



HEALTHY LIVING PROJECT

REFERENCE GUIDE



MEDICAL
COLLEGE
OF WISCONSIN

CENTER FOR AIDS INTERVENTION RESEARCH (CAIR)

Department of Psychiatry and Behavioral Medicine
Medical College of Wisconsin

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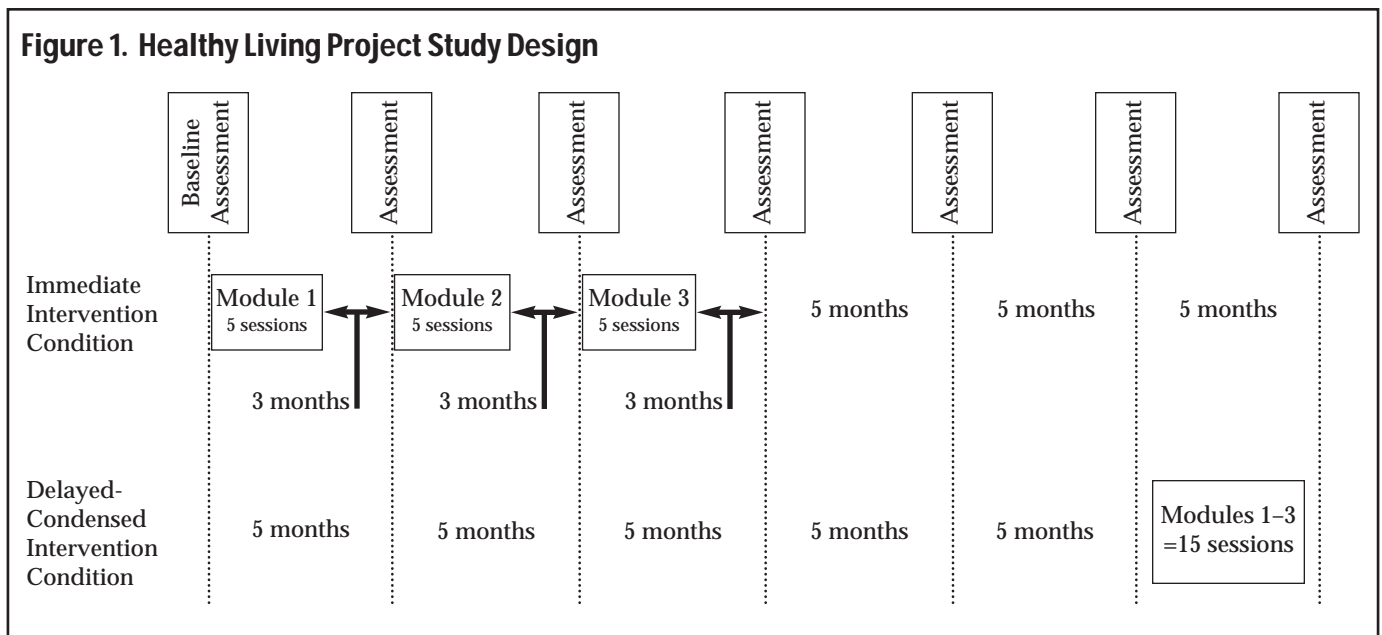
I. INTRODUCTION

Welcome to the Healthy Living Project. This Reference Guide is designed to complement the Intervention Manual. It will familiarize you with the study and with the intervention program being evaluated in the study. It describes the preferred facilitation style and techniques, as well as the basic skills that will be used in each session of the intervention. The diverse contextual issues that are expected to emerge in sessions are summarized. Finally, the Guide addresses procedural issues, and contains relevant readings. Your role as a Facilitator will be critical to the success of the project. Please become familiar with the Guide and refer to it often.

OVERVIEW OF THE HEALTHY LIVING PROJECT

The Healthy Living Project (HLP) is a research investigation that tests the efficacy of a one-on-one multi-session intervention program designed to help people with HIV infection to improve their quality of life in three broad areas: mental, physical, and sexual health. More specifically, the HLP seeks to assist people who have HIV infection to develop positive strategies for managing symptoms of depression, anxiety, complex medication regimens, injection drug use, and sexual risk behavior in order to avoid unwanted consequences for themselves, their friends, families, and partners. The HLP Participants will include women, injection drug users, and men who have sex with men. Overall, 1,200 Participants will be enrolled in the project, 100 from each subgroup at each of the four research sites.

Explanation of the Design. Because the HLP is designed to test the efficacy of an intervention, the intervention is nestled between multiple assessments. Figure 1 illustrates the study design described herein.



Participants begin by completing a baseline interview. They are randomly assigned to either an Immediate or Delayed Intervention condition. The intervention is grouped in fifteen individual sessions, and each session is 90 minutes long. Sessions are delivered in three modules of five sessions each. Each module will take approximately two months to complete, with sessions occurring about every other week. For the Immediate Intervention group, each module is separated from the next by three months to allow Participants time to incorporate the information from the program into their lives, and also to evaluate of the impact of each module on Participants' well-being. Thus, another assessment is conducted three months after each module is completed.

After Participants in the Immediate Intervention group complete the assessment following Module 3 and two subsequent follow up assessments, the Delayed Intervention group then begins participating in a condensed version of the intervention without the three month hiatus between modules. One additional assessment is conducted after they have completed the intervention. Participants in the Delayed Intervention condition complete assessments throughout the study at the same intervals as Immediate Intervention Participants, and those in the Immediate Intervention condition continue their assessments until the Delayed group completes the study.

Content of the Intervention. The content of the program is based on extensive qualitative interviews and focus groups, as well as on previous intervention research with people with HIV infection. Module 1 addresses stress and coping. Module 2 focuses on risky sexual and drug use behavior. Module 3 addresses treatment adherence. Facilitators will help Participants address these topics by using a core repertoire of cognitive-behavioral techniques in each session, including: trigger identification, problem solving, and goal setting. The rationale is that by teaching these skills, and how they can be used to address the diverse topics in each module, Participants will be able to use the skills independently to effectively meet challenges in their daily lives.

For the intervention to be effective, the content of each session will need to be tailored to the life-context of the individual participant. Facilitators will encounter a wide range of ethnic, educational, and socioeconomic backgrounds among the Participants because the project targets diverse groups of HIV-positive Participants from distinct geographical areas. Although it is of course impossible for us to predict every issue that Participants may bring to the study, many of the contextual factors that we anticipate are discussed in the section of this Guide entitled "Contextual Themes" (pages 43-58 of this Guide). It is imperative that you are well versed in these contextual factors prior to working with Participants.

RESPONSIBILITIES AND EXPECTATIONS OF THE FACILITATOR ROLE

Facilitator Responsibilities. On the most basic level, the responsibility of the Facilitator is to deliver the 15-session intervention described in the study protocol in an ethical manner. However, the style in which Facilitators do this is important. In this Guide, we make recommendations regarding the style of facilitation that we believe will be most successful, some of which can be taught and some of which cannot. Facilitators are required to participate in centralized training, during which they will be tested on specific skills and "certified" to begin working with Participants.

In addition, Facilitators are responsible for maintaining a file documenting each participant's progress in the program. They will also audiotape and complete quality assurance paperwork at each session. They are required to participate in regular clinical supervision at their research site. Finally, they may be required to undergo additional training in the study protocol, based on results of quality assurance paperwork.

Facilitator Expectations. It is expected that male Facilitators be able to deliver the intervention to male Participants; female Facilitators should be able to deliver the intervention to either men or women. Perhaps the most important point here is what is **not** expected of Facilitators.

FACILITATORS ARE NOT CLIENTS' THERAPISTS. It may be useful to think of the Facilitator as a type of coach who helps Participants achieve goals and make changes in their lives.

However, Facilitators are not expected to provide treatment for psychological disorders beyond what is contained in the intervention. Procedures for assisting Participants to obtain additional services when indicated are listed in the "Procedural Issues" section (pages 59–61 of this Guide). In addition, an emergency protocol has been prepared by each site and will be reviewed with each Facilitator.

RESEARCH PROTOCOL VS. THERAPY

The goal of the HLP, in addition to helping the Participants directly, is to develop an intervention that can be used by others on a broader scale if it is found to be effective. Therefore, Facilitators need to adhere to the program as detailed in this Guide and the Intervention Manual. To assist them in adhering to the study protocol, Facilitators will complete a checklist of required activities at the conclusion of each session. This is described in more detail in the "Procedural Issues" section (pages 59–61 of this Guide).

At the same time, it is also important to the success of the project that Facilitators maintain the individual style that they have developed through years of prior experience as a social worker, counselor, or therapist, in order to connect with Participants. We anticipate that for some Facilitators, especially those with less experience delivering manualized interventions, combining the study protocol with existing clinical skills and style will be challenging. For this reason, although we have included core activities to be delivered as an active part of the program, we have left these activities open to be tailored to each participant, and, in addition, we have designated the beginning and end of each session to be adapted to each participant.

Nevertheless, based on your experience, you may feel that there is a better way to achieve the goals than the program described in this Guide and the Intervention Manual. If you find that you are uncomfortable delivering the intervention according to protocol, it is important that you discuss this with your clinical supervisor rather than deviating regularly from the protocol.

II. FACILITATION

Although the Healthy Living Project is not psychotherapy, it is necessary for the Facilitator to have many of the same skills, characteristics, and attitudes of a therapist.

FACILITATION GOALS OF THE HEALTHY LIVING PROJECT

There are five main facilitation goals for the Healthy Living Project:

Facilitate the enhancement and/or development of positive behavior changes

The Healthy Living Project is designed to help Participants (hereafter referred to as Clients) to decrease harmful behaviors, including needle sharing, unprotected sexual activities, and non-adherence to a medical treatment regimen. Within the Client-centered approach, the Facilitator must be cognizant of the Client's life context and the meaning or definition assigned to his/her desire for a less stressful, more fulfilling, and healthier life.

Facilitate the enhancement and/or development of effective coping skills

Within each Healthy Living Project session, the Client learns new or more effective ways to cope with life situations. The Facilitator must be mindful of the realities within the Client's relationship and environment(s) to guide the Client toward coping strategies that eliminate or at a minimum, alleviate stress, anxiety, and negative feelings/experiences.

Facilitate effective problem solving

Another skill built into every Healthy Living Project session is the practice of identifying specific problematic issues. The Facilitator assists the Client to develop a "menu" of alternative solutions to identified problems, evaluating each for the emotional, physical, financial, relationship, and/or personal cost or benefit. Woven within this problem-solving process is the self-reflection, analysis, and realization of the Client's values, emotions and attitudes, abilities, and goals that influence coping and behavior choices.

Facilitate positive interpersonal relationships

The Facilitator assists the Client to evaluate the multi-dimensional and layered relationships that make up his/her social networks. Communication and negotiation activities focus the Clients to assess the positive or negative impact others have on his/her life quality. The Facilitator guides the Client in the decision-making process on closure or improvement of existing relationships, and development of positive, supportive relationships.

Facilitate the Client's future growth and development

The structure of the Healthy Living Project is based on skills development and practice. The safe environment and trusting bond created between Facilitator and Client provides the opportunity to try out new roles without fear of failure or judgment. The Facilitator introduces a skill, assists with and encourages development or enhancement, and provides consistent positive reinforcement for any and all progress. The ultimate facilitation goal is for the Client to leave with a fully integrated repertoire of effective coping and behavioral skills.

FACILITATION CHARACTERISTICS

While many facilitation characteristics are general, there are several areas important to mention as they relate specifically to people living with HIV.

Non-Confrontational Style

One basic aspect of the Facilitator-Client relationship more specific to working with people who have HIV infection is a sense of neutrality. Most mental health professionals recognize that being judgmental, confrontational, or having goals that are divergent from a Client's rarely result in positive outcomes. This is especially true for this program as it relates to sexual behavior and disclosure of HIV serostatus.

Although you may feel strongly that "people with HIV must not engage in sexual risk behavior" or "people with HIV infection need to disclose this to all of their sexual partners," these are very personal, and often very difficult choices. The underlying approach of the program is to help Clients develop the skills that will allow them to successfully change their behavior or disclose their HIV status when they are ready to do so.

