOR, 1999; MALBERGIER; SCHOFFEL, 2001; FLORES, 2012; BRITO; SEIDL, 2015; POLETTO et al., 2015; NOGUEIRA, 2016; KAHHALE et al., 2010; SILVA, SANTANA, 2025).

Illness represents a rupture in life and projects, requiring the individual to find ways to cope. This process involves a dynamic in which thoughts, emotions and actions influence the ways of dealing with health problems (KAHHALE et al., 2010). The Cognitive Model, developed by Aaron T. Beck, highlights that thoughts, emotions, and behaviors are influenced by the way people assign meaning to situations (KNAPP; BECK, 2008; JUDITH BECK, 2022).

Cognitive-Behavioral Therapy (CBT) assists in the restructuring of distorted thoughts through therapeutic interventions, promoting problem-focused strategies and adaptive changes in cognitive, emotional, and behavioral patterns related to living with HIV. Distorted cognitive patterns and unwanted behaviors can aggravate the experience of becoming ill with HIV, exacerbating symptoms and hindering adherence to antiretrovirals, compromising the production of care. Cognitive and behavioral interventions have shown efficacy in chronic diseases, reducing psychological and psychiatric changes, promoting treatment adherence and improving the patient's clinical condition (KNAPP; BECK, 2008; FLORES, 2012;

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JUDITH BECK, 2022; POLETTO et al., 2015; BRITO; SEIDL, 2015; ITO, 2004, SILVA, SANTANA, 2025).

Psychological practice in the Infectious Diseases Service is necessary due to the possibility of evidencing emotional dysregulation, cognitive distortions and exposure to risk situations in patients with HIV. The role of the psychologist in the interdisciplinary team is fundamental to identify and modify the dysfunctional cognitions related to living with HIV, using therapeutic strategies based on CBT. These interventions aim to reduce the psychological and emotional impact of the diagnosis and promote adherence to ART. From this comprehensive perspective, the following question is asked: *Can CBT contribute to the health care of PLHIV with low adherence to treatment?.*

CBT is seen as a clinical approach in the field of Psychology, effective in mental health care. This communication is intended to contribute to the production of care for PLHIV with low adherence to treatment, strengthening theoretical-practical foundations of a clinical nature, benefiting the community of users of specialized HIV services in public health, as well as broadening comprehensive horizons of psychological practice. The relevance of expanding studies in this area is highlighted, given the scarcity of research on the subject. It is important to highlight that the information evidenced in this article derives from knowledge elaborated from studies carried out within the scope of the Professional Master's Program in Psychology - Practices and Innovations in Mental Health, at the University of Pernambuco (UPE).

2 METHODOLOGICAL PATHS

An integrative literature review was carried out focusing on the theoretical contributions and clinical procedures of CBT in the health care of PLHIV with low adherence to ART. Integrative review is indicated for research that seeks to map concepts, analyze studies related to the researched theme, and present an overview when there is a scarcity of specific studies or methodological heterogeneity. In this way, this approach allows for the analysis and integration of different theoretical and methodological perspectives, providing a broader understanding of the current state of knowledge. It should be noted that despite the scope provided by the narrative review, this approach does not aim to perform meta-analyses and quantitative syntheses of the data. Thus, the expected results focus on the integration and qualitative analysis of the available information, providing a broad and contextualized view of the theme (MENDES; SILVEIRA; GALVÃO, 2008).

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Studies that met the following criteria were considered for inclusion: articles in Portuguese, publications in scientific journals, books and academic chapters recognized and focused on the researched theme. Studies that presented content unrelated to the central theme, non-peer-reviewed studies, and duplicate or outdated publications were excluded. It was decided not to delimit a time interval for the selection of studies due to the complexity and scarcity of specific publications on the subject, thus allowing the inclusion of relevant studies regardless of the year of publication. However, in order to minimize the risk of inclusion of obsolete studies, a careful evaluation of the timeliness and relevance of the articles was carried out during the full reading, ensuring that the information incorporated reflected the most recent state of knowledge on the subject.

