

# THE ROLE OF SOCIAL WORK IN MEDICATION TREATMENT ADHERENCE: HIV/AIDS AS A CASE STUDY

## Participant Manual



NASW HIV/AIDS  
SPECTRUM PROJECT

***NASW HIV/AIDS Spectrum: Mental Health Training &  
Education of Social Workers Project***



# **The Role of Social Work in Medication Treatment Adherence: HIV/AIDS as a Case Study**

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National Association of Social Workers (2009)

## OBJECTIVES

- Define adherence and understand the importance and challenges of medication and treatment adherence
- Review key concepts to ensure culturally competent practice
- Understand the unique role of social work in promoting adherence
- Learn how to apply **ADHERE**, a model for application of adherence strategies

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## ADHERENCE

- The quality or state of adhering; fidelity, steady attachment. To follow a prescribed course of action.
- The extent to which a person's behavior (e. g., taking medications, following diets, or executing lifestyle changes) coincides with medical or health advice.
- A steady devotion to recommended treatment in order to reach a therapeutic aim
- Adhere – to stick to, to follow a prescribed course of action; fidelity

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## WHY IS ADHERENCE SO IMPORTANT FOR PERSONS LIVING WITH HIV/AIDS?

- Reduces morbidity and mortality by suppressing viral replication to as low as possible for as long as possible
- Improves immune system functioning and increases CD4 levels
- Reduces the emergence of resistance and cross-resistance to medications
- Improves the quality of life for clients living with HIV/AIDS and other chronic illness

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# UNDERSTANDING HIV/AIDS PROMOTES ADHERENCE

*Viral load is the best predictor of disease progression. The goal is to maintain undetectable level of viral load.*

- The virus mutates rapidly and may become resistant to the drugs
- High level of adherence needed (95-99%) to achieve maximum viral load suppression, but this may vary by regimen
- Ensure use of U.S. Public Health Service treatment guidelines in prescribing Highly Active Antiviral Therapies (HAART)
- Work with health provider to monitor status and change regimen if needed.

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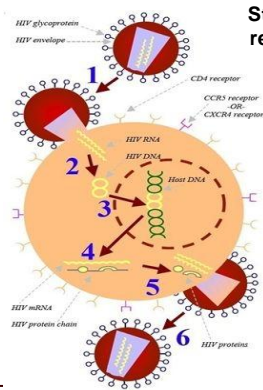
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Stages of HIV reproduction

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Antiretroviral drug class	Approved to treat HIV	How they attack HIV
Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)	1987	NRTIs interfere with the action of an HIV protein called reverse transcriptase -- which the virus needs to make new copies of itself.
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)	1997	Stops HIV from replicating within cells by inhibiting the reverse transcriptase protein.
Protease Inhibitors (PIs)	1995	PIs inhibit protease, which is another protein used in the HIV replication process.
Fusion or Entry Inhibitors	2003	Fusion or entry inhibitors prevent HIV from binding to or entering human immune cells.
Integrase Inhibitors	2007	Integrase inhibitors interfere with the integrase enzyme, which HIV needs to insert its genetic material into human cells.

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## Some common HIV medication side effects

- Fatigue
- Anemia
- Gastro-intestinal & Digestive Problems
- Diarrhea, Gas and Bloating
- Lipodystrophy (re-distribution of body fat)
- Skin Rashes
- Neuropathy (painful nerve damage)
- Loss in Bone Density

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## ADHERE MODEL™

<b>A</b>	<b>ASSESS</b>
<b>D</b>	<b>DIALOG</b>
<b>H</b>	<b>HOLISTIC</b>
<b>E</b>	<b>EMPOWER</b>
<b>R</b>	<b>REINFORCE</b>
<b>E</b>	<b>EVALUATE</b>

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## ADHERE MODEL

### ASSESS

- Based on a bio-psychosocial-spiritual assessment, including culturally based beliefs, assess client knowledge and readiness for medication adherence
- Assess current perceptions of health status, efficacy of treatment and perceived ability to adhere to a treatment plan at this time
- Use the stages of change to help client understand his/her readiness and to understand that change is a process

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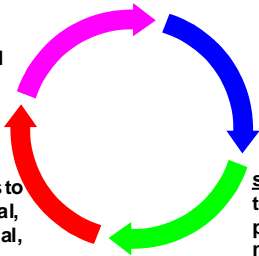
## BIO/PSYCHO/SOCIAL/SPIRITUAL

**bio** (biology) refers to the physical and medical aspects of ourselves

**psycho** (psychology) refers to the emotional aspects of our lives

**social** refers to socio-cultural, socio-political, and socio-economic issues

**spiritual** refers to the way people find meaning in their lives



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## CULTURAL COMPETENCE

Refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.

Cite: NASW Standards for Cultural Competence, 2001

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## WORKING WITH DIVERSE POPULATIONS: EXAMPLES OF CULTURALLY COMPETENT PRACTICE

Discuss with the client:

- What are their primary cultural beliefs and values?
  
- How do they view or conceptualize disease?
  - What are the cultural beliefs about the cause and treatment of disease
  
- Is there a historical context of culture and healthcare (that may lead to mistrust)?

Reference: Ka'opua, Lana and Ross, Mary and 2004 RAND Corp. and Oregon State University survey.

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## Assessing Knowledge & Readiness

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| <p><b>Knowledge—What do client &amp; significant others need to know about:</b></p> <ul style="list-style-type: none"> <li>■ Client's condition?</li> <li>■ Treatment options? Benefits &amp; challenges?</li> <li>■ Are there cultural beliefs that may influence decisions?</li> <li>■ What additional information does the client need to make a decision about treatment?</li> </ul> | <p><b>Readiness—What factors may impact adherence:</b></p> <ul style="list-style-type: none"> <li>■ Socioeconomic?</li> <li>■ Lifestyle changes?</li> <li>■ Co-morbid conditions?</li> <li>■ Beliefs and perceptions about HIV/AIDS?</li> <li>■ Views on health and wellness?</li> <li>■ Is client system prepared to align with treatment against disease condition?</li> </ul> |
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Cite: Giddens and Karopka

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## ADHERE MODEL

### Dialog

- Dialog with your client(s) about their health belief and options.
- Listen and normalize reasons for non-adherence.
- Discuss possible consequences of non-adherence.
- Review side effects and self-care strategies.

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## DIALOG WITH CLIENTS ABOUT THE BENEFITS & CHALLENGES OF ADHERENCE

### Benefits

- Improved health and energy
- Minimize episodes of health problems and side effects
- Clinical results (CD4 ↑, viral load ↓)
- Reduce occurrence of opportunistic infections
- Achieve other personal goals

### Challenges

- Medication side effects
- Pill burden
- Challenge to daily routine
- Disclosure issues
- Cost of medications
- Maintaining consistent health coverage

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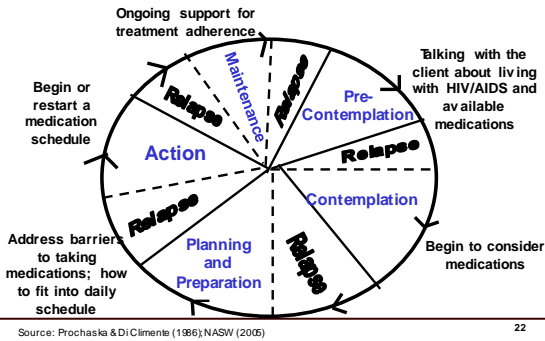
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## STAGES OF CHANGE BEHAVIOR