We believe that confronting Clients about the "right" thing to do will only inhibit them from attending the program. However, through their involvement in the entire program, it is likely that many Clients will choose to reduce their behavior or will decide to disclose their serostatus to potential partners. The program will be of the most benefit to those Clients who complete all three modules and are encouraged to discuss their reservations about these issues in a non-confrontational setting.

Facilitator characteristics and working with people living with HIV

Excerpt from Kelly, J.A. (1995) Changing HIV Risk Behavior: Practical Strategies. The Guilford Press, New York, NY, pp. 26-28

"[POSITIVE] REGARD FOR THE CLIENT BEING COUNSELED

Clients or Clients in HIV prevention programs are only likely to 'connect' interpersonally with a counselor who is perceived as having positive regard for them and genuinely caring about their well-being. Gay men are likely to sense quickly a potential counselor's homophobia, IDUs will sense when a counselor holds them in disdain because of their drug use habits... Some counselors are of the same background as the individuals they counsel in HIV [secondary] risk reduction programs. HIV prevention programs for gay men, IDUs, adolescents, and poor women are often staffed by counselors of the same background in order to increase credibility and understanding of the target population. However, in our experience, it is usually not essential that the counselors be of the same background as the people they counsel, provided they appreciate and understand the life circumstances of the Client and hold Clients in positive regard. One exception to this pattern involves HIV [secondary] prevention with women, who are often more comfortable relating with a female counselor than a man about sexuality concerns.

COMFORT DISCUSSING SEX AND DRUG ISSUES

Few people, including professionals, are immediately comfortable discussing sexual practices and sexuality. Almost all of us grew up with, and usually still have, inhibitions about discussing intimate and explicit aspects of sexual behavior. However, unless a counselor becomes experienced, comfortable and at ease talking about sex, he or she will have a difficult time eliciting important information about Clients' risk behavior, discussing risk reduction at anything other than a superficial level, or genuinely helping Clients. Training in sexual behavior interviewing is critical for all HIV [secondary] risk reduction counselors, including training in the street vernacular of sex and drug use, to promote an understanding of sexual practices that are uncommon and not in the counselor's own background of experience and to desensitize counselors and reduce discomfort concerning frank discussions with Clients about sex. Even with such training and experience, there is considerable variability in people's comfort talking about sex. The most effective counselors are those able to discuss sex openly with Clients and who are nonjudgmental in these interactions.

ABILITY TO FORM AN ADVOCACY ALLIANCE

The process of helping people change works best when there is an alliance between the Client and the counselor characterized by very close interest of the counselor in the personal circumstances faced by the Client and a shared investment in helping the Client succeed. Effective [secondary] risk reduction counselors demonstratively convey that they are 'on the Client's side,' want the Client to succeed, and will work together to bring change about. This is a very engaged style of interaction much different than simply making [a secondary] HIV risk education presentation to Clients or dryly reciting a list of safer sex [or drug] practices. Clients respond well to counselors whom they sense to be personally interested and willing to work closely with them.

STRONG REINFORCEMENT SKILLS

A key ingredient in any successful behavior change intervention is the reinforcement—through praise, commendation, encouragement, and enthusiastic support—of an individual's behavior change efforts. People who disclose their [continued] HIV sexual and drug use risk behavior patterns are disclosing information about themselves that many people would judge negatively, and reporting of risk behavior is itself a statement that the Client does things that increase [continued] vulnerability for [transmission or re-infection] for AIDS. In addition to not being judged for these disclosures, it is critical that counselors have well-developed skills to praise and reinforce steps that Clients take in an effort to reduce strongly, consistently, and demonstratively. Building in lots of reinforcement when Clients take steps, even very small ones, to reducing risk is important to motivate change, encourage efforts, and help Clients overcome change barriers, and make sessions enjoyable and positive. Counselors should be attuned not to scold or criticize failures but instead to reinforce and support change efforts enthusiastically and to problem solve difficulties that Clients encounter constructively.

LISTENING SKILLS

An old adage among therapists is that Clients will disclose only superficial problems in early therapy sessions and will open up and talk about their real problems later and only if they develop trust for the therapist. In a similar way, people may not disclose everything about their risk patterns—especially those involving sex, stigmatizing, or what is perceived as socially undesirable behavior—in initial counseling. It's up to the counselor to set a nonjudgmental tone of acceptance of and concern about the Client to facilitate honesty. But, accurate listening skills are also critical if one is to piece together a picture of the personal, relationship, and situational circumstances that are contributing to an individual's [continued] risk."

FACILITATION TECHNIQUE

Role Plays

Role-plays are used extensively in small group prevention programs. This effective technique enables Clients to enhance communication, negotiation, and problem-solving skills through practice in a safe environment. Working with one another, Clients recreate life situations in order to develop realistic, alternative solutions to sensitive (and sometimes aggressive or hostile) issues. The Facilitator's role is one of observation and guidance as he/she sensitively shapes the Clients' behavior toward assertive verbal and non-verbal communication.

The one-on-one relationship of the Healthy Living Project Facilitator and Client requires the same skills. Due to the very personal and sensitive issues, particularly in Module 2, Facilitators may choose to vary their approach to role-plays. Transference is a possibility in any one-on-one professional relationship. Facilitators should not automatically take an active part in role plays which address issues of sexual and/or drug use behaviors. Some Clients may have difficulty distinguishing or choose to not differentiate between role and reality. Suggested variations include:

Question/Answer

The Facilitator begins the "role play" by asking the Client what he/she would say in the identified situation. After responding, the Facilitator briefly summarizes and asks the Client how the other individual might respond. This allows the Client the opportunity to reflect on possible reactions. The Facilitator acts almost like a director, paying attention to the verbal communication, the body language, inflection, eye contact, and comfort level of the Client as he/she assumes both roles. This question/answer format continues until the Client has identified the most reasonable approach to the situation.

The Empty Chair

Commonly associated with Gestalt counseling, the empty chair technique provides the Client with an opportunity to act toward another person imagined sitting in the empty chair. The Client is instructed to speak directly to the identified individual as though they were really sitting in the chair across from the Client. The Facilitator then asks the Client to sit in the empty chair and assume the role of the identified person, and respond accordingly. Role reversal allows the Client to gain insight into his/her communication style, negotiation abilities, and interpersonal skills. The Client alternates chairs and roles until he/she is comfortable with the resolution of the problematic situation. This technique is used to enhance desired communication/behavioral skills, replace ineffective approaches, and to practice new roles within current relationships.

Use of Silence

Silence is a very effective, yet little-used technique. Often this is due to the discomfort of the Facilitator with lapses in conversation during the limited time with the Client. It is important during the both the Skills-Building and Problem-Solving components of this intervention to allow the Client time to reflect on his/her life context relative to the session focus.

Excerpt from George, R.L. and Cristiani, T.S. (1990) Counseling: Theory and Practice. Prentice Hall, Inc., Englewood Cliffs, NJ, p. 150

"Clients need opportunities to explore their feelings, attitudes, values, and behaviors; initially they need someone to listen, even passively, to what they wish to share." "...but if the counselor can become sensitive to the various meanings of silence and skillful at handling these pauses, these silences can prove very useful. First, silence lets Clients know that the responsibility for the interview lies on their shoulders." "Second, silence allows Clients to delve further into thoughts and feelings and to ponder the implications of what has transpired during the session. Clients need this time to reflect and process without feeling pressured to verbalize every thought and feeling."

III. SESSION COMPONENTS

CHECK-IN

The first segment of each session is labeled “Check-In.” The main purpose for Check-In is to incorporate contextual themes as the Facilitator assesses how the Client is doing on the goals he or she has set in previous sessions, including the Client’s Life Project (described below). This time is also an opportunity to discuss the Client’s general concerns and/or well-being transitions into the main activity of the sessions.

Life Project

As people begin to come to terms with a chronic, life-threatening illness, questions pertaining to the meaning of life inevitably arise. Many patients begin to struggle with religious and philosophical perspectives that often give rise to new perspectives on one's meaning, purpose, and value in life. Through this experience, many people begin to examine what is really important to them and devote their energy to it. Some people begin to devote time and energy to projects that allow them to fulfill life-long goals. This often has the effect of giving people a sense that their life is important and has meaning which tends to enhance quality of life.

Developing a Life Project requires the individual to take stock of the finite amount of time they have left and decide what they want to accomplish. Part of this process is learning how to separate the "trivial" from the "important." This is a very powerful process because it can assist someone in enriching his or her life and accomplishing things he or she might not otherwise have attempted. Another important aspect is that the process can reduce anxiety regarding death.

In the context of the Healthy Living Project, the Life Project exercise serves three other important purposes:

- First, the Life Project gives the intervention a broader focus. Instead of addressing HIV related issues only, Clients have a supportive environment in which to generate and strive for goals that may not be related to HIV infection, and have the opportunity to discuss challenges and celebrate successes in meeting these goals. Although the Life Project need not be HIV-related, the skills and techniques used in the intervention to address HIV-related concerns (i.e., problem-solving, improved coping, goal setting), will be useful for most Clients' pursuit of these broader Life Project goals.
- Second, the Life Project, which is introduced in the first session, and is discussed at the beginning and end of all subsequent sessions, provides a positive way to build rapport with Clients and to allow extensive tailoring of the intervention to each Client’s life context so that the intervention does not seem too manualized or scripted.

- Finally, the Life Project may serve as a motivational factor for some Clients, in that in order to attain their Life Project goals they will need to attend to the mental and physical health aspects of the Healthy Living Project intervention in order to be healthy enough to move forward. This will not be obvious to all Clients, but Facilitators can make this point salient.

Facilitating the Life Project

It may be difficult for some Clients to identify goals for the Life Project. Issues that often come up and are "road blocks" to successfully implementing the Life Project exercise are related to low self-esteem, fear of failure, difficulty articulating a dream that has long been "deferred," and difficulty articulating what is really important enough to warrant significant action to attain it.

For these reasons, it is important for the Facilitator to convey an appreciation for the value of developing life goals, while at the same time not forcing the Client to revise the goals he or she generates. For example, a statement like "That's a tremendous accomplishment that you scheduled a trip to visit your friend" compared to "Are you sure you want to take a trip right now when you are struggling with trying to reduce your viral load?"

To help Clients generate Life Project goals, the Facilitator will need to assist in identifying core values, resources, and goals which provide enjoyment, fulfillment, and meaning. A real skill in this process is allowing the person to "brainstorm" and be creative about what is meaningful to them while at the same time providing enough structure so that the person can identify a goal they would like to begin working toward.

It is important to realize that goals that seem very modest to most people may seem very challenging for some Clients. For example, a Client who is homeless and an IDU may simply want to find stable shelter and food. It is not necessary that the Life Project goals be lofty, although goals such as having a poem published or writing an autobiography have emerged in the past. Whatever the goals identified for the Life Project, the skills and strategies taught in the intervention will likely be useful for them as well.

Once the Life Project goal or goals have been identified initially, the beginning of each session starts with a discussion of progress made toward achieving the goal. The Facilitator should elicit the steps that were taken to achieve the goal, being sure to give positive reinforcement for even the smallest amount of effort. Challenges to reaching the goal should be discussed. The Client's reaction to successes or challenges should also be discussed.

At the end of each session, discussion again focuses on the Life Project. At this point, Facilitators should help Clients to decide what they need to do next. This could entail breaking down the Life Project goal into sub-goals which can be achieved more readily, practicing skills necessary for achieving the goal (e.g., role-playing a conversation), discussion of how achieving the goal may change his or her life, or revising the Life Project goal. The Facilitator should consistently encourage the Client and convey a sense of importance about the Life Project.

The Life Project is an evolving process. Goals, and the entire focus of the Life Project, will likely change as Clients begin to work on them. Once a particular goal is achieved, Clients should be given the opportunity to set new goals, and the Client-Facilitator collaboration should begin anew.