The bibliographic search was carried out in the following electronic databases: Google Scholar, SciELO, PubMed, LILACS and the Virtual Health Library (VHL). In addition, bibliographic references of the selected articles were consulted to expand the research. The following descriptors and keywords were used: Mental Health Care, People Living with HIV, Low Adherence to Antiretroviral Treatment, Cognitive-Behavioral Therapy, Cognitive Distortions and Emotional Dysregulation.

From this stage, an initial screening was carried out by reading the titles and abstracts of the studies found, in order to verify their relevance to the proposed theme. Potentially pertinent materials were read in full to confirm their adequacy to the inclusion criteria, ensuring the consistency and quality of the final review sample. The selection of studies was carried out by a main evaluator, with the participation of a second evaluator to review and confirm the adequacy of the included articles, ensuring greater rigor and reliability in the selection process.

3 PRODUCTION OF CARE FOR PLHIV: CHALLENGES IN ADHERENCE TO ANTIRETROVIRAL TREATMENT

Adherence to treatment is a complex process that involves both the ingestion of medications and the emotional strengthening of PLHIV, being influenced by personal beliefs, personality characteristics, and psychosocial and socio-environmental factors (MINISTRY OF HEALTH, 2022). ART has promoted a significant reduction in morbidity and mortality among PLHIV in Brazil and worldwide. However, treatment imposes challenges on health services and professionals to ensure the continuity of the fight against the virus (MENEZES et al., 2018).

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According to the Epidemiological Bulletin on HIV and AIDS of the Ministry of Health (2022, p. 12), between 1980 and 2022, 1,088,536 cases of AIDS were reported in Brazil, with 371,744 deaths caused by the disease. In 2021, 11,238 deaths from AIDS were recorded (ICD 10: B20 to B24). Access to antiretroviral treatment contributed to a 26.4% reduction in mortality between 2014 and 2021. According to the survey, between 2007 and 2022, 437,803 cases of HIV were reported in Brazil, including 40,880 new diagnoses in 2021. Currently, approximately 960,000 people live with HIV in the country, of which about 727,000 are on treatment. Lack of treatment or low adherence to antiretrovirals represent significant challenges for controlling the epidemic, which will only be possible with proper diagnosis and treatment of all those infected.

The main objective of ART is to suppress the HIV viral load, promoting the reconstitution of the immune system and improving the patient's survival and quality of life. Treatment transformed HIV from a lethal condition to a chronic health condition, requiring prolonged and continuous use of the medication. The patient's knowledge and interpretation of HIV, their motivation, resilience, expectations, as well as protagonism in self-care are fundamental for the development of cognitive, emotional, and behavioral strategies, which can facilitate or hinder treatment adherence (CABRAL et al., 2021).

Mendes (2012, p. 35) understands self-care and protagonism in health as complex and subjective phenomena, which demand careful evaluation by health teams about the context, attitudes, beliefs, trust in professionals, motivations, importance attributed to the condition of the treatment, in addition to the patient's social support. Thus, the capacity for self-care and protagonism can vary between insufficient and sufficient. Patients with insufficient self-care capacity often have unrealistic thoughts and expectations about rapid healing, which can lead to frustration and hopelessness. These factors increase vulnerability and can lead to abandonment of self-care, especially in individuals with difficulty understanding the treatment, in denial, socially isolated, with low self-efficacy, distorted beliefs about themselves or affected by psychological and psychiatric disorders.

The Ministry of Health (2014, p. 117) emphasizes that strengthening self-care and protagonism in health depends on the recognition of the uniqueness of each patient. Even with similar diagnoses, needs and priorities vary, requiring the construction of a Singular Therapeutic Project (PTS) with realistic and personalized goals. Thus, self-care should be seen as a health-relevant construction. To this end, person-centered clinical approaches are suggested, as well as interventions (individual or group), based on Cognitive-Behavioral

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methods, which make it possible to understand and act on the patient's demands. The production of health care is a patient-centered process, constituted in the relationship between the patient and the health professionals. These meetings aim to promote patient autonomy and the sharing of decision-making. It is up to the professionals to exercise welcoming, accountability and offer resolution in the face of health support demands.