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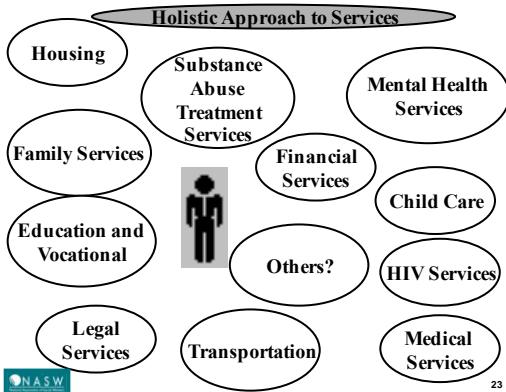
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### Holistic Approach to Services



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## ADHERE MODEL

### Empower

- Empower all clients to implement action plan
  - Remember, it's the client's plan.
- Work with clients to identify cues, reminders and current activities (e.g. television or radio programs or current daily self-care regimens) that will increase adherence success.
- Strengths-based focus
  - Normalize that everyone makes mistakes
  - Encourage them to ask for more help when needed
  - Develop an action plan for the unexpected and special events, like weekends and vacations

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## ADHERE MODEL

### Reinforce

- Reinforce strategies, reassess successful options, and revise as needed
- Reinforce the message that the ADHERE model is client-centered: the client determines strategies that work best for them
- Re-educate as needed
- Help identify medication side effects that may create adherence challenges
- Review and reinforce wellness plans

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## ADHERE MODEL

### Evaluate

- Review the treatment and adherence plan with your client
- Ask directly, "How is this plan working for you?"  
"What do you feel are the biggest benefits and challenges to your plan?"
- Evaluate your role in the client's adherence plan. Revisit the adherence checklist
- Are you involving all members of the client's treatment "team" (e.g., doctors, nurses, nutritionist, etc.)
- Are you seeking supervision? Staying current in HIV medications and related treatments?

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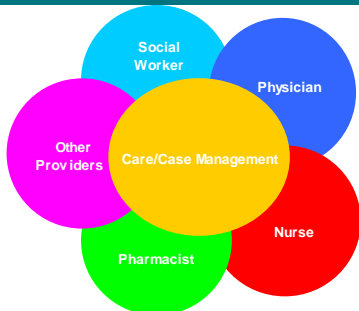
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## "THE ROLE OF SOCIAL WORK IN HEALTHCARE PROVISION"



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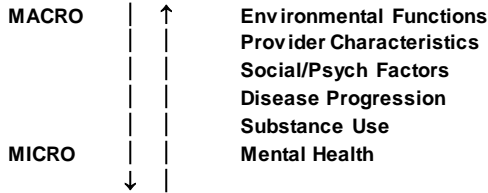
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## Adherence & the Micro/Macro Continuum



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## CHALLENGES TO MEDICATION ADHERENCE

Disease Factors	Treatment Regime	Individual and Family Context
<ul style="list-style-type: none"> <li>•Chronicity of illness</li> <li>•Presence of symptoms</li> <li>•Changes in symptoms</li> </ul>	<ul style="list-style-type: none"> <li>•Frequency of dosing</li> <li>•Convenience/inconvenience</li> <li>•Complexity/difficulty</li> <li>•Number of medications prescribed</li> <li>•Side effects</li> <li>•Perceived efficacy of drugs</li> <li>•Degree of behavior change required</li> </ul>	<ul style="list-style-type: none"> <li>•Client cultural and health beliefs</li> <li>•Client/provider relationship</li> <li>•Mental health or substance abuse history</li> <li>•Life stressors</li> </ul>

Cite: Linsk and Bonk, 2000

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## DETERMINANTS OF SUCCESSFUL ADHERENCE

Access/Resources	Social Support	Adherence Techniques
<ul style="list-style-type: none"> <li>•Consistent access to medication &amp; other treatment services</li> <li>•Access to support services</li> <li>•Access to mental health &amp; substance abuse treatment</li> <li>•Stable Economic resources including housing</li> </ul>	<ul style="list-style-type: none"> <li>•Personal support</li> <li>•Support for caregivers</li> <li>•Relationship with health provider</li> <li>•Social care: Case management, psychotherapy</li> <li>•Support groups</li> <li>•Clients cultural and health beliefs and practices</li> </ul>	<ul style="list-style-type: none"> <li>•Provider/capability building</li> <li>•Engaging client</li> <li>•Maintaining the relationship</li> <li>•Ensuring client understands implications of adherence</li> <li>•Empowering client role in selecting therapies</li> <li>•Use of ADHERE Model</li> </ul>

Cite: Linsk and Bonk, 2000

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## HIV & Mental Health

- Many clients with HIV/AIDS experience mental health concerns that affect their day-to-day functioning and as a result, their ability to adhere to medications
- Other clients may be diagnosed with mental health problems that emerge as a result of stressors of a HIV diagnosis or other life events
- A holistic assessment promotes early detection of mental disorders and referral of clients to appropriate treatment services.
- With proper treatment, persons with mental health diagnosis can achieve successful medication adherence for both conditions

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## Substance Use and Medication Adherence

- Active substance use may complicate a client's ability to adhere to a HIV treatment plan
- Assess where the client is in terms of ability to engage in treatment for HIV and the substance use
- Consider the potential for relapse and the impact on adherence to HIV treatment plan
- Client capacity to remain sober provides an opportunity to build on current coping mechanisms, support systems and routines

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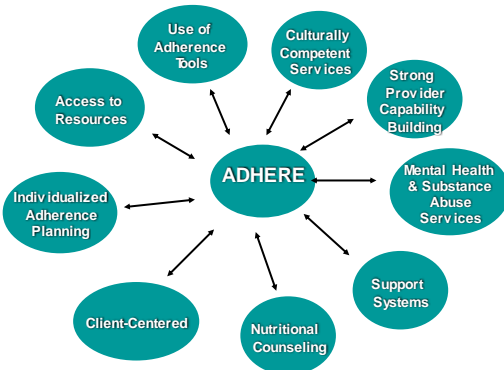
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AIDS Action 2001

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Case Study

Worksheets

ADHERE Model

## Danielle

### Part One

Danielle is 29-year-old African-American woman who lives in a densely populated, low to moderate-income community. Her husband, Jack (a 35 year old Latino man) welcomes you at the door--- leaving you to talk in private with Danielle while he cares for their infant son. Danielle is friendly, and she is very knowledgeable about HIV.

In addition to being prescribed two types of anti-HIV medications, Danielle takes two types of antibiotics to treat infection, and pain medication when needed, the latter to be taken as needed. According to Danielle, she is able to therapeutically adhere her medication schedule, and states that her physician is considering changing her anti-HIV regime to one that is she is told is more effective and also more complex . She is in regular contact with medical services, and sees you (her mental health provider) on a (minimum) of bi-weekly basis. Danielle learned of her HIV status when she was denied a life insurance policy. While she describes herself as occasionally depressed and anxious, she attributes this to “feeling useless” now that she can no longer work full time. Danielle would like to return to work or enroll in the nearby community college.

Both Danielle and Jack take great pride in their respective cultural traditions, and talk of using traditional therapies to help with their physical and mental well being.

Danielle reports that her husband, is “very supportive” of both she and their infant son. Jack is HIV negative, and is currently active in a substance abuse recovery program, and works full-time as a security guard. Danielle states both are looking forward to the return of her six year old son who was removed from the family home about 3 months ago while jack was in a substance abuse treatment program and Danielle in medical crisis. This son is scheduled to return to his parents since their successful completion of drug treatment, parenting, and anger management classes. Both children are HIV negative.

The family gives and receives emotional and tangible support with Danielle’s parents who live in a nearby neighborhood.

## Danielle

### Part two

Danielle is in final preparations for their son's return to the home. The couple is discouraged by quality of life issues---specifically, the impact that the illness (i.e., medication side effects) is having on the children. Danielle talks about the affect of the current medications on her everyday life: "During on of his recent visits, my older son watched me throw up in the sink... and break out with hives...so sick I couldn't celebrate his birthday" She shares that she is sure they are frightened that Mommy was going to die. And that she would like to take a holiday from being sick all the time.