Transitioning to Session Content

As part of the transition to the main activities of the session (i.e., skills-building and problem-solving), Facilitators should begin by discussing how the topic of the session (e.g., stress, sexual relationships, medications) impacts the Client's life. This can be accomplished by helping the Client to describe what the particular topic "means" to him or her. This Client-led discussion can be on many levels, from very concrete and practical to abstract and philosophical. Facilitators can then use the Client's "meaning" to tailor the content of the session to fit the needs of each Client. Facilitators can get a sense of the range of "meanings" reported by people with HIV on different topics by reading the "Contextual Issues" section of this Guide. Prompts to initiate this discussion are provided for each session in the Intervention Manual.

SKILLS-BUILDING

Following the Check-In, each session includes an activity to help participants build relevant behavioral skills. Because each session includes a different activity, we describe only the general techniques that apply to most of the activities in this section. Explicit activity instructions for each session are included in the next section, entitled "Session Activity Instructions" (pages 24–42 of this Guide).

One of the foundations of the skills-building component is trigger identification. Triggers, cues, or antecedents are terms that refer to those events or factors that influence behavior.

Antecedents and Positive Reinforcement

Excerpts from Watson, D.L. & Tharp, R.G. (1993). Self-Directed Behavior: Self-Modification for Personal Adjustment. Brooks/Cole Publishing Co., Pacific Grove, CA, pp. 117 and 133.

*"Throughout our lives, most of our actions are controlled by **cues** (signals). ...In any hour of our lives, the environment provides thousands of cues. The world is rich with stimuli—conversations, sounds, sights, events, smells—and our behaviors are orchestrated into this complexity... A cue identifies the conditions in which an action will or will not be reinforced. It is a cue that helps us discriminate conditions when the behavior will be followed by reinforcement from other conditions when the behavior will not be followed by reinforcement.*

Role of Antecedents in Avoidance Behavior and Extinction

To avoid an unpleasant outcome, you have to know that such an outcome is about to occur. This means that your avoidance behavior is guided by the antecedents—the cues—you get from your environment. If your avoidance behavior is successful, the unpleasant event does not occur.

Identifying Antecedents

An effective plan for self-improvement depends on accurate discovery of your current systems of cues. Discovering antecedents is the first task in designing an effective plan."

Identifying Triggers/Stressors/Barriers/Challenges

Identifying antecedents is part behavior self-monitoring and part detective work by the Client. Clients often initially provide global reasons for a resulting behavior or state of mind. It is the Facilitator's responsibility to assist Clients to specify antecedent factors associated with the challenge in question.

Module 1

If the issue is a Client's stress, as in Module 1, the Facilitator might ask the Client to close his/her eyes and picture a recent stressful situation. The Facilitator then Guides the Client through the events, thoughts, feelings, and underlying beliefs, and physical reactions (e.g., racing heartbeat, sweaty palms) which may have influenced the stressful reaction.

It is important to allow enough time to probe for the "who, where, what, when, and how" of the situation as well. Clients may feel more stress if they encounter new or different situations alone, perhaps large crowds increase their stress level, or it may be a particular situation that causes stress (job interview, assertive communication with a co-worker or family member, attempting to complete a task when tired or distracted by personal problems). It is most helpful if the Client can recall several other stressful occasions, as triggers may generalize across situations.

Example of Module 1 stressor

The Client states, "I worry about money all the time." The Facilitator might begin by asking the Client, "When was the last time you worried about money?" Since the Client stated he/she worried about money all the time, this may be an important indicator of the severity or level of anxiety. Additional probes could include:

- Where was the Client when he/she began worrying (e.g., at home, in a store, what kind of store [food, clothing, music, etc.]
- What did the Client experience physically (e.g., shortness of breath, sweaty palms, light headed)
- What did the Client experience emotionally (e.g., panic, tearful, anger, sadness)
- How did he/she get past the worrying state last time (e.g., leaving where he/she was with/without purchasing anything, engaged in another activity, relaxation exercise, threw things, cried, yelled at someone)
- What was his/her biggest specific worry ("running out of money" is not specific enough; the Facilitator needs to probe further for the Client's definition of "running out" to determine if this is a realistic concern).

Further probes might include areas surrounding past experience with money shortages, if yes, how did the Client handle those past experiences. If the Client says "no," how could he/she plan ahead to ensure a shortage of money may not happen again.

Module 2

Triggers that may influence risky behavior are most often related to the categories of "People, Places, Moods/Feelings, and Substances." Module 2 of this intervention deals specifically with risky sexual and needle use behaviors.

Clients can often readily define those **People** or qualities of people that may influence them toward risky behavior (e.g., an ex boy/girlfriend, spouse or significant other, great eyes, a good body, provides easy access to drugs, perceived wealth or power).

Places are often identified as bars, drug houses, dance clubs, beach, an apartment or home, parks, or a party.

Moods and feelings is a more complex and multi-layered category. Often one thinks of one of the more positive moods or feelings as a contributing factor that may lead to risky behavior (feeling good about oneself, celebratory, self-reward). Negative emotions are powerful influences on behavior as well. Low self-esteem, depression, anger and revenge may propel an individual toward participating in risky behavior (e.g., "He/she cheated on me—now I'll show him/her," "Nothing in my life is going right—but he/she seems to be interested in me").

Substances should not be limited to a definition of alcohol or drugs. Other influencing substances can include cologne/perfume, music, candlelight, warm breezes, smell of an ocean/lake, food, etc.

Example of Module 2 trigger

Risk behavior triggers are often multi-layered and inter-related. The Client might be asked to describe the last risky encounter. This approach works best with Clients who acknowledge behaviors of continued risk. An alternative technique would be to ask the Client to close his/her eyes and describe the ideal romantic encounter.

The Facilitator may need to probe for specifics in each of the identified categories:

- "Who are you with, could you describe what he/she is wearing?"
- "What do they smell like—cologne, perfume, shampoo, earthy?"
- "What about this person attracts you?"
- "Describe how you're feeling when you see, think about being with, or are actually with this person."

- "Where does this romantic encounter take place?"
- "Describe what else is going on—is there music, alcohol, drugs, what are the sounds you hear, is it warm or cool where you're describing."

Module 3

The reflection technique used in Module 1 is also applicable to addressing difficulties with adhering to a medical/personal health regimen as in Module 3. The Client is asked to visualize the most recent (or last several) occasion(s) when he/she skipped a dosage, missed an appointment, didn't exercise, did not choose a nutritious meal, etc. The Facilitator guides the Client through the "who, what, where, when, and how" of the situations in as much detail as possible.

Example of Module 3 barrier/challenge

The Client states, "I'm worried about my health." The Facilitator will want to probe for a specific example of health-related issues or situations. The Client may report a sore throat and has concerns about seeing the doctor. The Client might be asked to visualize the last time he/she visited his/her physician, and detail that appointment, (e.g., time of day—early morning appointments might indicate anxiousness the evening before, tiredness, no time to eat breakfast, transportation issues, etc.).

Other probes might include:

- Where is the clinic in relation to the Client's residence
- What is the atmosphere in the clinic; whom the Client sees first (receptionist, nurse, physician)
- How did the Client feel during those personal interactions
- What about the appointment was most stress producing (the waiting room, having blood drawn, waiting in the examining room, waiting to hear lab results, getting lab results, asking questions [of whom specifically])
- How did the Client feel during that experience (heart pounding/racing, palms sweating, a "trapped feeling," light-headed, anxious, panic, etc.)
- What did the Client believe might happen (would receive bad news, would be ignored/disrespected by clinic personnel, would forget to ask questions)

The Facilitator records identified triggers/stressors and assists the Client to assess the impact of each on the target behavior. After prioritization, the Client is ready to move on to problem-solving how to handle the triggers/stressors within the context of his/her life.

PROBLEM-SOLVING

The problem-solving process is analogous to a dining experience. The Client often "comes to the table" with the belief that the only choice (solution) is the meal that is being served (solutions they have used in the past). The Facilitator's role is to assist the Client in developing a menu of potential solutions.

It is important for the Facilitator to make the Client aware of how often during any given day he/she solves problems and makes decisions based on that process. To come to today's appointment, the Client had to:

1. Show up on the correct day and time
2. Be dressed appropriately
3. Arrange for transportation

Each of these actions involved a problem-solving process although it took place with little awareness. For example, it requires that the Client write down the appointment on a calendar or keep an appointment card somewhere convenient, set their alarm, and arrange their daily activities around the appointment time. Decisions surrounding dressing appropriately meant determining what is appropriate for this particular appointment—bathing suit, evening gown, no shoes, etc. Arranging for transportation requires consideration of a variety of options—car, taxi, subway, car service, friend drives, bus, etc. Normalizing the problem-solving process, and formalizing the steps as described below eliminates the possible fear or stress of learning a new skill.

Developing the Steps

The problem-solving process always follows the same format and becomes a precursor for the session goal setting:

- 1. Identify the trigger, stressor, barrier, or challenge.** The Client has just been guided through trigger identification and prioritization. The Client should choose one trigger to problem solve.
- 2. Determine the goal.** The Facilitator should assist the Client to clarify the goal to be realistic within the Client's life context.
- 3. Brainstorm alternative solutions.** This begins the development of the "menu" approach to problem-solving. The Facilitator may initially need to model generation of alternatives. The Client should be encouraged and reinforced for any and all participation in this process, particularly in the early stages.
- 4. Evaluate those solutions.** Client should review the solutions generated, and determine those which seem most appropriate to his/her life context.
- 5. Choose the most appropriate and best solution.** Client should prioritize those solutions deemed most appropriate.

6. Develop an action plan. Development of a step-by-step plan of how the goal may be successfully completed.

7. Act. If after the plan has been developed, the Client determines he/she cannot act on the steps, another alternative should be considered.

Sample Problem-Solving Issues

Module 1: Stress and Coping

- Identified stressor: stress of living on SSI funds

- Goal: To develop a realistic weekly budget

- Alternative Solutions

1. Write down all expenses

2. Prioritize expenses

3. Record when stress level increases around money issues (daily, weekly, monthly)

4. Record emotional and physical responses to money related stress (feelings of panic, depression, anger, increased heart rate, etc.)

5. Develop a list of enjoyable activities that cost little or no money

Module 2: Risk Behaviors

- Identified trigger: alcohol use

- Goal: To decrease the number of drinks on Friday and Saturday nights from six a night to four

- Alternative Solutions

1. Take only enough money for a specified number of drinks

2. Go to a different club or bar

3. Use the "buddy system" with a friend who will watch the number of drinks consumed

4. Go out only one evening during the weekend

5. Alternate between non-alcohol and alcohol drinks

Module 3: Health Behaviors

- Identified barrier/challenge: asking my physician questions about my health/treatment
- Goal: To increase comfort of asking at least two questions at my next appointment.
 - Alternative Solutions:
 1. Practice assertive communication in the mirror
 2. Practice assertive communication and question asking with a friend or family member
 3. Write questions down before medical appointment
 4. Call the clinic and let staff know that you would like a little extra time at your next appointment to ask the physician questions
 5. Write the questions down and mail them to the physician before your next appointment

WRAP-UP

Goal Setting

Goal setting is a process throughout which the Facilitator guides and encourages the Client to begin making self-determined, positive changes in behavior. It is like an informal contractual plan with the Facilitator in which the Client specifies how he/she will work on an identified issue between sessions.

One of the most important functions for the Facilitator is to ensure that the Client develops goals that offer opportunities for success. There is often a great deal of enthusiasm about what has been discussed in a particular session and the Client may suddenly want to do and try everything immediately.

Goal setting offers the opportunity to try out new skills within the supportive facilitative environment. Barriers to success can be discussed, and more effective alternative solutions suggested. Every attempt to reach a goal, no matter how small, must be positively reinforced as a great learning experience. The ultimate purpose of the exercise is to increase successful and lasting change in behavior. This individualized building process requires the careful attention of the Facilitator to help tailor goals both in focus and difficulty.

General Guidelines

- Listen carefully to your Client throughout all sessions. Information and experiences shared by the Client about stress and coping in Module 1 may influence how realistic a goal of disclosure may be in Module 2, or asking questions of a physician in Module 3.
- Consider the Client's discussion of "meanings" and prior life experiences when guiding the goal setting. This exercise must be tailored to the gender, cultural, and life context of the individual to be truly meaningful and effective.