Adherence to treatment is essential for symptom control, improvement of clinical outcomes, increased quality of life, and prevention of complications and mortality. However, this knowledge does not always guarantee that patients correctly follow medical prescriptions. In cases of chronic diseases that require continuous treatment and multidisciplinary follow-up, non-adherence can be seen as dysfunctional behavior. Although common sense suggests that a person would take a medication that improves their well-being, this does not always occur. Silva and Santana (2025) show that it is not the fact that the patient is aware of his diagnosis and the benefits of antiretrovirals that guarantee adherence to treatment, they warn about the patient's experience when he falls ill. In this sense, it is seen that cognitive distortions, emotional dysregulation and the doctor-patient relationship are factors that contribute to low adherence to treatment. The authors emphasize the importance of investigating psychopathologies that can exert a relevant influence on this dynamic, aggravating adherence to HIV treatment.

CBT stands out for its effectiveness in increasing adherence to treatment and reducing behaviors related to relapse and non-adherence (WRIGHT et al., 2010, p. 220). The authors highlight that adherence is a dynamic factor that can vary throughout the treatment. Instead of labeling the patient as non-adherent, he proposes to classify it into three levels: total, when there is complete refusal of treatment; partial, when the patient accepts only part of the interventions; and never, when there is occasional omission of doses or periods without medication. According to Silva and Santana (2025), non-adherence is related to the avoidance behavior that the patient may present in order not to experience the discomfort resulting from living with HIV, as it is a diagnosis with a high stress load and associated stereotypes that can make the patient's mental health vulnerable.

The patient's inconsistency in their treatment can be due to multiple reasons, often associated with different defense mechanisms. Among the most common factors are: denial, as part of the process of adjusting to the diagnosis and the prospect of death or loss of health, which can generate feelings such as anger and sadness; rejection, which manifests itself as an extension of denial, being interpreted as an emotional response; negative personal

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experiences related to the treatment, whether lived by the patient himself or by people close to him, and forgetfulness combined with disorganization, making adherence to the medication regimen difficult (WRIGHT et al., 2010, p. 220).

In the psychotherapeutic dimension, authors highlight the presence of cognitive distortions, as well as beliefs of helplessness, hopelessness and worthlessness. In the theoretical conception of CBT, this way of thinking can compromise adherence to treatment, interfering with conducts such as the correct use of medication, protagonism in self-care, and the maintenance of bonds with health professionals (JUDITH BECK, 2022, WRIGHT et al., 2010, SILVA, SANTANA, 2025).

The belief of helplessness is related to the perception of lack of control, which contributes to resistance to treatment. From this perspective, the patient perceives medication as an instrument of external control, leading to cognitive distortions about being controlled by professionals or institutions, cultivating the erroneous thought that they do not exercise control over what is happening to their life, losing confidence in their ability and feeling out of control. This perception can generate feelings of fear and anxiety, weaken self-confidence, and lead to treatment refusal. Patients who associate treatment with loss of control tend to have low adherence, unless they are able to make their beliefs and attitudes more flexible (WRIGHT et al., 2010, p. 220).

During the process of accepting the treatment, when they become aware of the need to live with a chronic health condition, the patient may feel despair and elaborate thoughts of hopelessness about the future. These factors, together with obstacles such as side effects, prolonged fatigue and stigmatization, can compromise treatment adherence. Such difficulties can lead to reduced therapeutic effort or even giving up. Health problems often negatively impact self-esteem, leading the patient to develop devaluing self-affirmations. This pattern of thinking can result in the perception of the uselessness of the treatment, compromising its adherence (WRIGHT et al., 2010, p. 221, SILVA, SANTANA, 2025). Based on these premises, the next step will be to present the psychotherapeutic model in the light of CBT and its contributions to the clinical treatment of PLHIV in mental health.