Thus far, Danielle has worked to develop a schedule for taking all her medications, including use of a pillbox and written and environmental reminders. Today she shares that she has decided to proceed with a new, more complex anti-HIV medication regime. Danielle also says she has been offered and is considering a part-time job in the school that her older son attends

### Part three

It has been over a month since your last session with Danielle, due to her adapting to a new schedule with work and family. She tells you she is adapting to the new, more complex regime. Her viral load is decreasing, thus suggesting that the HIV is successfully being suppressed. While she is openly thankful to her husband, her family, and her faith in "staying focused", Danielle reports that perfect adherence is not easy and that her HIV illness has its "ups and downs".

During your re-assessment of Danielle, she discloses she was taken to the emergency room by her husband with chest pains and difficulty breathing. She was subsequently diagnosed with an anxiety disorder, and upon seeing the clinic's psychiatrist, was given medications. She has not yet filled the prescription.

## ADHERE MODEL

**A ASSESS** client knowledge and readiness

**D DIALOG** about health beliefs

**H HOLISTIC** approach including environment and culture

**E EMPOWER** client to implement action plan

**R REINFORCE** strategies and revise as needed

**E EVALUATE** progress and resources

<p><b>Assess client knowledge and readiness</b></p>	<ul style="list-style-type: none"> <li>➤ Assess client understanding of drug therapy. Explain that discussions of adherence are an ongoing part of initiating drug therapy.</li> <li>➤ Explore knowledge and issues through open-ended, non-confrontational questions. Ask, for example: <ul style="list-style-type: none"> <li>❑ What have you <i>heard</i> about HIV treatments?</li> <li>❑ How do you <i>feel</i> about your treatment options and decisions?</li> <li>❑ What do you think might be <i>obstacles</i> to successful taking your medication?</li> </ul> </li> <li>➤ Provide verbal and written information in appropriate language and reading level on treatment choices</li> <li>➤ Create an environment that encourage the development of cooperative strategies and solutions and skill building</li> <li>➤ Include a bio-psychosocial-spiritual assessment, including addressing culturally-based beliefs</li> <li>➤ Assess current perceptions of health status, efficacy of treatment and perceived ability to adhere to a treatment plan</li> </ul>
<p><b>Dialog about health beliefs and options</b></p>	<ul style="list-style-type: none"> <li>➤ Dialog with client about their health beliefs</li> <li>➤ Normalize the reasons for non-adherence, so client understands that adherence is challenging for everyone. Give examples such as exercise, diets, common medications (antibiotics)</li> <li>➤ Outline possible consequences of non-adherence</li> <li>➤ Help client assess the relative benefits and costs of the recommended treatment so they may make an informed decision</li> <li>➤ Let client know you are there to support, not to judge</li> <li>➤ Inform client that sharing challenges, concerns and successes with medical treatment adherence has shown to improve outcomes</li> <li>➤ Review side effects and reduce anxiety by considering what the side effects might be and their likelihood</li> <li>➤ Be client centered.</li> <li>➤ Help client to decide whether they are ready to initiate drug therapy</li> </ul>
<p><b>Holistic approach including environment and culture</b></p>	<ul style="list-style-type: none"> <li>➤ Think environmental! Work with client to complete an adherence “Support List.”</li> <li>➤ Remind client and discuss that social support improves adherence but may require disclosure</li> </ul>

	<ul style="list-style-type: none"> <li>➤ Address how family, work, access to health care, etc. support or challenge adherence</li> <li>➤ Share resources to address concerns about adherence as well as other needs that may affect successful adherence. These may include mental health services, child care, support groups, etc.</li> <li>➤ Create goals that involve the client, health provider, family and friends, as appropriate</li> </ul>
<p><b>Empower client to implement action plan</b></p>	<p><u>For clients who have not yet chosen medical treatment for HIV:</u></p> <ul style="list-style-type: none"> <li>➤ Help clients identify the cues, reminders and current activities to associate with medication usage—triggers such as meals, television programs and exercise.</li> <li>➤ Help clients find a way to record when they take medication</li> <li>➤ Help clients develop an action plan to anticipate the unexpected</li> <li>➤ Consider privacy issues, storage issues and other possible adherence challenges and how these can be incorporated into an action plan</li> <li>➤ Normalize that while everyone is concerned they may make mistakes, planning and corrective action will allow them to be increasingly successful, adherent and improve their health</li> <li>➤ Encourage them to review plan with health provider and ask for more help when needed</li> <li>➤ <i>Contract</i>—Discuss concept and have client sign his or her own treatment plan to reinforce that he or she is in charge of approving and implementing it.</li> </ul> <p><u>For clients who are currently on HAART</u></p> <ul style="list-style-type: none"> <li>➤ Review current success and concerns</li> <li>➤ Have client review the treatment plan and personal challenges with adhering to it.</li> <li>➤ Ask, “How are you coping with this plan? What is going well and what may need some attention?”</li> <li>➤ Inquire about non-adherence by asking client to <i>be specific</i> about non-adherence, i.e. “How many doses did you miss in the past day, 2 days, or week?”</li> <li>➤ Assess level of satisfaction with current action plan</li> <li>➤ Assess need to make changes in the treatment regime and how to approach health provider about this</li> </ul>

<p><b>Reinforce strategies and revise as needed</b></p>	<ul style="list-style-type: none"> <li>➤ Reinforce clients' successes and ability to maximize adherence</li> <li>➤ Assess if treatment regimen can be better tailored to his or her life situation</li> <li>➤ Reinforce the message that client will determine those strategies best for her or him</li> <li>➤ Share strategies that have helped other clients overcome adherence challenges</li> <li>➤ Review that 95-100% adherence is the goal, but it is best approached in steps; will get easier over time</li> <li>➤ Problem solve and "brainstorm" strategies to improve adherence and role play possible situations. For example, for the active or busy client, develop approaches that ensure that the medication is physically near the activity or devise ways to ensure that medication is portable (medication boxes, etc.)</li> <li>➤ Discuss disclosure: who knows, what they know and why</li> <li>➤ Create plans for weekends, vacations, and stressful times</li> </ul>
<p><b>Evaluate progress and resources</b></p>	<ul style="list-style-type: none"> <li>➤ Check in with the client, the family and other identified support persons or systems, to evaluate how the treatment and the adherence plan is going.</li> <li>➤ Ask the client (and others as agreed): "What do you feel are the biggest benefits and potential challenges to your plan?"</li> <li>➤ Having reviewed the strategies ask how your client feels about each approach she/he has developed and implemented</li> <li>➤ Reassess strategies and revise with your client, as needed</li> </ul>

## Fitting Treatment into our Lifestyle: A Worksheet

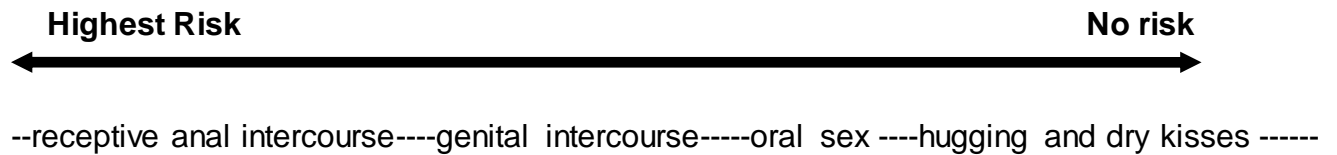
<b>My Eating Habits</b>	➔	<b>When and how many times a day do you eat</b>	
<b>My Sleeping Patterns</b>	➔	<b>When, how often and how long do you sleep</b>	
<b>My Daily Commitments</b>	➔	<b>Include paid employment, child care, volunteer work or school</b>	
<b>My Regular Exercise</b>	➔	<b>Walking, Aerobics, Dance or going to the gym</b>	
<b>My Social Supports</b>	➔	<b>Include your friends, family, partner, spiritual organization or support group</b>	
<b>My Financial/Legal Situation</b>	➔	<b>Include all related issues, such as income, insurance, citizenship or prison</b>	
<b>My Housing Situation</b>	➔	<b>Stable housing, safety or homelessness</b>	