- The Facilitator must assist the Client to identify and define each goal as:
 - Realistic—one that can reasonably be expected to be completed between sessions
 - Clear—so that the Client understands exactly what steps must be taken to successfully complete the goal
 - Not too easy and not too hard—the goal should be challenging, but not impossible or too global
 - Have a clear end point—the Client should know when a goal has been successfully completed

After the Client has decided on a goal, the Facilitator may want to ask him/her to rate his/her level of confidence for achieving the goal on a scale from 1 (low) to 10 (high). An appropriate goal should be rated somewhere around the middle—not too easy and not too hard.

Goals should gradually increase in difficulty. If a Client attempts to set unrealistic goals, the Facilitator should assist him/her to set sub-goals toward the realization of more global goals. Should the Client want to set a goal that requires the participation and/or cooperation of another person, a back-up goal that can be accomplished alone should also be developed. A Goal Card should be completed at the end of each session. The Client should take the Card with him/her, and the Facilitator should record this goal on the Goal Recording Sheet (see the “In Every Session” section of the Intervention Manual).

Sample Goal Setting

Module 1: Stress and Coping

- Identified stressor: stress of living on SSI funds
- Goal: To develop a realistic weekly budget
 - Session Goal: Keep a written record of all money spent for the next week
 - Session Goal: Record emotional and/or physical reactions to money issues for the next week
 - Session Goal: Write down enjoyable activities that cost little or no money

Example Stress and Coping Goals

- Client is worried about keeping up with household chores**
 - List and prioritize household chores
 - Focus on cleaning just one room per day
 - Divide or delegate some chores to partner and/or children
 - Investigate volunteer services which might help with light housework
 - Request assistance from family members and/or friend

- **Client is afraid that there will not be enough money at the end of the month for food**
 - Make a weekly menu
 - Shop once a week (shopping list is developed from the menu)
 - Investigate assistance from a food pantry or cooperative market
 - For one week, write down every time you eat out (including fast food and purchase snacks)
 - Cook meals in larger quantities and freeze for future use
- **Client is worried about re-entering the workforce after not having a job for over one year**
 - List those skills developed while being out of work that are transferable to employment
 - Write or update résumé
 - Read the Employment section of the newspaper and circle jobs which sound interesting and for which you are qualified
 - Investigate opportunities with a temp service
 - Practice interviewing for a job with a family member or friend
- **Client is angry that future goals or plans may not be realized**
 - List what you most value in life
 - List what you have accomplished thus far
 - List those qualities you want people to know most about you
 - Write down one future goal or plan you hope to accomplish
 - Identify barriers you perceive to accomplishing the identified future goal or plan
- **Client is fearful of facing his/her parents and/or friend(s), lover, partner, children, since his/her HIV status was disclosed over the phone**
 - Practice in the mirror what you would like to say to this person
 - Talk with a close friend or family member who is familiar with the other individual
 - Write the person a letter expressing your feelings, hopes and desires, but do not mail it

- Write down what you anticipate could be the worst scenario and problem-solve how to handle it
- Think about the last time you may have been fearful of facing someone and reflect on how you handled it

Module 2: Risk Behaviors

- Identified trigger: Alcohol
- Goal: To decrease the number of drinks on Friday and Saturday nights from six a night to four
 - Session Goal: Go out only one night this weekend (either Friday or Saturday)
 - Session Goal: Go out to the bar/club only if a friend (who knows of my goal) goes along
 - Session Goal: Keep a record (on a small notebook) of how many drinks with alcoholic and without alcohol I actually have during an evening

Example Sexual Risk Goals

- **Client is not currently sexually active**
 - Become comfortable handling/identifying different types of condoms
 - Learn where to purchase or obtain condoms and actually purchase female or male latex condoms
 - Practice insertion and removal of the female condom and/or correct placement of a male condom
 - Practice (in the mirror) how to introduce a condom to someone you want to have sex with, including assertively responding to possible objections
- **Client is currently sexually active, but has no experience with condom use**
 - Become comfortable handling/identifying different types of condoms
 - Learn where to purchase or obtain condoms and actually purchase female of male, latex condoms
 - Practice insertion and removal of a female condom and /or correct placement of a male condom
 - Practice (in the mirror) how to introduce a condom to someone you want to have sex with, including assertively responding to possible objections

- **Client is currently sexually active and has access to condoms**
 - Discover new places to have condoms easily available
 - Create "sexy" situations that include using a condom
 - Practice insertion and removal of a female condom and /or correct placement of a male condom
 - Practice (in the mirror) how to introduce a condom to someone you want to have sex with, including assertively responding to possible objections
- **Client is currently a sex industry worker**
 - Identify location/resources for free condom access
 - Discover new places to have condoms easily available
 - Practice insertion and removal of a female condom and /or correct placement of a male condom
 - Practice early insertion of the female condom
 - Practice (in the mirror) how to introduce a condom to someone you want to have sex with, including assertively responding to possible objections

Module 3: Health Behaviors

- Identified barrier/challenge: asking my physician questions about my health/treatment
- Goal: To increase comfort of asking at least two questions at my next appointment.)
 - Session Goal: Write down two concerns about my current health/treatment
 - Session Goal: Role-play assertively asking two health/treatment related questions with at least three friends or family members in the next week
 - Session Goal: Write down at least six questions that I would like to ask my health care provider

Example Adherence Goals

- **Client is fearful of going on medication**
 - Write a list of pros and cons for taking combination medication
 - Schedule a special appointment with my physician to discuss going on a combination therapy
 - Talk with someone who has been on combination therapy
 - Take "candy" pills to experience the medication regimen (number of pills per dose, number of times per day, following any special instructions, etc.)

- **Client has minimal knowledge of his/her medication**

- Make a list (or ask a family member or friend to make a list for me) of all medications including how many pills per dose and number of times per day they are to be taken, and any special instructions
- Write down questions (at least one question per medication) about my medications
- Schedule a special appointment with my physician to discuss my questions
- Ask a family member or friend to attend my next appointment with me (to help me remember information or ask questions about my medication)

- **Client has no affiliation with a health care system**

- Make a list of the benefits of entering the health care system
- Research the location for the most convenient health care providers
- Research how to develop a relationship with a health care provide.
- Make a list of the reasons I have not wanted a relationship with a health care provider

- **Client has difficulty making health care appointments**

- Research alternative transportation (family members, friends, subsidized health care vans or car services, public transportation schedules and routes) for getting to my appointments
- Think of the last missed appointment, and write down the reasons I was unable to get there
- Reschedule my next appointment for a day and time more convenient for my daily schedule
- Post reminders of the appointment date and time in several locations (refrigerator, calendar, dresser mirror, bathroom mirror, keep with medication, etc.)
- Ask a family member or friend to remind me of my appointments

- **Client has difficulty maintaining medication regimen**

- Use a weekly pill box that has day of the week and time of day indicators
- Keep medication in a convenient location (kitchen table, bathroom, next to bed, etc.)
- Make copies of the medication schedule and keep in several locations (post on bedroom or bathroom mirror, keep under pill box, next to the TV remote, etc.)
- Reward myself with _____ each week that I maintain my medication regimen

Life Project Review

- The last part of each Wrap-Up is devoted to discussing the Life Project. When a goal was not accomplished, it is important to review what happened and assist the Client to identify barriers to successful completion. These barriers may impact how the next goal is defined.
- Reinforce any and all attempts to accomplish the goal. If the Client admits to not working on the goal, reinforce the positive aspects of the goal definition process. Even contemplation of change is movement in the right direction. The valuable lesson learned in each goal setting exercise enhances the Client's ability to define more realistic future goals within his/her life context.

IV. SESSION ACTIVITY INSTRUCTION

MODULE 1

Session 1 Activity—"Life Context Form"

This activity is designed to help the Facilitator get a sense of the Client's background and current life issues, as he/she enters this program. Though much like an "intake" in many ways, it is not a full therapeutic intake session. Much of this will entail gathering demographic information, but it will also be important to note the personal strengths and challenges the Client perceives related to each area. In addition, it may be helpful for the Facilitator to reassure the Client that this information will be kept completely confidential and is only for the Facilitator's reference during these sessions. This activity will not only give the Facilitator relevant information on the Client's background, but will also be an important way for the Facilitator to begin building the rapport and trust that will be the foundation of his/her interactions with the Client throughout all 15 sessions.

The image shows two overlapping forms. The top form is titled "ACTIVITY: LIFE CONTEXT FORM" and contains sections for "PHYSICAL/MEDICAL HISTORY", "PSYCHIATRIC HISTORY", "SUBSTANCE USE/ABUSE HISTORY", "STRESS/DISCRIMINATION EXPERIENCES", and "CHOICES". The bottom form is titled "CLIENT'S CURRENT LIVING SITUATION" and contains sections for "CLIENT'S CURRENT LIVING SITUATION", "SOCIAL AND PROFESSIONAL RELATIONSHIPS", "BACKGROUND AND FAMILY HISTORY", "HOBBIES AND INTERESTS", and "CHOICES". Both forms include a footer with "MODULE SESSION 1" and the number "6".

Using the "Life Context Form" (pages 5 and 6 of the **Intervention Manual**), probe for relevant information regarding the Client's life—history, experiences, living situation, relationships, family, education, work, etc.

Any additional information gleaned from this session should be noted in the Session Notes, and will be kept, along with the "Life Context Form," in the Client's file, so that you can refer back to it in future sessions.

Session 2 Activity—"Personal Stressors List"

The image shows a form titled "ACTIVITY: PERSONAL STRESSOR LIST". It consists of a header section followed by a large area with horizontal lines for writing. At the bottom, there is a footer with "CHOICES" and "MODULE 1 SESSION 2 12".

After discussing stress and its impact on the Client's life, use the "Personal Stressors List" (page 12 of the **Intervention Manual**) to help the Client make a list of as many of the current life stressors he/she can identify. This list can include anything the Client finds stressful—or contributing to his/her feelings of stress—from the very broad to the very specific. You might encourage the Client to list whatever comes to mind, without evaluating, prioritizing, or filtering any of it out yet. Record each item the Client names on the worksheet.

Session 2 Activity—"Personal Stressors Worksheet"

STRESSOR	CHANGEABLE	UNCHANGABLE	REASONS WHY
1. General			
Stressor			
A.			
B.			
C.			
D.			
E.			
F.			
2. General			
Stressor			
A.			
B.			
C.			
D.			
E.			
F.			

Using the "Personal Stressors List" as a starting point, assist the Client in choosing one or two of the more general stressors on the list (i.e., broad enough to be broken down into specific stressful factors or situations). The stressor(s) chosen should be personal in nature and directly impact the daily functioning of the Client, resulting in symptoms of anxiety or depression.

- General stressful conditions are often described in BIG terms, like always, everywhere, or everyone. Some other good examples might include "my health" or "my relationship with my mother."

Once the Client has identified one or two of these broad or general stressful conditions, assist him/her to narrow them down into smaller, more manageable, specific stress factors or stressful events, using the "Personal Stressors Worksheet" (page 13 of the **Intervention Manual**).

- One way to narrow the scope of a general condition is to ask questions that begin with who, what, where and when. In this way, a general, global stressful condition may be broken down into specific stressors, which can then be dealt with individually. For example, the general stressful condition, "Being infected with HIV," could be broken down into:
 1. Finding out my T-cell count dropped below 100
 2. A sore throat which I fear could be an opportunistic infection
 3. Thinking about who will care for my children if something should happen to me," etc.

Assist the Client in deciding what is changeable about the specific stressor and what is unchangeable. Using the "Personal Stressors Worksheet," explore the Client's perception of what makes the stressor changeable or unchangeable.

- Questions like, "What can I do to change the situation?" "What can someone else do to change the situation?" or "What can be done to avoid or eliminate the situation?" will reveal changeable or unchangeable aspects of the stressor.)

Ask the Client to describe how his/her thoughts impact moods and perceptions of the identified stressors as changeable or unchangeable. List the reasons in the "Reasons Why" column on the "Personal Stressors Worksheet."