4 COGNITIVE-BEHAVIORAL THERAPY (CBT) AND COGNITIVE DISTORTIONS

Aaron Beck, an American psychiatrist and psychoanalyst, in the 1950s, sought to scientifically validate psychoanalytic concepts in order to obtain recognition from the American School of Psychotherapy and the scientific community. In the 1960s, when

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investigating the psychoanalytic hypothesis that depression stems from hostility towards oneself, he analyzed the dreams of depressed patients and found that, instead of hostility, themes of failure, loss, and deprivation predominated — contents similar to the conscious thoughts of these patients (JUDITH BECK, 2022, p. 20).

Beck's findings led to questioning the psychoanalytic idea that depression is linked to a need to suffer. Faced with the possibility that psychoanalytic concepts would be questioned, he observed that his patients had two types of thinking: free association and negative automatic thoughts about themselves, directly related to emotions. Based on this, he developed a therapeutic approach aimed at identifying and modifying these dysfunctional thoughts, which resulted in significant clinical improvement in patients (JUDITH BECK, 2022, p. 21).

Beck went on to teach the therapeutic approach to his psychiatry residents at the *University of Pennsylvania*, who also observed improved patient responses. This motivated scientific research to prove the effectiveness of the method, which would later be called Cognitive Therapy (CT). In 1977, studies demonstrated that CT was as effective as antidepressants, a result considered innovative because it represents one of the first direct comparisons between psychotherapy and medication (JUDITH BECK, 2022, p. 25).

In the late 1970s, Beck developed CT, now synonymous with Cognitive-Behavioral Therapy (CBT). Since then, he and other researchers have demonstrated the effectiveness of CBT in treating a variety of psychiatric disorders and psychological problems. The first treatment manual with this approach, published by Beck and collaborators in 1979, represented a milestone in the area of mental health (JUDITH BECK, 2022, p. 25).

In the same period, Beck and his colleagues began scientific studies on the application of CBT in various psychiatric disorders, such as anxiety, substance use, personality disorders, and bipolar affective disorder. The process involved clinical observations, identification of maintenance factors and cognitions associated with the disorder, followed by empirical tests and treatment adaptations through randomized controlled clinical trials. This method gave rise to the current psychotherapies based on scientific evidence (JUDITH BECK, 2022, p. 26).

CBT has been widely adapted to different levels of education, income, cultures, and age groups, and is applied in a variety of contexts, such as clinics, hospitals, schools, and organizations. It can be used in individual, group, couples, and family sessions. Treatment is based on a cognitive formulation that considers the patient's life experiences, maladaptive

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beliefs, behavioral strategies, and factors that maintain psychological distress (JUDITH BECK, 2022, p. 26).

The Cognitive Model proposes that dysfunctional automatic thoughts directly affect mood and behavior, being common in different forms of psychological distress. By learning to evaluate these thoughts in a more realistic and adaptive way, the patient tends to improve their relationship with their emotions and behaviors (JUDITH BECK, 2022, p. 51).

CBT helps the patient validate their thoughts, identifying possible cognitive distortions and allowing a new perspective on their experiences. This favors a better relationship with more functional feelings and behaviors, facilitating the achievement of healthier life goals. For a lasting improvement in mood and behavior, it is essential to work on the different levels of cognitions in the treatment (JUDITH BECK, 2022, p. 52).

Automatic thoughts are superficial, fast, spontaneous cognitions that do not result from conscious reasoning. The Cognitive Model proposes that emotions, behaviors, and physiological reactions are influenced by the interpretation of events. Thus, the way the patient feels and acts is related to the way he interprets a certain situation, although he often does not perceive these thoughts, being more attentive to the reactions that follow (JUDITH BECK, 2022, p. 52).