# ADDENDUM MATERIALS

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# TRANSMISSION AND EARLY INTERVENTION OVERVIEW<sup>1</sup>

The relative efficiency with which sexual contact can transmit HIV exists along a continuum:



- receptive anal intercourse carries the highest risk; it is slightly easier to pass the virus from a man to a woman than it is from a woman to a man;
- oral sex appears to be less risky than genital intercourse, but there are documented cases in which oral sexual (male to male) activity appears to be the only known means of HIV exposure.
- any sexually transmitted disease that causes ulcers or inflammation can increase the risk of becoming infected because access to the bloodstream becomes easier during sex;
- hugging and dry kissing constitute no risk of HIV exposure

## OTHER IMPORTANT ISSUES

### Alcohol and other Drugs

- use of drugs or alcohol may also increase the risk of HIV during sexual encounters due to the lowering of inhibitions and decision making abilities.
- during intravenous drug use, a quantity of blood is drawn into the needle; if immediately used by another party, a microscopic transfusion of residual blood may occur.
- sharing a “cooker” in which dry materials (such as heroin powder) is brought in solution for injection may also be a means of transmission.

### Personal Relationships

- there is no risk of HIV transmission from shaking hands, using public toilets, coughing, sneezing, or being bitten by any type of insect.
- there are no cases of transmission traced to non-sexual contact: dry kissing on the cheeks and lips; sleeping together; sharing linens, toothbrushes, and razors; sharing kitchens and bathrooms; and sharing food cooking and serving facilities and utensils.

## BARRIER PROTECTION

### Male and Female Condoms

- Intact latex condoms provide a physical barrier, which the virus is unable to cross.
- Nonoxynol-9 is a spermicidal agent, which has been shown capable of inactivating HIV when placed inside the tip of the male condom and/or after the insertion of the female condom.
- Common reasons for condom failure include: not using early enough, not leaving a reservoir in the tip of the condom, not withdrawing from one's partner before the penis becomes flaccid, and using petroleum-based products.

### DENTAL DAMS

- squares of latex that fit over a women's vulva, for use during oral sexual contact
- "homemade" can include: surgical gloves cut in half lengthwise; condoms cut lengthwise

### FINGER COTS

- surgical gloves, worn in full or with finger sections only, for use when penetrating the anus or vagina

<sup>1</sup>Drawn from "Medical, Psychological, and Social Aspects of HIV", APA HOPE Project, Washington, DC, 1995.

### **SKILL-BUILDING: Taking a Sex and Drug History**

Because of the growing prevalence of HIV and other sexually transmitted diseases, a thorough sex and drug use history is now recommended for all adolescent and adult patients. With practice you will be able to take a sex and drug history in 1-5 minutes. Most patients will be pleased to know they can discuss these important issues with their care provider. Here are some guidelines to consider.

### **Preparing to Ask Questions**

**Rapport** Before asking questions about a client's sex and drug use behavior it is important for the client to feel relaxed and comfortable. Begin by introducing yourself, reassure the client that your conversation is confidential, and ask them to explain why he/she has come to see you. The sex and drug history should come after you have established good communications and rapport.

**Context** A sex and drug use history can be integrated with other questions related to the client's overall health history, or it can be done separately. Either way, the questions should be asked within a context. People frequently will not share information, especially if they feel the information is irrelevant or intimate. So explain why you need the information.

- explain that you will be asking some personal questions
- acknowledge that the client may feel awkward or embarrassed
- ask permission from the client to proceed with the questions
- acknowledge that the client can choose not to answer some questions

**Tone** Be as natural and comfortable with the subjects as you can. This may require you to practice with colleagues before taking a sex and drug history with clients. If you feel awkward or uncomfortable, your clients are likely to sense your uneasiness and feel more anxious or uncomfortable themselves.

**Language** Use language the client understands; be sure to clarify technical terms or acronyms.

- be specific; avoid using vague terms or euphemisms that could be misinterpreted (i.e., sexually active, sexual contact, regular sex, protected sex, drug use, etc.)
- focus on behaviors rather than labels or categories; instead of asking, "Are you homosexual or heterosexual?" ask, "Do you have sex with men, women, or both." Instead of asking, "Are you an IV drug user?" ask "do you use injection needles?"
- avoid terms that may be perceived as negative or judgmental, such as promiscuous (use "more than one partner"), or prostitution (use "sex for money or drugs").

**Listening** A good interviewer is a good listener. Be aware of the flow of the conversation and allow it to progress naturally. Careful listening may give you more information than a rote list of questions. In addition, regimented questions can make clients feel depersonalized and convey the message that the questions are more important to you than the answers.

- paraphrase, or restate in your own words, what the client tells you; this shows that you are listening and allows them to clarify the information they share with you.
- don't assume you know what a term means; a client who says she has protected sex may mean she uses oral contraceptives rather than latex condoms, so ask patients to define or clarify the meaning of the terms they use.

Source: Fundamentals of Mental Health and HIV/AIDS: The CHIME Project: (CMHS HIV/AIDS Illinois Mental health Provider Education); June 1995

## ASSESSMENT: A BRIEF SEXUAL HISTORY

### (If you have time for only one question):

- What do you do to protect yourself from sexually transmitted diseases, for example, AIDS?

### (If you have 3-5 minutes):

- Have you had a sexual experience with another person in the past year?
- (If yes,) With how many different people in this year?
  - One?
  - Two or three?
  - Four to ten?
  - More than 10?
- (If yes,) In this year, have you had sex with
  - Men?
  - Women?
  - Both men and women?
- Can you tell me about your sexual life before this last year?
- Have you ever had a sexually transmitted disease of any kind?
- Have you ever shared a needle or injection equipment with another person for any reason?
- Have you ever felt that a sex partner put you at risk for any reason?
- What do you do to protect yourself from STDs? from AIDS?
- What do you do to protect yourself from unplanned pregnancy?
- Is there anything else that I need to know?

Drawn from: Guest, F. *A Brief Sexual History*. Southeast AIDS Education and Training Center, Emory University (1992)

## Drugs of Abuse: Use and Effects

Drug Classification	Drug Type	Methods of Administration	Possible Effects	Overdose Effects	Withdrawal Syndrome
<b>Stimulants</b>	<u>Cocaine</u> Amphetamines Methamphetamine Phenmetrazine Other Stimulants	<u>Sniffed, smoked, injected</u> Oral, injected	Increased alertness, excitation, euphoria, Increased pulse rate and blood pressure, Insomnia, appetite loss	Agitation, increased body temperature, hallucinations, convulsions, possible death	Severely depressed mood, prolonged sleep apathy, irritability, disorientation
<b>Depressants</b>	<u>Alcohol</u> Barbiturates Methaqualone Benzodiazepines	<u>Oral</u> Oral, injected	Slurred speech, disorientation, staggering, drunken behavior	Shallow respiration, cold and clammy skin, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors, delirium, convulsions, possible death
<b>Narcotics</b>	<u>Opium</u> <u>Morphine</u> <u>Codeine</u> <u>Heroin</u> <u>Methadone</u> Other Narcotics	<u>Oral, smoked</u> <u>Oral injected</u> <u>Oral</u> <u>Injected, smoked</u> <u>Oral, injected</u>	Euphoria, drowsiness, slow respiration, nausea	Slow and shallow, breathing, clammy skin, constricted pupils, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite, tremors, panic, chills and sweating, cramps, nausea
<b>Hallucinogens</b>	LSD Psilocybin Mescaline, peyote <u>Amphetamine variants</u> <u>Phencyclidine</u>	Oral  <u>Oral, smoked</u> <u>Oral, smoked</u>	Visual illusions, hallucinations, altered body perceptions, increased emotionality	More prolonged episodes that may resemble psychotic states	Not reported
<b>Cannibals</b>	<u>Marijuana</u> Tetrahydro-cannabinol <u>Hashish</u>	<u>Smoked</u> Oral <u>Smoked</u>	Euphoria, relaxed inhibitions, increased appetite, impaired memory and attention	Fatigue, paranoia, at high doses a hallucinogen-like psychotic state	Insomnia, hyperactivity