Session 3 Activity—"Stress and Coping Worksheet"

Coping is what individuals do in response to situations that they perceive to be stressful. It can be internal, in the form of thoughts, or can be external, in the form of actions. The overarching question that determines the range of adaptive coping options is whether or not the outcome of the situation can be changed. The range of options is also influenced by the person's resources for coping, including social, material and physical resources.

Coping has two main functions:

1. It can help address the problems that give rise to stress (problem-focused coping).
2. It can help regulate feelings that arise from stress, including anxiety, anger and sadness (emotion-focused coping).

In general, the best fit occurs when people use problem-focused coping in situations that are changeable and use emotion-focused coping in situations that are not changeable. Stress management strategies, then, can be categorized as primarily problem-focused or emotion-focused.

Review Client's "Personal Stressors Worksheet" (from Session 2). Discuss Client's current coping strategies for handling stressors. These strategies may include exercise, relaxation techniques, substance use, leaving the situation, social support, others.

Discuss Principles of Emotion-Focused vs. Problem-Focused Coping Strategies with Client:

Emotion-focused strategies are mainly used to deal with aspects of the stressor situation that are unchangeable and are intended to help the person to feel better, especially in unsolvable situations. They don't help to solve the particular problem, but rather, address how one feels about not being able to solve it. Some examples of this type of coping strategy are:

- Humor (films, cartoons, laughing exercises)
- Downplaying the importance of the situation
- Confiding in someone close; diverting attention by working on another task
- Physical techniques to reduce distress (exercise, jogging, meditation, etc.)
- Looking for the positives in the situation
- Accepting the situation
- Using substances (prescription drugs, alcohol, cigarettes, recreational drugs, etc.)
- Hugging
- Looking for what was learned from the situation; "retail therapy," etc.

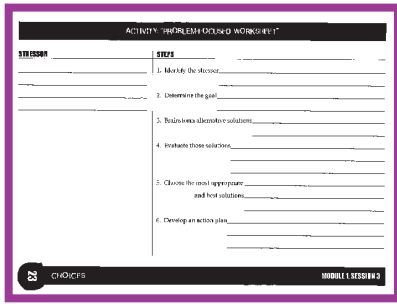
Problem-focused strategies are used when the situation or an aspect of the situation can be changed. They emphasize the development or enhancement of problem-solving skills for use in changeable situations (i.e., communication, decision-making and negotiation). Some examples of this type of coping strategy include:

- Getting more information
- Asking someone for help
- Changing your mind, etc.

After discussing the differences between these two types of coping strategies, refer back to strategies already identified by the Client as his/her personal coping strategies to determine his/her personal coping style. The purpose of this discussion is to make the Client aware of any potential imbalance between use of emotion-focused vs. problem-focused coping strategies. Some people may show a definite tendency toward one style or the other; others may already be employing both types of coping strategies. Guide the Client toward recognizing any imbalances in his/her personal coping style.

Using the "Stress and Coping Worksheet" (**page 20 of the Intervention Manual**), choose a few stressors from the Client's "Personal Stressors Worksheet" (from Session 2) and write them in the "Stressor" column on the Worksheet. Ask the Client to determine whether the most appropriate coping strategy for each stressor should be Emotion-Focused or Problem-Focused and record that on the Worksheet, along with the Client's reasons for choosing one strategy over the other. Remind Client, as needed, that whether the stressor is changeable or unchangeable determines which coping strategy is most appropriate.

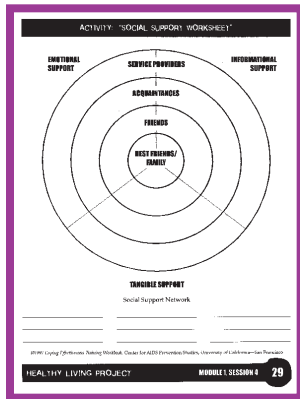
When the "Stress and Coping Worksheet" has been completed, assist Client to choose one unchangeable stressor from that Worksheet and using the "Emotion-Focused Worksheet" (**page 22 of the Intervention Manual**), problem-solve for that stressor. The Worksheet will take you through the problem-solving steps.



Then, assist the Client to choose one changeable stressor from the "Stress and Coping Worksheet" and to problem-solve for that stressor, using the "Problem-Focused Worksheet" (page 23 of the Intervention Manual).

As time allows, assist Client in additional problem-solving for other life stressors, utilizing emotion-focused or problem-focused strategies.

Session 4 Activity—"Social Support Worksheet"



Background: Using the "Social Support Worksheet" (page 29 of the Intervention Manual), discuss the three types of social support:

- Emotional—words and actions that make a person feel cared about, understood, and affirmed. May include empathy, caring, love, and trust.
- Informational—information, advice, or suggestions
- Tangible—money, labor, assistance, etc.

Discuss positive vs. negative social support:

- **Positive social support** enhances the Client's ability to make healthy choices, feel better about himself/herself, etc.
- vs.
- **Negative social support** encourages self-defeating thoughts, feelings, and behaviors.

Discuss the impact of the Client's mood on his/her ability to develop or maintain positive Social Support.

Using the "Social Support Worksheet," assist Client to identify his/her personal social support network; as well as which members Client believes would be most appropriate for each support category.

Activity—"Personal Stressor Worksheet"/"Social Support Worksheet"

Using the "Personal Stressor Worksheet" (from Session 2), assist Client to determine which support category is most appropriate for each of the stressors identified on the worksheet.

Then, using both the "Personal Stressor Worksheet" and the "Social Support Worksheet," assist the Client to determine individuals in his/her social network(s) who would be most appropriate to provide support for each stressor.

MODULE 2

Session 1 Activity—"Continuum of Risk"

ACTIVITY: CONTINUUM OF RISK

LITTLE OR NO RISK SLIGHTLY RISKY SOMEWHAT RISKY RISKY VERY RISKY

LITTLE OR NO RISK SLIGHTLY RISKY SOMEWHAT RISKY RISKY VERY RISKY

CHOICES MODULE 2, SESSION 1

After discussing the Client's attitudes and beliefs regarding transmission routes and risky behaviors, assist him/her to complete the "Continuum of Risk" (arrow) worksheet (page 42 of the **Intervention Manual**).

It may be easiest to begin with the generic examples listed on page 41 of the **Intervention Manual**:

- Anal sex without a condom (even with withdrawal)
- Vaginal sex without a condom
- Oral sex, stopping before ejaculation (including precum)
- Mutual masturbation ("outcourse").

Ask the Client to list each example in the appropriate column on the arrow, according to the level of risk he/she perceives for each one. As you discuss this with the Client, you will get an idea of where the Client's knowledge level is regarding risk behaviors. Use your own judgement on whether or not it may be necessary to provide additional education/information on levels of risk. Take the time to do that here, if you think it is needed.

Next, ask the Client to think of other activities to place on the risk scale and ask them to list them in the appropriate column, according to level of risk. These activities could be actual activities that the Client has experienced. Some Clients may have difficulty disclosing risky sexual experiences. An alternative way of inviting input on other activities would be to ask the Client to describe sexual or drug use fantasies or things he/she may have heard/read about and to rate those activities on the continuum. If the Client still cannot come up with any risk-related activities to rate, you may have to suggest some further examples:

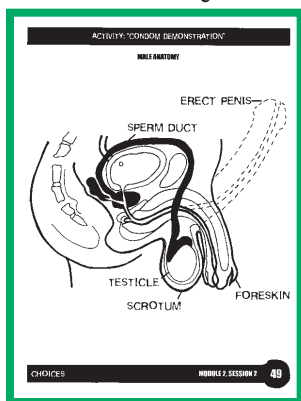
- Having sex in the shower
- "Barebacking"—the deliberate and conscious disregard for risk while choosing to engage in unprotected anal sex
- Oral sex with a dental dam
- Others

When the Client has generated a list of activities and rated them on the Continuum of Risk sheet, discuss ways that the most risky activities could be made less risky, and then rate these newly-modified activities on the Continuum as well.

After completing the listing of activities on the Continuum of Risk, ask the Client to draw a vertical line indicating his/her personal risk limit goal—i.e., targeting a goal point beyond which he/she is unwilling to go, in terms of personal risk.

***Note:** Choose one of the more risky personal activities on the list to use in the trigger identification process, which comes next in this session.

Session 2 Activity—"Condom Demonstration"



Using the Male Anatomy chart (page 49 of the **Intervention Manual**), briefly review Client's knowledge of male anatomy.

Demonstrate the proper placement of a male condom, using the wooden penis model. Steps:

1. Always choose a **latex** condom.
2. Check the expiration date on the package (or on the box).
3. Test to make sure there is still an air bubble in the package.
4. Open package being careful not to tear the condom. Do not open the package with your teeth and use extra caution with long fingernails.
5. Place the condom on the head of the penis, making sure that the reservoir tip sticks out. (Putting a drop of lubricant inside the condom tip may give extra feeling.)
6. Pinch the reservoir tip to get any air out.
7. Slowly unroll the condom all the way down to the base of the penis.
8. **If lubrication is desired, choose water-based** (i.e., K-Y® Jelly) rather than oil-based (i.e., Vaseline®) lubricant.
9. Immediately after ejaculation, hold the condom at the base of the penis and carefully withdraw (pull out) before the penis becomes flaccid (soft).
10. Roll the condom down and remove it from the penis, making sure the contents of the reservoir tip do not spill.
11. Dispose of the condom in a trash can. Do not flush condoms down the toilet.

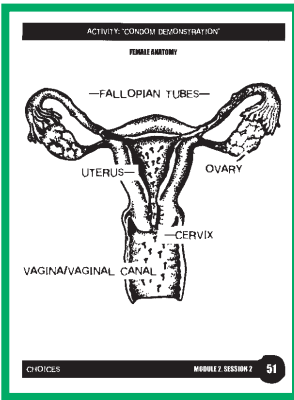
Assist the Client to practice proper placement of a male condom, using the wooden penis model.

Ordering Information for Wooden Penis Models:

Ansell Healthcare

Meridian Center 1 • Two Industrial Way • Eatontown, NJ 07724

Phone 1-800-327-8659 • Fax 908-542-7678



Using the Female Anatomy chart (page 51 of the Intervention Manual), briefly review Client's knowledge of female anatomy.

Demonstrate the proper placement of a female condom, using the vaginal model. Steps:

- Check the expiration date on the condom package. The manufacturer says that the female condom can be use up to one year beyond the expiration date, but always check the date.
- Carefully open the package without tearing the condom. Do not open the package with your teeth and use extra caution with long fingernails.
- Unroll the condom and separate the two rings. The loose ring inside the pouch is called the "inner ring," and the ring connected to the opening of the pouch is called the "outside ring."
- Gently rub the condom to evenly spread the lubricant.
- Grab the inside ring between the thumb and middle finger and pinch the edges together like a diaphragm.
- Place the index finger between the thumb and middle finger to prevent the condom from slipping.
- Still squeezing the condom, use the index finger to guide the condom into the vagina, being careful not to twist the condom. (The other hand may be used to spread the vagina during insertion.)
- Push the ring in until the cervix is completely covered. The ring will then fall into place (like a diaphragm).
- The outside ring remains outside the vagina protecting the labia (or lips) around the vagina.
- Insert the index finger through the inside of the condom to make sure the condom is not twisted or loose.
- Until both partners are comfortable using the female condom, guide the penis into the condom.
- Immediately after ejaculation, squeeze and twist the end of the condom that is protecting the labia.
- Remove the condom by pulling, being careful not to spill the semen inside the condom.
- Dispose of the condom in a trash can. Do not flush down the toilet.

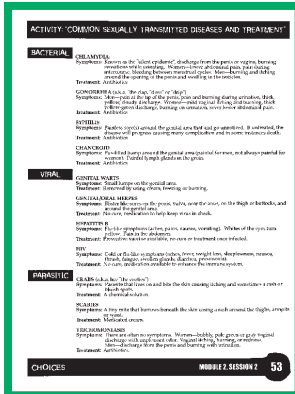
Assist the Client to practice proper placement of a female condom, using the vaginal model.