Even when aware of automatic thoughts, the patient tends to accept them without question, considering them to be true. By their automatic nature, these thoughts do not undergo critical evaluation. CBT seeks to promote the identification and evaluation of these thoughts, also observing changes in affect, behavior, and physiology. When realizing that their interpretations are wrong, the patient often reports improved mood, more functional behaviors, and reduced uncomfortable physiological reactions. These thoughts are linked to underlying beliefs and can be classified according to specific cognitive distortions (JUDITH BECK, 2022, p. 52).

According to Judith Beck (2022, p. 53), from childhood, people develop beliefs about themselves, others, and the world. Core beliefs, or core beliefs, are deep and lasting understandings, seen as absolute truths. Adjusted individuals tend to hold realistic and positive beliefs, but they all have latent negative beliefs that can be activated in the face of stressful situations or vulnerabilities.

Adaptive Core Beliefs are flexible and realistic ideas about oneself, which reflect efficiency, agreeableness, and personal values. They involve a balanced view of the world, recognizing both predictability and uncertainties, and an accurate perception of people,

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recognizing their qualities and possible risks. As for the future, they include a belief in the possibility of positive experiences and the ability to face adversity if necessary. These beliefs express efficiency, kindness, and personal and interpersonal appreciation (JUDITH BECK, 2022, p. 53).

Dysfunctional Core Beliefs are extreme, negative, and unrealistic ideas, often associated with feelings of helplessness, unlove, and worthlessness. Individuals may exhibit one or more of these belief categories. Between automatic thoughts and core beliefs are Intermediate Beliefs, which involve attitudes, rules, and assumptions, influencing the way deeper beliefs manifest themselves (JUDITH BECK, 2022, p. 53).

CBT seeks to act on dysfunctional automatic thoughts and nuclear and intermediate beliefs, since there is evidence that these cognitive patterns can be modified. The treatment aims to promote the development of more realistic and functional beliefs, as well as strengthen healthy coping strategies. In this way, the patient tends to interpret their experiences in a more constructive and adaptive way (JUDITH BECK, 2022, p. 53).

Since its initial publication in 1977, CBT has been extensively researched and applied clinically, with studies proving its effectiveness in treating a variety of psychiatric disorders, psychological problems, and medical conditions with emotional components. CBT has also been shown to be effective in preventing and reducing the severity of future episodes. The theories developed by Beck continue to be studied, adapted, and used in different clinical contexts, consolidating CBT as the most practiced psychotherapeutic approach in the world and widely taught in graduate programs, especially in the United States (JUDITH BECK, 2022, p. 54).

In recent years, there has been a movement in search of innovations in the health area, including mental health, with an emphasis on approaches aimed at the recovery of patients with chronic conditions — a perspective that underlies the proposal of this study. In this context, recovery-oriented CBT stands out, a branch of traditional CBT that prioritizes cognitive formulation centered on adaptive beliefs, behavioral strategies, personal qualities, skills, and resources of the patient, instead of focusing exclusively on symptoms and psychopathology (JUDITH BECK, 2022, p. 55).

According to Leahy (2019), cognitive distortions are often at the origin of various psychological problems, intensifying the patient's vulnerability by interpreting life experiences in a negative way, which contributes to behavioral dysfunctions and suffering. Poletto et al. (2015) analyze the most common cognitive distortions and core beliefs related to HIV and

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AIDS, highlighting that the diagnosis makes the patient more vulnerable to feelings such as denial, anger, guilt, rejection, and self-punishment. Psychological intervention, in this context, can favor the construction of coping strategies and the reformulation of perceptions about the new health condition. However, behaviors that compromise physical and emotional integrity may emerge, affecting personal values and beliefs. The authors emphasize that HIV diagnosis carries a derogatory stigma, sustained by moral judgments imposed by society.