## STAGES OF CHANGE

### Stage 1: Precontemplation

- The person has no intention of changing in the foreseeable future.
- The person is unaware of their problems. “It isn’t that they can’t see the solution. It is that they can’t see the problem.”
- Others around the person are aware of the problems and often pressure the client into treatment.
- The person resists recognizing or modifying problems/behaviors.

### Stage 2: Contemplation

- The person is aware that a problem exists and is seriously thinking about overcoming it but has not yet made a commitment to take action.
- The person weighs the consequences of the problem; the pros and cons of the solution to the problem. He/she struggles with the positive evaluations of the behavior and the amount of effort, energy, and loss it will cost to overcome the problem.
- The person states she/he is seriously considering changing the behavior in the next six months.

### Stage 3: Planning and Preparation

- The person intends to take action in the next month and has unsuccessfully taken action in the past year.
- The person may have made reductions in his/her behavior (reducing use, delaying the onset of daily use) but has not successfully changed the behavior (abstinence).

### Stage 4: Action

- The person actually modifies his/her behavior, experiences, or environment to overcome the problems.
- This stage requires considerable commitment of time and energy.
- Modifications of behavior made in this stage tend to be most visible and receive the greatest external recognition.
- The person has successfully altered the behavior for a period of one day to six months.
- Modification of the target behavior to an acceptable criterion and significant overt efforts to change are characteristics of this stage.

### Stage 5: Maintenance

- The person works to prevent relapse and consolidates the gains attained during action.
- Although traditionally viewed as a static stage, it is a continuation (not an absence of) change.
- This stage extends from six months to an indeterminate period past the initial action.
- Stabilizing behavior change and avoiding relapse are the hallmarks of the maintenance stage

### Relapse

- Occurs throughout the process.

(Prochaska, J.O., & DiClemente, C.C. (1986).

# MOTIVATION

A counselor often judges a person's "motivation" from a number of behaviors such as the following:

- ❖ *Agreeing with the counselor*
- ❖ *Accepting the counselor's diagnosis (e.g., admitting that he or she is "an alcoholic")*
- ❖ *Expressing a desire or need for help*
- ❖ *Appearing to be distressed about his or her condition*
- ❖ *Following the counselor's advice*

**Conversely, a counselor may tend to judge as "unmotivated" (or "resistant" or "in denial") and adhere to a specific change strategy.**

**"Motivation"** can be defined as the probability that person will enter into, continue, and adhere to a specific change strategy.

**Motivational interviewing** wants to find an alternative to falling into what is called the confrontation-denial trap—we are each in rigid roles, or a tug of war—we play the costs and they play or pull for the benefits. The counselor knows what s/he is doing is right but they are just not succeeding with the client. So, in essence, we want the client, rather than the counselor, to experience and explore the ambivalence conflict and if it is appropriate, present reasons to be concerned about substance use and arguments for change.

To be clear, the counselor has the desire or point of view to encourage change. And motivational interviewing has a clear directive component but it is also client-centered, empathizing with the client's experience of the ambivalence conflict. Working with it, rather than getting ahead of it. Psychological judo. Sometimes the counselor will take the lead. Sometimes s/he will follow. The conscious direction pursued by the counselor is the understanding of the client's ambivalence.

**So, our working definition of motivational interviewing is as follows:** a directive, client-centered counseling style for helping clients express, experience, explore and resolve ambivalence about behavioral change.

The appearance of a motivational interviewing session is quite client-centered, yet the counselor maintains a strong sense of purpose and direction, and actively chooses the right moment to intervene with incisive approaches. Motivational interviewing specifically avoids argumentative persuasion, and instead operationally assumes the validity of the client's subjective experiences and perspectives. This involves listening to, acknowledging, and practicing acceptance of (though not acquiescence to) a broad range of client concerns, opinions, preferences, beliefs, emotions, styles, and motivations.

**Motivational interviewing** is a particular tool to help people recognize and do something about their present or potential problems. It is particularly useful with people who are reluctant to change and ambivalent about changing. It is intended to help resolve ambivalence and get the person moving along the path to change. For some people this is all they really need. Once they are unstuck they have the skills and resources they need in order to make a lasting change. For others, motivational interviewing is only a prelude to treatment. It creates an openness to change, which paves the way for further important therapeutic work.

This model is a strength-based approach that relies on a client rediscovering the skills, competencies and resources to solve their problem. It is a way of pointing a client towards health and positive choices; guiding not leading.

## **R**eview

- ❖ *Counselor style is a powerful determinant of client resistance and change.*
- ❖ *Confrontation is a goal, not a style.*
- ❖ *Argumentation is a poor method for inducing change.*
- ❖ *When resistance is evoked, clients tend not to change.*
- ❖ *Client motivation can be increased by a variety of counselor strategies.*
- ❖ *Even relatively brief interventions can have a substantial impact on problem behavior.*
- ❖ *Motivation emerges from the interpersonal interaction between client and counselor.*
- ❖ *Ambivalence is normal, not pathological. Helping people resolve ambivalence is a key to change.*

# C

ONTRASTS BETWEEN CLIENT-CENTERED AND MOTIVATIONAL INTERVIEWING

Centered Approach	Motivational Interviewing Approach
<b>Allows the client to determine the content and direction of the counseling.</b>	<b>Systematically directs the client toward motivation for change.</b>
<b>Avoids injecting the counselor's own advice and feedback.</b>	<b>Offers the counselor's own advice and feedback where appropriate.</b>
<b>Empathic reflection is used non-contingently.</b>	<b>Empathic reflection is used selectively, to reinforce certain processes.</b>
<b>Explores the client's conflicts and emotions as they exist currently.</b>	<b>Seeks to create and amplify the client's consciousness of discrepancy in order to enhance motivation for change.</b>

## *B*eginning with a Client

Common traps in to which counselors can fall at the very beginning of work with a client:

- ❖ ***The Question-Answer Trap***
- ❖ ***The Confrontation-Denial Trap***
- ❖ ***The Expert Trap***
- ❖ ***The Labeling Trap***
- ❖ ***The Premature-Focus Trap***
- ❖ ***The Blaming Trap***

**Content drawn from: Texas HIV Connection (Austin, TX) and Steps Toward Change: Training Resource Book (2<sup>nd</sup> Edition) S.U.S.E., Gay Men's Health Crisis, New York, NY. 1999**

## PROVIDER BURNOUT

Work with HIV+ clients brings both clinical challenges and personal rewards.

Burnout is referred to by some as bereavement overload. HIV disease has brought many social workers into the field of death and dying counseling. Additionally, social workers are called upon to work with care givers facilitating normal grieving or dealing with complicated grief as an occupational aspect of AIDS work. Social Workers working in this field need to understand burnout to be effective with care givers at risk and to understand their own potential for burnout.