Ordering Information for Vaginal Models:

Lindi plastic pelvic model:
Ortho McNeil Pharmaceutical
Omni Education
P.O. Box 401 • Raritan, NJ 08869-0602
1-800-631-5273

Latex pelvic model:
Jim Jackson and Company
33 Richdale Avenue
Cambridge, MA 02140
1-617-864-9063

Activity—"Common STDs and Treatment"



Using "Common STDs and Treatment" worksheet, (page 53 of the **Intervention Manual**), assess and discuss STDs, as appropriate to Client need. Discussion could include:

- Common types of STDs—i.e., chlamydia, gonorrhea, genital warts, etc.
- Differences in causes of STDs—i.e., bacterial, viral and parasitic
- Differences in treatments for STDs
- Prevention of STDs

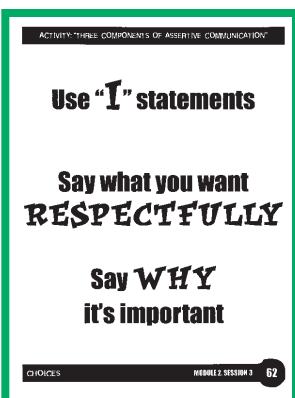
Activity—"Area Needle Exchange Information" (For IDUs and Partners of IDUs)



Using "Area Needle Exchange Information (page 55 of the **Intervention Manual**), briefly assess Client's knowledge of local needle exchange programs and review information as appropriate. Discussion could include:

- Location, hours of operation, procedures
- Provide and review printed materials, including phone numbers

Session 3 Activity—"Three Components of Assertive Communication"



Using the sheet, "Three Components of Assertive Communication" (page 62 of the **Intervention Manual**), discuss the basics of assertive communication with the Client (including the distinctions between assertive, non-assertive/passive, and aggressive communication). Focus on the three key components listed on the sheet:

- Use "I" statements
- Say what you want respectfully
- Say why it's important

Activity—Role-Play Assertive Communication Skills

Assess the Client’s current ability to communicate assertively by engaging him/her in a role-play to practice assertive communication skills. Begin with a non-sexual scenario (i.e., partner taking out the garbage; sharing household chores; deciding on television shows; sending food back in a restaurant; asking for service at a store; etc.). **(*Also see suggestions for role-play techniques on pages 7-8 of this Reference Guide.)**

ROLE PLAY VIGNETTES

SEXUAL CONSENT—CURRENTLY SEXUALLY ACTIVE

- You have continuously fought with your partner about his/her refusal to use condoms. He feels that because you are both HIV+ it's okay to have unprotected sex. The last time you tried to negotiate with him, he became very angry. He has shown some related behaviors in the past. How do you assertively convince him/ her to try safer sex?
- Both you and your partner tested HIV+ three years ago, and have been on combination antiretroviral therapy for six months. When you received your test results, you made a commitment to each other to always practice safer sex. Recent lab work shows both viral load levels to be undetectable. Your partner suggests having unprotected sex on one occasion. How do you respond? Can you brainstorm strategies your commitment to safer sex?
- You have a casual partner who knows your HIV+ status and helps you out with a few dollars each week that prevents his car from being towed. How would you handle this situation? What would you do?

CURRENTLY NOT SEXUALLY ACTIVE

- Your boyfriend of three months is pressuring you to have sex and saying much better about not being thinking about how your partners would be able to protect you from HIV?
- Your partner is making signs. How would you discuss this with him?
- You are very close to your 16-year-old son from your HIV status. You have a feeling that your relationship is about to end. Your son has given you permission to have sex with him?
- You find a condom in your son's pants while doing about your laundry?
- You have just met someone wonderful. The relation but you would like to progress into something more but you have never discussed the possibility of it.

CHOICES

HOW WEIRD SCENARIOS

- You have been out and having a good time at the bar. You've had a lot to drink. It is getting close to closing and someone invites you to his or her place to keep the party going. They bring out some "cider" or their apartment, and have saying you should "just kick back and relax." How would you bring up the issue of safer sex?
- You've been trying to find a job all day. You haven't been very successful and decided to stop at one of your favorite hangouts to have something to eat. You see a person that you haven't seen for awhile. This person used to be a part of your trusted circle of friends that shared needles and needles. (She talks you about some great drugs at a shabu party. You don't have a clean needle with you. How would you bring up the subject of safer needle practice?
- Your partner is on HIV meds in combination with being in a medical rehab program. The drug use is very active, and he is afraid his medication will be ruined if someone recognizes him. You're concerned that he has gone back to having trouble in getting needles, what ever he can. How would you convince him to use safer needle practice?

CHOICES **MODULE 2, SESSION 3 64**

Continue the role-play exercise using a sexual and/or drug related scenario appropriate to the Client’s life context. **If needed, see suggested examples of Role-Play vignettes on pages 63-64 of the Intervention Manual.**

Session 4 Activity—"My Decision-Making Process"

Assist Client in identifying the factors which influence his/her decisions regarding disclosure of HIV status. This discussion could include issues like personal safety, stigma, positive social support, health status and health care, employment, legal issues, housing, or other relevant topics. The Facilitator should refer back to past disclosure experiences (if any) discussed by the Client earlier in this session.

ACTIVITY: MY DECISION-MAKING PROCESS

1 NO THOUGHT 2 LITTLE THOUGHT 3 SOME THOUGHT 4 A LOT OF THOUGHT 5 WELL THOUGHT OUT

CHOICES **MODULE 2, SESSION 4**

Using the "My Decision-Making Process" worksheet (page 71 of the Intervention Manual), guide the Client’s reflection on how much thought preceded his/her decisions regarding disclosure—from “no thought” (1) through “well-thought out” (5). This discussion may include the following topics:

- Impulsive disclosure vs. thoughtful planning of disclosure (i.e., situational, person-specific, etc.)

- Pressure to disclose through environmental factors like health clinic, employment situations, etc.

- Thoughtful planning when choosing not to disclose. Assist the Client in becoming more aware of their own decision processes regarding disclosure and ways they may want to modify or fine-tune those processes.

- Feeling overwhelmed
- Physical illness
- Others

Assist Client in role-playing assertive communication skills related to adhering to a medical regimen or decision-making process. **See suggested techniques for role-plays—pages 7–8 of this Reference Guide.** Scenarios for role-playing may include:

- Physician is always hurried
- Client unsure of Physician’s instructions
- Client doesn’t want to hurt anyone’s feelings
- Others

Session 3 Activity—Self-Efficacy and Assertive Communication

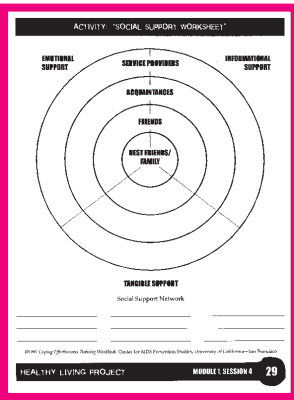
Discuss Client’s perceptions of self-efficacy regarding adherence to his/her medical regimen, including Client’s ability to handle all adherence issues (treatment appointments, transportation, finances, prescription refills, dosage, medication special instructions, etc).

Discuss Client’s comfort talking about general health concerns with someone in his/her support network. Discuss in terms of:

- Who** Client is comfortable talking with
- How comfortable** Client feels (i.e., not comfortable, fairly comfortable, very comfortable)

Discuss Client’s comfort talking about personal health concerns with someone in his/her social support network, when he/she is NOT feeling well. Again, discuss **who** Client is comfortable talking with; and **how comfortable** Client feels (i.e., not comfortable, fairly comfortable, very comfortable.)

Discuss Client’s comfort taking medications in front of someone else. Discuss in terms of **who** Client is comfortable with and **how comfortable** (i.e., not comfortable, fairly comfortable, very comfortable)

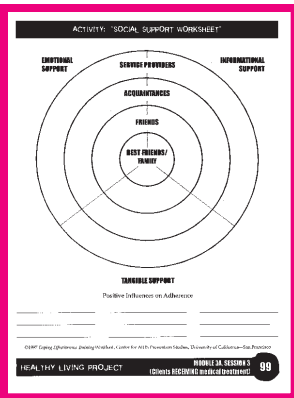


Using the "Social Support Worksheet" (in Client File), review the three types of social support:

- Informational—information, advice, or suggestions
- Emotional—words and actions that make a person feel cared about, understood and affirmed. May include empathy, caring, love, and trust.
- Tangible—money, labor, assistance, etc.

Review Negative Vs. Positive Social Support (from Module 1, Session 4—page 28 of this Guide)

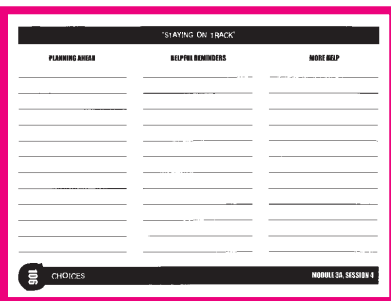
Review Client’s identified "Social Support Network" (see "Social Support Worksheet"—in Client File).



Using “Social Support Worksheet” (page 99 of the Intervention Manual), assist Client to identify members of his/her personal support network who could positively impact his/her adherence to a medical regimen. Record the names of identified members on a new "Social Support Worksheet" (page 99).

Session 4 Activity—"Staying on Track Worksheet"

Discuss Client’s personal strengths and organizational skills that could enhance long-term adherence to a medical regimen.



Using the "Staying On Track" worksheet (page 106 of the Intervention Manual), assist Client in identifying organizational steps, reminders, and tools for increased adherence to his/her medical regimen. Topics under the heading "Planning Ahead" may include:

- Ask doctor to make a list of all medications and doses
- Keep a medication diary
- Make up a weekly schedule which includes all appointments, medication doses and other activities

- Keep extra medication at work
- Plan ahead for handling medication/regimen on weekends and holidays
- Others

Topics under the heading "Helpful Reminders" may include:

- Use regular activities as reminders to take medication
- Look for activities that fit medication intervals (i.e., going to the bathroom in the morning, TV shows, walking the dog, etc.)
- Take medication before or after reminder activity on a regular basis
- Use mealtimes as reminders
- Take medications at bedtime or first thing after waking
- Keep medications where they can be seen (i.e., by bedside for morning doses, in kitchen for mid-day doses, etc.)
- Others

Topics under the heading "More Help" may include:

- Use a pill box to organize medications
- Set up a pill box at the same time each week, for use in the week ahead
- Set a timer for next dose during the day, and an alarm clock for doses during the night
- Wear a watch/consider getting a watch with an alarm
- Have a friend call or page at dose time
- Develop a support network of people who can help to remind when medication should be taken
- Others

Discuss the Client perceived challenges for developing and maintaining the identified organizational skills listed on the "Staying on Track" worksheet.

MODULE 3B - (FOR CLIENTS NOT RECEIVING MEDICAL TREATMENT)

Session 1 Activity—"My Personal Health Plan"

Using "My Personal Health Plan" worksheet (page 119 of the **Intervention Manual**), assist Client in identifying his/her personal health routine. Topics to cover in this discussion are included on the worksheet and include:

- Current health status
- Medication (present or past)
- Personal health routine
- Current use of complementary health care providers.

"My Personal Health Plan" worksheet should be kept in the Client File, for future reference as needed.

Session 2 Activity—Assertive Communication with Complementary Health Care/Service Providers or Others who Influence Adherence to a Personal Health Routine

Using the sheet, "Three Components of Assertive Communication" (page 62 of the **Intervention Manual**), review the three key components of assertive communication with Client:

- Use "I" statements
- Say what you want respectfully
- Say why it's important.

Assist Client in identifying barriers to assertive communication with complementary health care/service providers or others who influence adherence to a personal health routine.