The authors highlight the prevalence of cognitive distortions in PLHIV, such as: catastrophizing, labeling, selective abstraction, personalization, blame, mind reading, and guesswork. In addition, they point to beliefs linked to impurity, inadequacy, worthlessness and lack of love as cognitive vulnerabilities that intensify uncomfortable emotions and favor risky behaviors, contributing to the postponement of appropriate treatment.

The findings of Poletto et al. (2015) are reinforced by the study by Silva and Santana (2025), who identified cognitive distortions and other factors associated with low adherence to ART. Among the main distortions observed are: use of "should", catastrophizing, prediction of the future, tendency to blame, labeling, thoughts such as "what if...?" and hasty conclusions. In addition, factors such as sadness, lack of motivation, and insufficient doctor-patient relationship were related to low adherence to treatment.

Silva and Santana (2025) propose a Cognitive Model to understand low adherence to HIV treatment, based on the assumptions of CBT. According to the authors, upon receiving the diagnosis and in the face of the demand for continuous treatment, the patient may intensify their cognitive distortions from the negative interpretation of the experience of illness, which influences mood and generates emotions such as sadness, demotivation and anxiety. In addition, physiological changes may also be related to these emotional states, and not only to the effects of antiretrovirals. In this context, the patient resorts to avoidance behaviors, avoiding situations that cause physical and psychological discomfort, which results in low adherence to treatment and non-compliance with the health team's guidelines.

In view of the diversity of approaches consolidated in psychology over time, different theoretical and practical perspectives have been considered by researchers as viable strategies to promote mental health care in the context of public services. In this scenario, CBT stands out as a recommended approach.

5 RESULTS AND DISCUSSIONS

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Therapeutic interventions will be presented aiming to favor cognitive restructuring, emotional regulation and strengthening of motivation for behavior change, with the support of motivational interviewing in health. It is hoped that such practices will contribute to a resignification of the experience of illness, favoring the patient's health role and adherence to antiretroviral treatment.

5.1 COGNITIVE RESTRUCTURING

CBT offers a set of procedures and techniques aimed at managing cognitive distortions, with emphasis on cognitive restructuring. This process aims to teach the patient how to identify, examine, and modify dysfunctional thoughts. By appropriating these distortions, it is believed that the patient can develop a more conscious, rational and functional relationship with the experience of living with HIV. Thus, CBT can favor adherence to ART and other health care procedures.

Among the clinical procedures of CBT aimed at cognitive restructuring, techniques such as: recording the situation, thought, emotion and behavior; distinguishing between thought, feeling and facts; categorization of cognitive distortions; verification of thoughts; examination of evidence; analysis of the advantages and disadvantages of thoughts or behaviors; exercise of the defense lawyer; differentiation between behavior and person; use of behavior to reformulate dysfunctional thoughts; and therapeutic dramatizations (LEAHY, 2019). In clinical procedures aimed at cognitive restructuring, complementary therapeutic strategies such as emotional regulation are selected. It is believed that, in psychological practice, the combination of these techniques can benefit patients, promoting more effective mental health care in PLHIV.

5.2 EMOTIONAL REGULATION

Just like automatic thoughts, we all experience different emotions, pleasant or uncomfortable, such as anxiety, fear, anger, disgust and sadness. However, uncomfortable emotions should not be seen as a problem in themselves, but as experiences that require strategies to be recognized, accepted, and faced. Sometimes, the patient feels overwhelmed, fears his emotions and adopts self-destructive behaviors, such as avoidance, flight or paralysis. Such reactions compromise effective and resolute attitudes. Leahy, Tirch and Napolitano (2013) highlight that emotions are essential to give meaning to life, guide changes and connect to needs and others.