Burnout is a lowered energy, enthusiasm and idealism for doing one's job. Garfield describes it as a loss of concern for the people we serve and for the work we are doing. Unlike fatigue, burnout does not resolve after a given amount of rest and recreation. (Garfield, 1989)

**Symptoms:** (Garfield, 1989)

- reduced productivity
- impaired performance
- increased opposition to change
- chronic fatigue, insomnia, bodily aches and pains
- decreased interest in interacting with coworkers and clients
- dislike of work environment
- expressed dislike for recipients of service
- increased use of formal procedures to process complaints

**Elements that Contribute to Burnout:**

- lack of social support systems in the work area
- isolation on the job
- many difficult and repetitive situations
- no breaks in the action
- too much direct contact with recipients of services
- unrealistic self-expectations: wanting to do it all
- excessive individual responsibility
- no self-monitored time out
- lack of support and collaboration

**Stressors Inherent in Work with HIV+ Persons:**

- stigma (for example, the triple stigma often associated with being a gay man, having AIDS, and dying) compounds all other stressors and denies care givers reinforcement for their work
- weight of the responsibility: (for example, decisions regarding treatment vs. no treatment, drug treatment (addiction), and pain control; being the client's sole source of support or advocacy)
- negotiating conflicting personal rights and needs: of clients, the client's family, significant others, staff and self.
- systems frustrations: working within a system that is not set up to deal with clients as they are dying, with substance abuse (addictions) and infectious diseases.

### ***Managing Burnout at Work:***

- case staffing
- case consultations with an expert
- clear assignment of specific duties (particularly to hospital staff)
- drawing and maintaining clear boundaries on professional obligations
- enlisting help of volunteers from community organizations
- “time-out” activities
- varying tasks and responsibilities
- building in “mental health days”
- continuing education
- staff retreats
- discussion/process/support groups
- memorial services

### ***Managing Burnout in Private Life:***

- meditation, relaxation, self-hypnosis
- massage
- regular exercise
- personal growth, recovery work
- recreational activities
- peer support group
- individual therapy
- working on AIDS Quilt panel
- grief work
- sharing experiences, feelings with family/peers or “Telling our Stories:

Source: Psychology, Gay Men & HIV Disease: Trainers Manual American Psychological Association (1993).

## WAYS TO MINIMIZE CULTURAL/BLOCKS<sup>1</sup>

1. Plan to spend more time with patients holding values different from yours. The relationship is more complex and it may take longer to establish trust.
2. Anticipate that past frustrations with insensitive or inappropriate health care systems may have made the patient angry, suspicious, and resentful.
3. Acknowledge the past frustrations.
4. Acknowledge the differences between your experience and that of your patient.
5. Individualize: A patient is more than "poor", a "substance abuser" or from a particular ethnic group. Get to know the person.
6. Encourage disagreement and negotiation to ensure a workable plan.
7. Anticipate multiple needs, medical, legal, social and psychological.
8. Be prepared to advocate for the patient who may not have the resources/knowledge/experience to negotiate the health care system.
9. Assist the patient in getting to other resources.
10. Involving friends and family can be helpful in ensuring that the patient gets to other needed services.
11. Confidentiality may be even more important than usual because of shame, e.g. loss of face, within their family or community.
12. Pay attention to communication; nonverbal, expressive style and use of and meaning of words.
13. Learn the strengths of a culture, e.g. in Latino culture the value of "respecto", demonstrating appropriate social respect, can be used to support condom use.
14. Make use of providers from other cultures, cultural consultants.
15. Expect differences of beliefs about:

Help Seeking Behaviors	Caretaking/Caregiving
Cause of Disease/Illness	Sexuality/Homosexuality
Death and Dying	

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<sup>1</sup> From: Training for Cultural Competence in the HIV Epidemic: Lana Ka'opua. MSW. ACSW and the Hawaii Area AIDS Education and Training Center; January 1992.  
NASW  
Trainer Manual ADDENDUM

## THE CULTURALLY SENSITIVE INTERVIEW<sup>2</sup>

The Culturally-sensitive Interview: Despite similarities among patients from a specific ethnic group, each patient must be seen as an individual who may or may not adhere to a particular set of beliefs and practices. It is important to ask specifically about health beliefs. One way to begin such exploration has been proposed by Harwood (1981).

I know that patients and doctors (nurses/social workers/health educators) sometimes have different ideas about diseases and how they affect you. So, it's important in treating a disease to get clear on how both the doctor and the patient think about it. That's why I'd like to know more about your ideas on HIV. That way I can know what your concerns are, and we can work together in treating your illness.

Expect culturally-specific beliefs in the following areas. To facilitate the interview process, a number of questions are suggested for each area.

a. Causes of illness/disease

"What do you know about HIV?"

"How do you think HIV affects your body? How does the disease work?"

"What can you do to prevent the infection from spreading?"

b. Death and dying

"What did your doctor tell you about what will happen to you?"

"What do you think will happen to you?"

"What do you believe happens when someone dies?"

"What are the signs that death is near?"

"Does death have a purpose or symbolic meaning?"

"What are the responsibilities of the living when someone close to them is dying?"

"What needs to be done once someone dies?"

"How is death in the hospital viewed?"

"What do you want done with your body after you die?"

"What ceremonies or rituals would you find comforting?"

c. Sexuality/homosexuality

"Is it acceptable in your family or in your community for men to have sex with other men?"

"How do people in your community react when someone has a same-sex partner?"

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<sup>2</sup> From: Training for Cultural Competence in the HIV Epidemic; Lana Ka'opua. MSW. ACSW and the Hawai'i Area AIDS Education and Training Center: January 1992.  
NASW  
Trainer Manual ADDENDUM

d. Caretaking/caregiving

"Are there any people you can talk to about your HIV status?"

"Is there anyone in particular who helps you when you're sick?"

"What makes you feel better when you are sick?"

"What is an average day like for you?" (note lifestyle practices, key people, etc.)

"Are there any medical procedures which you do not want?"

e. Culturally familiar health care beliefs

"What kinds of treatment have you tried - medication, home remedies, or natural therapies?"

"Are there any specific medicines or healing agents that you want to use in your treatment?"

"Is there anything else that you think is important to include in your treatment?"

f. Coping style

"What are other stressful situations you have experienced? How did you deal with them?"

"Would you like to have done anything differently?"

g. Spirituality/Religion

"Can you help me understand your spiritual or religious beliefs?"

h. Substance Abuse

"What does drinking/using particular substances mean in your family?"

"Is substance use connected to a custom or ritual?" "How were the use of substances introduced to your people?"

"How common is substance use among your family and friends?"

"Who do you drink/shoot up with?"

"In what circumstances do you use substances?"

i. Other Culturally-affected Health Care Issues

"Are there special food preferences which you have that are important to you?"

"What do you think about autopsy?"

## The Culturally Competent Practitioner<sup>3</sup>

Often health care practitioners focus on the cultural systems of their clients without acknowledging the importance of their own cultural values, attitudes, and beliefs. However, in order to become a culturally competent practitioner, one must first understand one's own cultural heritage and how it influences one's world view and interactions with others, including clients from other cultures.

Becoming a culturally competent practitioner is an ongoing process. There really is no end point but varying points on a continuum of competency. Nevertheless, a number of authors have defined what they believe to be the essential ingredients of a culturally competent provider (*Sue, Arredondo, McDavis 1992*). The following is a compilation of these characteristics.