Barriers may include:

- Little or no Client participation in decision-making process
- Intimidation
- Fear
- Language
- Education

- Lack of time
- Influence by others
- Feeling overwhelmed
- Physical illness
- Others

Assist Client in role-playing assertive communication skills related to adherence to a personal health routine or decision-making process issues. Scenarios may include:

- Provider is always hurried
- Past negative experience(s) with a health care/service provider
- Client unsure of provider’s instructions
- Client doesn’t want to hurt anyone’s feelings
- Client wants to request resource list for additional information or services
- Others

Session 3 Activity—Self-Efficacy and Assertive Communication

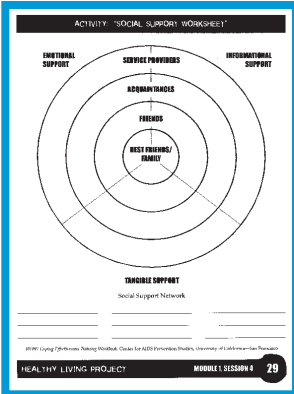
Discuss Client’s perceptions of self-efficacy regarding adherence to his/her medical regimen, including Client’s ability to handle all adherence issues (treatment appointments, transportation, finances, maintaining exercise schedule, nutrition, other self-care.

Discuss Client’s comfort talking about general health with someone in his/her support network. Discuss in terms of:

- Who** Client is comfortable talking with
- Degree of comfort** Client feels (i.e., not comfortable, fairly comfortable, very comfortable)

Discuss Client’s comfort talking about personal health concerns with someone in his/her social support network, when he/she is NOT feeling well. Again, discuss **who** Client is comfortable talking with; and **degree of comfort** Client feels (i.e., not comfortable, fairly comfortable, very comfortable.)

Discuss Client's comfort taking medications in front of someone else. Discuss in terms of **who** Client is comfortable with and **degree of comfort** Client (i.e., not comfortable, fairly comfortable, very comfortable.)

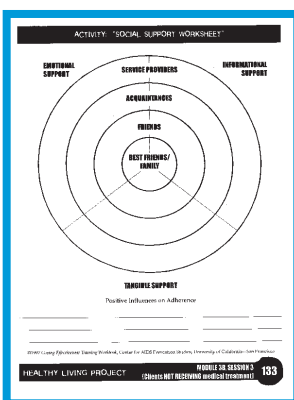


Using the "Social Support Worksheet" (page 29 of the **Intervention Manual and/or Client File**), review the three types of social support:

- Emotional—words and actions that make a person feel cared about, understood and affirmed. May include empathy, caring, love, and trust
- Informational—information, advice, or suggestions
- Tangible—money, labor, assistance, etc.

Review Negative Vs. Positive Social Support (from **Module 1, Session 4—page 28 of this guide**)

Review Client's identified "Social Support Network" (see "**Social Support Worksheet**"—page 29 of the **Intervention Manual and/or Client File copy**).



Using "Social Support Worksheet" (page 133 of the **Intervention Manual**), assist Client to identify members of his/her personal support network who could positively impact his/her adherence to a personal health routine. Record the names of identified members on a new "Social Support Worksheet" copy (page 133).

Session 4 Activity—“Staying On Track Worksheet”

Discuss Client’s personal strengths and organizational skills that may enhance long-term adherence to a Personal Health Routine

Discuss strategies for keeping informed about health issues and services

The image shows a worksheet titled "STAYING ON TRACK" with three columns: "PLANNING AHEAD", "REPEL REMINDERS", and "MORE HELP". Each column has several horizontal lines for writing. At the bottom left, there is a logo for "CHOICES" and at the bottom right, it says "MODULE 4B, SESSION 4".

Using the "Staying on Track" worksheet, (page 141 of the **Intervention Manual**), assist Client in identifying organizational steps, reminders and tools for increased adherence to his/her personal health routine and for keeping informed about health issues and services.

Topics under the heading "Planning Ahead" may include:

- Keep a personal health diary
- Exercise
- Diet
- Sleep
- Complementary treatments
- Make up a weekly schedule which includes all appointments and other activities
- Ask family, friends, and/or co-workers about health services available
- Keep extra workout clothes at the office
- Plan ahead to maintain routine for weekends and holidays
- Plan out weekly menus for more nutritious diet
- Check phone book, library and/or Internet regarding local health resources
- Others

Topics under the heading "Helpful Reminders" may include:

- Use regular activities as reminders to maintain routine
- Keep healthy food in the house at all times
- Schedule weekly appointments on the same day/time
- Schedule appointments to investigate health care options
- Others

Topics under the heading "More Help" may include:

- Do health routine activities with a friend
- Develop a support network: people who maintain a health routine
- Ask a friend or family member to go with you to investigate a new health care option
- Subscribe to health-related magazines

Discuss the Client's perceived challenges for developing and maintaining the identified organizational and information-gathering skills listed on the "Staying on Track" worksheet.

V. CONTEXTUAL THEMES

This is a time of great hope for people infected with HIV. New treatments have led to HIV being seen by many as a long-term, chronic illness rather than a fatal disease. Along with this hope comes many challenges. In this section, we describe some of the more common challenges faced by people with HIV infection. The themes described emerged from interviews with HIV-positive men and women in New York, San Francisco, Los Angeles, and Milwaukee.

SPECIAL ISSUES: WOMEN

- **Children.** For most of the women interviewed, issues surrounding children were high on their lists of concerns. These concerns were for children of all ages—from unborn babies through grown, adult children. Included in the specific concerns regarding children were disclosure (by the mother) of HIV status to children—when, where, how, etc.; the effect of the mother’s hospitalization on the children; the effect the early death of the mother could have on the children; dying before the children were raised and leaving them to fend for themselves in the world—easy prey to drugs, crime, etc.; having children removed from the mother’s care; fear of transmitting HIV to children, particularly to unborn children; fear of children contracting HIV on the street, through sex, drugs, etc.

"Okay, my daughter right now being away. She's in Puerto Rico and me being here. I was little upset. Someone told my daughter I was positive. I never had the opportunity to tell her. I wanted to tell her face to face. We spoke all the time over the phone and wrote, but I didn't feel that was appropriate for me to tell her. I wanted to tell her personally. Someone told her and she finally...she always let me...I had a feeling that she knew, but I just didn't want to believe that and it finally came out about three weeks ago. We finally spoke and I said, 'What do you mean, I'm sick and I'm not feeling good.' She said, 'Mommy, I know.' I said, 'You know what? What?' So, anyway, that crushed me. She said, 'Mommy, it's okay.' I wanted to be there in case it was going to hurt her. Just to comfort her, to let her know this and I'm okay. She said, 'As long as you take care of yourself and that. I see your pictures. I see you healthy. So, I know you're okay.'"

"Kicking the bucket before everything I think needs to get done, gets done. I mean dying, because the thing is...my biggest most important job, I guess, is staying alive long enough for my last two kids to be self-sufficient. I want them to be able to get out of the house. Yeah, they'd be all right if I died tomorrow, because I managed to build a pretty good foundation for them, up to this point, spiritually and emotionally, but I'm still the best person for the job. They would be better at being themselves and...and coming into their full being if I was the one there...to be there and do it with them and be there for them."

- **Regarding childbirth.** *"When A. was born, my last baby, um, it was already known I was HIV positive and I was taking AZT for her and she also took anti-viral medication when she was born for six months...I would feel very bad. I would feel very bad that I did that to them...to my...to my baby, yeah."*

• **Depression.** Many described the debilitating effects of depression on their everyday lives. For some, it has been a constant in their lives, while others saw it as a thing of the past. Some were in or had previously sought mental health treatment/counseling due to a history of psychiatric illness that preceded their HIV diagnosis. Among these, some had histories of abuse, rape and violence. For others, the HIV diagnosis itself or the death of loved ones led to their depression and anxiety.

"I've always been depressed and low self-esteem."

"I was in a mental health complex four times...they diagnosed me with all these different things. Trauma, depression, chronic depressive, manic depressive, postpartum, trauma as a child...a lot of antidepressants. Prozac, Paxil, Serzone, Elavil, Thorazine, Xanax, there's been a lot of them. I have a whole drawer of them."

"...the depression came along with my disease. And my main thing is my disease..."

"Feeling very fatigued where I have no ambition whatsoever, not even to just get out of bed. It's a major project to sometimes to get out of bed on some mornings. I really gotta push myself. I get very depressed. I just lay around. I'm very emotional. I cry a lot."

• **Employment and Work.** Many women had significant worries related to employment and work. Their concerns included fear of discrimination; becoming ill at work; getting and keeping work, not losing it due to HIV; income, insurance and entitlements for themselves and for their children.

"Oh, another thing I worry about is employers. It...it's like are they going to...I know there's a law, they can't fire you. But are they going to discriminate against me because I have HIV and I can't tell them that I have that. If my health gets bad, I can't tell them that."

"Yes. And...or like I also worry about getting drop-dead sick where you feel you're fine one minute and the next minute you're just like...(plugh!)... You want to...you want to lay down."

"Job security because today, you take a month or two off your job because of your illness, you have a chance of losing your job. It's really hard to get jobs today...because a lot of us are determined to work, but if an illness would cost us our job and there's nothing we could do to fight that, what's the sense of looking?"

"A lot. Yeah, I worry about that a lot. I worry about...because it's always going into Congress about something or another...about SSI or...you know with medical benefits, they want to cut those and all that kind...so, yeah, I worry. Now, I've had to pay a co-payment just to get rides on the Carevan, plus, they're charging me on my Title 19. You know, so, you know, you worry. You worry all the time."

- **Disease Progression, Death and Dying.** These concerns included fear of sickness/pain; living with debilitating effects of HIV—i.e., losing eyesight; fear of death in general; becoming dependent on the care of others; becoming incapacitated and unable to carry out daily tasks for self and family.

"Ohhh. How progressive this disease is and how progressive this virus is going...taking my body... Yeah, I know my body is changing from my lab works."

"Oh, my God. For me it's a simple question. Death. I'm the uh...I'm petrified of getting sick."

"Getting sick to the point where I can't do anything. That kind of is a big thing in my life because I'm very independent, normally, and I'm like, well, if I can't do anything, maybe I'll just shoot myself. I'll have thoughts like that. I don't want to be able to not do anything."

- **Pregnancy.** Within several contexts, pregnancy was listed as an issue. In most cases, the issue pertains to HIV transmission, but other concerns included cesarean section deliveries and preventing further pregnancies. Other women and their partners still held desires to have more children.

"Now, what stays on my mind is my kids and the pregnancy..."

"My pregnancy...because I'm HIV positive. I have a very big concern because this is going to be the first time I'll be having a cesarean... Yeah. Because it's better to have a cesarean when you're HIV positive than it is to have it regularly..."

"We use them (condoms) every day but sometimes we'll be, let's say we're going to do sex and now it would be like, 'Let's try to have a baby.' So he doesn't put it on and we just do it like that. We just put HIV on the side. Even though we know we have it, we put it on the side, and we do it to see."

"He said...I had to go to the bathroom and my stomach was really bloated and I get really bloated when my stomach is nice and full and it looks like I'm pregnant and I said, 'Look at this.' I remember I used to touch it when I was pregnant and he goes...he touched and said, 'I wish you would have never tied your tubes so we could have had a little girl.' And, I told him even if I didn't, I couldn't have a child now. He said, 'I know.' So, that's a touchy subject."

- **Issues Surrounding Sex:** Many issues emerged related to sex and sexual practices.

- **Importance of Sex.** A range of feelings about the importance of sex was apparent, from not important to very important and in some cases, having changed in importance over time. Some women reported no change in their sexual behavior since being diagnosed HIV-positive, others reported having very little sexual activity or less than before they were diagnosed. A few reported engaging in sexual behavior at least two to three times per week.

"Well, like I say, you know, I don't... but sex is not really one of my priorities...you know, I don't want it."

"It's not important whether I have sex or not. I can live with it or without it."

"It's still very important to me."

- **•Safer Sex.** The majority of these women defined safer sex in mechanical terms—i.e., using a condom during sexual intercourse—but for others, the meaning of safer sex went beyond the mechanical aspects to include the purpose of safer sex—i.e., to protect self and/or others. A number recognized that unsafe sex may result in STD acquisition and that knowledge of the risk of STD contraction and risk of transmission of HIV and other STDs to a partner were given as reasons why an undetectable viral load did not, or would not influence these women to have unprotected sex. There remained, however, several who held erroneous beliefs about safer sex, like confusion between contraception and HIV/other STD protection, as well as actual modes of HIV transmission.