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In this context, it is essential to understand that patients living with HIV, faced with stressful situations and the need to adhere to continuous treatment, may manifest disproportionate emotional responses, characterizing a picture of emotional dysregulation. This emotional intensification can generate suffering, stress, and dysfunctional behaviors, such as resistance to treatment adherence. Leahy, Tirch, and Napolitano (2013) define emotional dysregulation as the difficulty in processing and dealing with emotions, categorizing it into two types: excessive intensification—when the emotion is felt as oppressive, intrusive, and disproportionate—and emotional deactivation—which involves dissociative reactions, such as numbness, depersonalization, or splitting. The authors highlight emotional regulation as an essential skill to face emotions adaptively, favoring more assertive attitudes aligned with the patient's personal goals.

Emotions play a fundamental role in human life, influencing decisions, driving change, and strengthening interpersonal relationships. Emotion regulation techniques aim to develop skills to recognize, name, and use emotions in a functional way, assisting in decision-making and in defining values and goals. Such strategies promote the understanding of the emotional nature, the restructuring of dysfunctional interpretations, and the learning of adaptive forms of emotional management (LEAHY; TIRCH; NAPOLITANO, 2013).

Next, therapeutic techniques aimed at emotional regulation are presented, with the objective of contributing to the mental health care of PLHIV: access to emotions through emotional diary and identification of avoided emotions, free expression and acceptance of emotions, in addition to psychoeducation aimed at recognizing emotional schemas and beliefs, using the Leahy-II Emotional Schema Scale (LEAHY; TIRCH; NAPOLITANO, 2013; LEAHY, 2019).

Continuing the clinical procedures aimed at the emotional regulation of PLHIV, mindfulness-based meditation techniques, often used in CBT, stand out. These practices have been shown to be effective in the psychotherapeutic context, helping patients to deal with their emotions in a more conscious and functional way.

The practice of mindfulness contributes to increased awareness, attention, and acceptance of internal experiences, favoring a new relationship between the patient and their emotions. By promoting non-judgment and acceptance, it reduces the guilt associated with uncomfortable emotions, encouraging their full experience instead of avoiding or controlling them. In this sense, *mindfulness* training is indicated as a therapeutic strategy to develop attention to the present moment and improve emotional regulation. Among the techniques

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used, the following stand out: progressive muscle relaxation, full attention to diaphragmatic breathing, space expansion (conscious acceptance of emotions), three-minute breathing, and *mindfulness* in daily activities (LEAHY; TIRCH; NAPOLITANO, 2013; LEAHY, 2019). In the context of mental health treatment for PLHIV, CBT can be enriched by the theoretical and practical framework of Motivational Interviewing, which will be presented below.

5.3 MOTIVATIONAL INTERVIEWING (MS)

With scientific advances, there have been significant changes in the health scenario, including the cure of some diseases, the development of new treatments and strategies for infection control, which has increased the life expectancy of patients. However, despite this progress, there is a trend of neglect regarding healthy behaviors and lifestyles. Thus, behavior change becomes an essential element in health treatment, encompassing attitudes that people can adopt to promote their own well-being. Therefore, it is difficult to conceive an effective treatment without the patient's behavioral change being considered fundamental for prevention, treatment and health maintenance (ROLLNICK; MILLER; BUTLER, 2009).

Motivational Interviewing (MI), developed in 1983 as a clinical counseling modality, is an effective approach to promote changes in health-related behaviors. It is an approach focused on motivating patients to start, maintain and complete treatment, in addition to encouraging participation in follow-up consultations and the reduction of behaviors that are harmful to health (ROLLNICK; MILLER; BUTLER, 2009).

MS arose from the perception that patient motivation often constitutes an obstacle to change, and is successfully applied in various contexts, including HIV treatment and prevention (ROLLNICK; MILLER; BUTLER, 2009). According to Silva and Santana (2025), patient demotivation and the lack of an empathetic and motivational doctor-patient relationship are relevant factors that hinder adherence to ART, representing a concern for health professionals and services.

MS is a model that seeks to understand patients' motivations to promote behavioral changes in favor of their health. Based on a collaborative, evocative approach centered on respect for the patient's autonomy. MS is guided by four principles: resisting the reflex to fix things, understanding the patient's motivations, listening attentively, and strengthening the patient (ROLLNICK; MILLER; BUTLER, 2009).