A culturally competent practitioner:

- has moved from being culturally unaware to being aware and sensitive to his/her own cultural heritage.
- is aware of his/her own values and biases and how they may affect clients from culturally diverse communities.
- is comfortable with differences that exist between themselves and clients in terms of culture and its effect on values, beliefs, and attitudes.
- possesses knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect both their clients and themselves personally and professionally.
- understands the historical events that may have harmed particular cultural groups.
- possesses specific knowledge and information about the particular cultural group(s) s/he is working with.
- respects the unique, culturally defined needs of clients from diverse communities.
- understands that diversity within cultures is as important as diversity between cultures.
- seeks out opportunities to learn more about various cultural communities through:
  - interactions with clients
  - participation in cultural diversity workshops
  - reading of articles and books on cultural dynamics
  - participation in community events
  - consultations with cultural experts in the community

- makes continued, sincere attempts to understand the others' point of view.
- is flexible and tolerates ambiguity well.
- has a sense of humor.
- is open minded and non-judgmental.
- is willing to relinquish control in clinical encounters.
- has the willingness to risk failure and to look within for the source of frustration, anger, and resistance.
- acknowledges that process is as important as product.

Clearly, there are few, if any, totally culturally competent practitioners. However, the above list of characteristics can guide practitioners in their journey to become more understanding and responsive to the needs of their clients from culturally diverse communities.

The following series of exercises are designed to facilitate practitioners' exploration of their own cultural heritage and its influence on interactions with clients.

<sup>3</sup> Randall-David, E. (1994) Culturally competent HIV Counseling and Education. Washington, DC: Maternal and Child Health Clearinghouse.

**AIDS:** acquired immunodeficiency syndrome. A diagnosis of AIDS comes with HIV infection and one of the following conditions: one or more of 25 opportunistic infections; severe symptoms of HIV disease; or a CD4+ count below 200 cells two or more times over the course of six months.

**Adherence:** the condition or process of carefully following instructions; used to refer to the practice of precisely following the directions and dosing schedule of a treatment regimen.

**AIDS dementia complex:** a neurological condition that can be caused by HIV infection, resulting in loss of coordination, depressed moods, memory lapses, and personality changes.

**Albumin:** a type of protein evaluated by laboratory tests that gives important information about a person's nutritional status.

**Amenorrhea:** the absence of a menstrual cycle (period).

**Anemia:** a condition caused by a lack of red blood cells, usually resulting in fatigue or loss of strength.

**Antiretroviral therapy (ART):** treatment aimed at slowing or stopping the activity of HIV in the body.

**Bacterial pneumonia:** a lung infection often affecting women with HIV disease.

**Branched DNA (bDNA):** a type of blood test that measures HIV RNA copies, also known as Quantiplex™ or the "Chiron assay" (Chiron Corporation).

**Candidiasis:** a fungal infection of that may occur in the vagina or other parts of the body.

**CD4 + cell count:** a blood test that measures the number of CD4+ cells.

**CD4 + cells or CD4 + lymphocytes:** a type of white blood cell; one of the components of the immune system that helps the body fight infection. Also known as T-cells, T-helper cells, or CD4+ lymphocytes. When HIV infects these cells they become the site of HIV replication and are killed as a result of this process.

**Cerebrospinal fluid (CSF):** fluid that surrounds the brain, the spinal cord and its coverings (called meninges).

**Cervical dysplasias:** irregular growths on the surface of the cervix, which may be benign or an indicator of problems, including cervical cancer.

**Clinical trial:** a study of a drug or treatment strategy in human subjects. All drugs must go through three distinct phases of clinical trials in the US, regulated by the *US Food and Drug Administration*, before they can be prescribed legally as a treatment. Participants in clinical trials may have access to a treatment before it is generally available.

**CMV:** Cytomegalovirus, a type of herpes infection that may cause serious illness in patients with AIDS, most often among those with CD4+ counts of less than 50 cells. CMV disease can occur in almost any part of the body, but most often manifests in the retina of the eye, the colon, the esophagus, or the nervous system.

**Colposcopy:** a medical procedure in which the surface of the cervix is examined with a small microscope for signs of cancerous or pre-cancerous cells.

**Combination therapy:** the current clinical standard in HIV treatment, consisting of three or more different antiretroviral drugs taken at the same time to inhibit HIV replication.

**Cross-resistance:** (see **resistance**) a type of HIV resistance that affects more than one drug, usually of the same class.

**Disease progression:** in HIV disease, the development of HIV symptoms or any other decline in health, such as the onset of an **opportunistic infection**.

**Estrogen:** a type of hormone, present in higher quantities in women than men, produced in ovaries, testes, and placenta. These hormones regulate various functions, especially the menstrual cycle.

**Expanded access:** drug availability before it is fully approved by the US **Food and Drug Administration**, usually for people who have advanced HIV disease and have no other treatment options--also known as "compassionate use."

**Food and Drug Administration (FDA):** agency of the US Department of Health and Human Services that regulates the testing of experimental drugs and approves new medical products for marketing based on evidence of safety and effectiveness.

**Genital secretions:** any substance secreted by the female or male genitals, such as vaginal fluids or semen.

**Genotypic test:** a type of blood test used to assess HIV drug resistance. It analyzes the genes or "genome" of HIV to identify **mutations**, some of which indicate **resistance**.

**HAART:** (highly active antiretroviral therapy), currently used to refer to a potent treatment regimen using three or more drugs.

**Hepatitis:** an inflammation of the liver that may be caused by hepatitis viruses or by medications. Physical symptoms include yellow skin color (jaundice), nausea, fatigue, and fever.

**HIV RNA:** genetic material of HIV that gets converted to HIV DNA and is then incorporated into the DNA of an infected cell. Each viral particle of HIV contains HIV RNA.

**Human immunodeficiency virus (HIV):** the virus that disables the human immune system, eventually leading to AIDS.

**Human papilloma virus (HPV):** a common sexually transmitted disease that may not produce noticeable symptoms but may lead to warts, often in or on the genitals.

**Hypersensitivity reaction:** an unusual syndrome of symptoms, most often including fever, rash and digestive problems, related to a severe response to Ziagen (ARC). Symptoms tend to subside when ARC is stopped, restarting use after this problem is potentially fatal.

**Immune system:** the complex set of tissues, organs, and cells that protect the body from damage by foreign organisms such as viruses, bacteria, parasites, and fungi.

**Intensification:** a treatment strategy of adding one or more drugs to boost the potency of an existing regimen.

**Kaposi's Sarcoma (KS):** an opportunistic infection that creates painful lesions on the skin; may also occur internally on lungs and other organs. Very rarely seen in women.

**Lipodystrophy:** changes in the distribution of fat throughout the body, with no change in overall body weight.

**Lymph Nodes:** organs the size and shape of a small bean which are crucial components of the immune system. Lymph nodes are intricately interconnected to each other and the blood through a system of vessels. Germ-fighting cells gather in the lymph nodes to fight infections.

**Lymphocytes:** one of several classes of white blood cells in the immune system which includes CD4+ cells, CD8+ cells and others.

**MAC:** *Mycobacterium avium* complex, a common opportunistic infection caused by bacteria that may affect many different organ systems. MAC most often occurs among individuals with CD4+ count <100.

**Malaise:** vague feeling of bodily discomfort.

**Mutations:** changes in HIV genetic material that allow new strains of HIV to emerge that are slightly different

from previous ones. Mutations can sometimes cause HIV to become resistant to one or more drugs (see resistance).

**Neutropenia:** reduction in white blood cells.

**Non-nucleoside reverse transcriptase inhibitors (NNRTIs):** a class of antiretroviral drugs that block HIV replication by blocking the function of the viral protein reverse transcriptase. Drugs available in this class are DLV, EFV and NVP.

**Nucleoside reverse transcriptase inhibitors (NRTIs):** a class of antiretroviral drugs that block HIV replication by blocking the function of the viral protein reverse transcriptase. Drugs available in this class are AZT, ABC, ddI, ddC, d4T, and 3TC.