MS highlights three fundamental communication styles in the relationship with the patient: directing, guiding and accompanying. In addition, it emphasizes communicative skills

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such as asking, informing and listening, which, when combined, enhance the effectiveness of directing, guiding and monitoring treatment (ROLLNICK; MILLER; BUTLER, 2009).

Finally, the authors highlight that the three skills — listening, asking and informing — are employed in all MS communication styles: accompanying, guiding and directing. However, in the directive style, information predominates; in accompaniment, listening; and in orientation, there is a balance between the three skills. On the other hand, the patient may be ambivalent about the change, as he may be comfortable with his lifestyle, even if it is harmful to his health, perceiving disadvantages in changing it (ROLLNICK; MILLER; BUTLER, 2009).

Changing attitudes in search of healthy behavior can be uncomfortable or even painful for the patient, especially in HIV treatment, which involves having to deal with a diagnosis with a high stress load, enduring side effects of antiretrovirals, administering daily medications, attending appointments and performing tests to monitor viral load, among others. The patient can anticipate these challenges and compromises required by the change. Although the diagnosis of HIV is an event capable of motivating significant changes in favor of quality of life, in the process of attributing meanings, the patient may develop thoughts and behaviors contrary to change.

According to Rollnick, Miller and Butler (2009), the patient's motivations for change can be conflicting, simultaneously manifesting the desire and resistance to change. Ambivalence is an expected and common aspect in treatment, characterized by oscillating between reasons for changing and not changing, which can lead to paralysis. Thus, during the therapeutic process, the patient may experience situations that both approximate and remove the possibility of behavioral change. This understanding is corroborated by Silva and Santana (2025), who identified that PLHIV with low adherence to ART tend to adopt avoidance and paralysis behaviors in the face of the possibility of change, due to the physical and psychological discomfort associated with the disease.

Rollnick, Miller, and Butler (2009) highlight that the first step in supporting patient change is their ability to recognize and discuss the need for this change. For this, six themes are fundamental in the conversation: desire, capacity, reasons, need, commitment and initial steps. The patient initially expresses what they want to do (desire), why they would change (reasons), how they would do it (ability), and the importance of change (need). When these aspects are evoked, the patient approaches change. In the pre-engagement phase, it's crucial to explore your arguments, values, and hopes. The impairment gradually grows,

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making the patient more likely to take the first steps, which are essential for lasting behavioral change.

6 FINAL CONSIDERATIONS

By way of consideration, CBT has been shown to be an effective approach in the psychological management of PLHIV that has poor adherence to ART. One of the relevant contributions concerns when it informs about cognitive restructuring, which aims to identify and modify dysfunctional thoughts related to stigma and negative beliefs about the treatment and the disease process. These thoughts can affect motivation to follow ART consistently. In addition, emotional regulation is an essential strategy in the therapeutic process, as many patients face anxiety, guilt, and depression, which can interfere with the ability to make healthy decisions and maintain self-care habits. CBT offers techniques to clinical practices, such as monitoring automatic thoughts, problem solving, and training in coping skills, which promote autonomy and self-confidence in the patient in the face of treatment adherence.

Another relevance seen from CBT in the health field is the clinical procedure of motivational interviewing as a valuable resource to deal with the ambivalence common in people with low adherence to ART. This technique focuses on exploring the empathetic nature of internal motivation, strengthening the patient's personal commitment to treatment through clear goals and reinforcing self-efficacy. By integrating motivational interviewing with CBT, the psychologist can facilitate a collaborative, non-confrontational environment, in which the patient feels welcomed to reflect on their resistances and find personal reasons to adhere to ART. This combination of approaches enhances the therapeutic effects, promoting changes in behavior and a significant improvement in the quality of life of PLHIV, corroborating the care of this population in public health services.

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