**Nucleotide reverse transcriptase inhibitors (NtRTIs):** there are two drugs, under study but not yet approved for sale, that are similar to the NRTIs. They also block HIV's reverse transcriptase, but in a slightly different way than the commonly used NRTIs. Drugs available in this class are ADV and PMPA.

**Opportunistic infections (OIs):** infections that are more likely to occur in people with immune systems made weaker by HIV infection, cancer, or other causes. Examples of OIs related to HIV infection include

**PCP, toxoplasmosis, MAC, CMV disease, and bacterial pneumonia.**

**Oral ulcers:** painful condition of open sores in the mouth.

**Pancreatitis:** inflammation of the pancreas that can be fatal.

**Pap smear:** a test examining cells from the surface of the cervix. The test looks for cellular irregularities that may predict the development of cervical cancer.

**PCP:** *Pneumocystis carinii* pneumonia, a lung infection that is the one of the most common AIDS- defining conditions in the United States. TMP/SMX (Bactrim® or Septra®) helps prevent this disease in HIV- infected people with CD4+ counts <200 cells.

**Peripheral neuropathy:** disorder that affects the nerves of the hands and feet and is characterized by pain, numbness and/or tingling sensations.

**Phenotypic test:** a blood test used to assess HIV drug resistance. It measures how well HIV can replicate in the presence of various drugs.

**Polymerase chain reaction (PCR):** a laboratory procedure that allows the amplification and identification of specific DNA or RNA sequences, such as HIV RNA. PCR is repeated for many cycles to create millions of copies of the targeted sequence. The final step is the calculation of HIV RNA copies for viral load tests.

**Protease:** enzyme involved in viral replication that assembles the functional parts of HIV during later stages of viral replication.

**Protease inhibitors (PIs):** a class of antiretroviral drugs that bind to and block HIV protease to prevent the production of new infectious viral particles. Drugs available in this class include APV; IDV; NFV, RTV, and SQV.

**Resistance:** the ability of an organism, such as a virus, to not be affected by drugs. In the case of HIV; resistance usually refers to less or no effect of the antiretrovirals in keeping viral load at low levels.

**Reverse transcriptase:** an enzyme that HIV uses to reproduce itself. Reverse transcriptase inhibitors (RTIs) block this step of HIV reproduction.

**Salvage (also salvage therapy):** a treatment strategy for patients who have taken many antiretrovirals, using at least four, and as many as seven, drugs as intensive treatment after other efforts have failed.

**Side effects:** unintended, often unpleasant effects of a drug used in treatment. For instance, many drugs taken orally may irritate the digestive system, causing nausea, diarrhea or vomiting.

**Standard of care:** what leading medical and community experts consider to be the most beneficial method of treatment for a health condition. For example, triple-drug antiretroviral therapy became the standard of care when protease inhibitors became widely available in 1996.

**Switching (therapy):** changing one or more drugs in a treatment regimen due to drug resistance or side effects, among other reasons.

**Taste perversion:** a side effect that creates a lingering taste in the mouth or distorts taste sensations.

**Testosterone:** a hormone, present in both men and women, which plays a role in the maintenance of body weight and other functions. Sometimes given as a supplement to men and women with HIV infection, often used to treat wasting.

**T-helper cells (also T-lymphocytes):** a type of white blood cell, one of the components of the immune system that helps the body fight infection. Also known as CD4+ cells or CD4+ lymphocytes.

**Thrush:** generic term for fungal infections of *candida albicans*, also known as **candidiasis**. May affect the inner and outer surfaces of the oral area, the esophagus and lungs, or the vagina. Considered to be an OI if diagnosed in the esophagus.

**Toxoplasmosis:** a very serious opportunistic infection which can affect many different parts of the body, but most commonly causes swelling and lesions in the brain. For individuals with CD4+ counts <100 cells, who test positive for the toxo organism, TMP/SMX (Bactrim® or Septra®) may help prevent toxoplasmosis.

**Treatment failure:** increases in viral load, decreases in CD4+ cell counts, appearance of HIV symptoms, or an opportunistic infection, any of which indicate that an ART regimen is not working effectively to suppress HIV infection.

**Viral load:** the estimated amount of HIV present in your blood, this is not an absolute number and does not measure the amount of HIV in other fluids or organs in the body.

**Viral replication:** the process by which HIV is able to invade a CD4+ cell and use the cell's resources to reproduce or "replicate" to make more copies of HIV.

**Virus:** a tiny parasite consisting of genetic material, enzymes, and a protein shell; it must enter and infect a host cell to reproduce. Examples include the common cold, herpes, and HIV.

**Vital statistics:** basic facts about your body such as date of birth, age, weight, height, or hair color.

**Wasting:** severe, unintended weight loss caused by HIV or other diseases. When the loss is more than 10% of a person's ideal body weight, it is an AIDS-defining condition.

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## Impact of Street Drugs and Alcohol on Various Psychiatric Disorders

### Psychosis/schizophrenia

#### Stimulants:

(-) Increase positive psychotic symptoms (hallucinations, delusions, paranoia, thought disorder). Can cause independent toxic psychosis or induce mania.

(+) Decrease negative symptoms (social withdrawal, emotional blunting). Decrease blunting effects of anti-psychotic medications.

#### Depressants (alcohol, benzodiazepines, barbiturates, opiates):

(-) Increase disorientation (barbiturates). May cause paradoxical aggression due to disinhibiting effects (alcohol and benzos).

(+) Decrease auditory hallucinations. Decrease agitation/anxiety. Increase socialization.

#### Marijuana:

(-) May increase psychosis, or precipitate a psychotic episode.

(+) Decreases agitation/anxiety (with some exceptions)

#### PCP and Deleriants (many are anaesthetics):

(-) Increases hallucinations and aggressiveness.

### Mania

#### Stimulants:

(-) Trigger mania. May push mania into psychosis. Increases risk-taking behavior and irritability (+) Intensifies pleasurable feelings.

#### Depressants:

(-) May disinhibit some people. Could precipitate more rapid cycle into depression

(+) Calming, soothing. Takes edge off mania.

#### Marijuana:

(-) Can increase paranoia and irritability.

(+) May relax.

#### PCP and Deleriants:

(-) Aggressive outbursts. Increases suicide risk. Increases risk of traumatic injury.

### Anxiety disorders

#### Stimulants:

(-) Increase anxiety

(+) May have paradoxical effect of relaxation in ADD

Depressants:

- (-) May increase anxiety over time
- (+) Decrease anxiety and panic. Increase socialization.

Marijuana:

Idiosyncratic. May calm or exacerbate anxiety or panic.

PCP and Delirants:

Increase anxiety.

**Depression**

Stimulants:

- (-) Increase risk of acting out of suicidal impulses. Increase depression in withdrawal.
- (+) Elevate mood (temporarily). Increase socialization.

Depressants:

- (-) Intensify depression.
- (+) Elevate mood (temp.) May act as anti-depressant in women. Increase disinhibition.

Marijuana:

- (-) Causes cognitive problems. Makes differential diagnosis of amotivational syndrome difficult.
- (+) Elevates mood.

PCP and Delirants:

- (-) Increase self-destructive acting out.

**PTSD**

Stimulants:

- (-) Increase intrusive memories, hyperarousal. Decrease numbing response.
- (+) Distracting. Increase socialization.

Depressants:

- (-) May increase depression over time.
- (+) Block intrusive memories, etc. Soothe agitation. Decrease feelings of dysphoria.

Marijuana:

- (-) Increases intrusive thoughts.
- (+) Distracting. Soothing.

PCP and Delirants:

- (-) Increase acting of aggression, self-destruction.
- (+) Blunt affective experience.

Source: Patt Denning, Ph.D., Addiction Treatment Alternatives, 415/252-0669