"Safer sex is if you use a condom. That's pretty safe."

"When you get ready to have sex, you just go get the condom."

"There ain't no such thing as safer sex for me... Because...there's nothing that's one hundred percent safe that you will not catch HIV. There is nothing."

"Because I don't want to infect anybody else. It's enough of it going around there in this world."

"You can catch any kind of disease around the condom. If your hair touches that man's hair, there is something that could come from...off that hair to your hair and cause you to get sick."

"I'd have to be with a Norplant in my arm; I'd have to have my tubes tied; I'd have to have all of that protection. And then, I got to have a condom."

- **•Obstacles to Safer Sex.** Many women reported partner reluctance to use condoms as a major obstacle to safer sex. There was also a perceived loss associated with condom use—a loss of pleasure, of spontaneity, of a "natural experience." Other challenges cited were "Passion/Heat of the Moment," trouble/problems using condoms correctly, breakage/slippage, irritation from lubricants, partner acceptance of risk of transmission, desire for pregnancy, and partner's erroneous belief regarding undetectable viral load and transmission risk. More negative than positive attitudes and experiences about the female condom were expressed by both condom users and non-users. In addition, patterns of risk behavior seem to relate to relationship types such that there is likely to be more risk behavior with a well-known or "steady" partner.

"He chooses not to. That's his choice."

"My husband knows I'm HIV positive. He doesn't want to use a condom because this is...this is weird. This is a weird situation. I have never been in a situation like this before. He doesn't want to use a condom because he tells me he loves me just the way I am. He wants to show me that nothing has changed. You know, it's...he says that if I had it, he wants it, too. He wants to share that part with me."

"He used to say, 'I don't feel it' with the condom or it takes a long time for him to come."

"My boyfriend and I don't understand how to judge this yet, would like to have unprotected sex because he knows my viral load is low."

"...because we're both HIV positive and we've decided we're not using safe sex. It's just the way it is, you know. We're just together, you know..."

•Regarding the female condom—"It felt uncomfortable. It was like using a tampon or something."

- **Reinfection.** A number of women were well aware of the concept of reinfection and expressed concern about the idea of reinfection. Some endorsed the concept of universal protection regardless of partner HIV status, while others recognized the importance of safer sex between two HIV-positive partners. It was also clear, however, that knowledge of reinfection did not necessarily lead to safer sex for some women.

"All I've been told is that there are...the virus has...it's different forms, okay, or...it's different...it's different viruses, okay. A person can be infected with more than one at the same time. Like, he can have...like they say A,B,C,D,E,F,G, okay. He can have A, I can have B; he got C, I got D okay. And then we're back and...back...we're having sex back and forth, we are passing these things back and forth to each other continually, you know. And I doubt if there's any way you can get better, getting reinfected over and over again."

"...you can get re-infected. Because he's positive, and I'm positive, it doesn't mean we can just use unsafe sex."

"...what I've been told, assuming he was positive, okay, now we're not using any kind of protection, so in the process we will be reinfected each other constantly, you know."

- **Sexual Abuse/Rape.** A significant amount of rape was reported within all three study populations, including the women. These rapes occurred during childhood, adolescence and adulthood, and continues to be a salient issue affecting their lives, emotional, physical and sexual health.

"It was my half brother, my mom's son, when I was younger. He broke my virginity. I kept it secret from age twelve until I was like seventeen... It screwed up my whole entire life. Started running away from home. Then I ended up being abused by people just for a place to stay, for food, because I was on the run. People were taking advantage of me sexually."

"I was raped and sodomized at seventeen... It was someone that I knew. It happened two times. It happened immediately after I lost my virginity and the second time, it happened the same day I had an abortion."

"I was infected through rape. My life was shortened because he wanted a one-night stand."

"And I got raped by six guys. And, I have AIDS. I heard, 'I hope the bitch get AIDS and die.'"

- **Relationships.** In general, women expressed a desire for emotional ties to their partner, often in the context of a serious relationship. Several women expressed a clear preference for HIV-positive partners, citing greater psychological comfort with these partners, and the perception of shared experiences and understanding.

"Well, with the man, I feel better if he were positive because we could relate on things and I would feel more comfortable to have sex with the man because he already knows, he's already educated. He's positive and I'm positive, so he knows what to do, that we can get re-infected again."

"Uh,...the possibility that I may live alone for the rest of my life. That...live without a mate... because I've been alone for quite a while and I don't believe God created a human being to live in this world alone. I would like to have a mate, but then my standards are also high. So I don't want...just accept anything, so that precludes...you, know, excludes a lot of guys that I meet."

"Knowing that I have someone loving by my side. Because not a lot of people have that."

- **Medication/Treatment Adherence and Non-Adherence.** The women interviewed expressed a number of motivations for adhering to medication/treatment regimens. Not surprisingly, children and future orientation goals were at the top of that list, while other factors included the encouragement and support of others, physical symptoms, a desire to improve life, and the choice to participate in what was seen as a conscious act of self-care. Obstacles to adherence included fear of side effects—actual and potential; forgetting; special dietary requirements; self-appraisal of perceived need for medication; actual pill properties—i.e., size, taste and sheer number; other practical factors.

"I want to see my daughter grow up. I want...I don't want my kids to turn out positive. I want to live. I want to be able to finish high school. I want to have a successful job. I want something so people are...remember me...."

"No, I need it. My body tells me that. The virus lets me know. It's strange, but I know when the virus is acting up, so to speak. It's just something that I feel in my body, so I mean, I wasn't going to take any meds, but then I could feel myself being more tired. And, my body feeling just drained all the time. So, the medication, it makes me feel better."

"...but, every time I take the medicine, I know that my life is getting better..."

"No...I feel well, maybe, yeah...I feel better that I...that I do take them, you know, 'cause I know that it's part of keeping myself healthy."

"They press me to take them...my mother and my sister. 'Take your meds.' They've got my kid telling me every...three times a day, 'Tell her to take...tell you Mom to take her meds.'"

"I forget the schedule. I get too busy or I forget to take my medication, or forget to eat because I'm too busy. I get side-tracked."

"I know some people who just...their lives are just too crazy or...one person I talked to they were taking medicine you had to take with food and they were really broke and they just didn't eat regularly—they ate maybe once a day so that was not working for them."

"The pills I take are huge. They're really big. I have to take eight at a time. Then I take vitamins, then I take iron pills and...I have to take a lot of pills at one time and sometimes I just get tired of it, I think..."

"So the HIV hasn't done anything. It's the medication sometimes...that stops me from doing a lot."

"If it's going to make me sick, I'm not taking them."

SPECIAL ISSUES: MSM

- **Children.** The issue of having and parenting children came up within the MSM group in a number of different ways. Included in these concerns were the desire for children, disclosure to children of HIV status, responsibility for creating HIV-positive children, responsibility of being a parent/providing for children, having children removed from their care, dying before the children are raised, etc.

"Number one, I'm positive, how could I impregnate a woman to get a child? Impossible. They'd have HIV probably. So, that eliminates the whole thing right there. Number two, adopting or something like that, unless my health is perfect...I would not do that because I would want to bring them up correctly. And, I don't have the energy to have the proper way to take care of a child."

"I want to see my kids grow up..."

"...sometimes I think, you know, like if I would like to change my life now, I can't because I'm HIV positive. I cannot have children..."

"It used to be very important, but now I...I realize that it's an impossibility unless I adopt. And I'm not in a financial situation to do that, nor would I think, with my health status and my sexual orientation, finances and stuff, would I be in a situation to be in...to be a parent, although I used to really want to be, and I still would love to be. But it's not going to happen."

"I'm afraid if I did, the kid would be sick. I'm not going to mess with that."

"So, in a way, I'm living through my son. But that's not me, that's him. So, I'm saying, okay, what I miss, I want you to get."

- **Mental Health.** A number of issues related to mental health surfaced in the MSM group. These included depression, anxiety, psychological distress, use of psychiatric medications, recreational drugs as self-medication, mental illness predating HIV, etc.

"I had very real depression. When I first started getting sick, uh, I'd...I...reality hit and I realized I was not immortal. And, uh, knowing that...when reality hit, when I got the disease, when I got my first opportunistic infection, I knew that, you know, I'm no longer immortal..."

"I have to really watch myself. I have to pace myself. I have to watch so I do not get depressed. I refuse to let myself get depressed. I have to stay right in the moment to survive."

"Mental illness...I'm diagnosed as bi-polar, schizophrenic. I have to take medication every day. If I don't, I'm just as nutty as a fruit tree. It's true."

"...while you're on it (speed) and...and other medication or other drugs, it takes some of the depression away. It takes, you know, that...that false sense of...it gives you that false sense of security..."

"Yeah. I get a lot of that all the time (anxiety) when...when I know that I...I'm doing everything I possibly can to do right, to keep myself alive and keep going. But it seem like when...when something happens, it's like what did I do to cause this? And it's like everybody keeps telling me, it's not your fault that this stuff is happening. It's going to happen to you sooner or later. But I'm like, I don't want it to happen. Because (they) keep telling me, everything you're experiencing, sooner or later, you're going to experience it one way or another. You might not experience it now, but, you know, down the road, you're going to have these symptoms happen to you. And you should just be aware of...just...put yourself in that predicament that is happening to you already. And I'm like...right now, I don't want nothing else to happen. I want to deal with the situation that I have already, and then move on."

- **Quality of Life.** MSMs had a lot to say about quality of life and meaning in life. Some of this may be due to their having seen so many other MSMs pass through all the stages of HIV/AIDS, followed by death. Whatever the reason, these issues were clearly on their minds.

"If I was very sick and had no energy I would, at the drop of a hat, use amphetamines or I would use morphine or any pain killers, anything to bring quality of life back up and give me that last good couple of weeks, and then probably party one night a little too hard intentionally and..."

"...my quality of life has gone drastically down..."

"What type of... quality will I have at that point? It's you know, I don't expect to live like a king, but living on welfare or, you know, and.. and assistance...it just takes the rest of your life away. I... you know, on a fixed income, it's...it's unbelievably, impossibly hard in this day and age...."

"What is my purpose in life? The purpose in my life, I'm a warrior. I'm exposing a lot of people to a lot of things. I've settled down and to do good and to see the people that do the right thing. Just do the right thing in life and people around me do that. And, I expose people. I get on the inside and I look around and see this is ugly. ...I was sent from up there for a reason..."

"You know, hopefully people'll be able to, uh, share, you know, what we've discussed, you know, and some people'll get stronger. You know, when I'm out there in society, you know, and I meet people that are prostituting or...or that are using drugs intravenously, you know, I expand on my issues, you know...I contracted HIV and, you know, now I have to live...and before you contract it, you know, you better put a halt on that shit now. So, I think my life, it's very important."

"My life has, well it has a purpose. It has a meaning. I'm searching for the purpose and the meaning..."

- **Issues Surrounding Sex.** Most MSMs said that sex was fairly important to them, but a significant minority said that it was not important. A broad range of sexual behaviors were reported and many reported that since their HIV-positive diagnosis, they either have less sex overall or less risky sex. It is also not uncommon for these MSMs to have relatively little sex and for it to have different meanings for them than it used to.

Safer Sex. Definitions of safer sex are very condom-focused. However, substantial minorities also cite "no exchange of bodily fluids" and/or no penetrative sex at all. The large majority report safer sex all or almost all the time. There is a strong sentiment to have no sex at all rather than have unsafe sex. The main reported motivation for safer sex is to avoid transmitting HIV to others. Self-protective behaviors are more rarely cited.

"Safe sex would be using, or even if you use condoms, you know how the situation is, it could break and all that stuff, but there is other stuff that you can do that can be...safe sex is basically almost no sex for me."

"Dry fuck. We call it the Princeton Rub. Princeton College, that's the way the boys do it there. You can tell them back in Argentina, when you're (at) tea parties, this guy was telling me about the Princeton Rub."

"This is something I wouldn't wish on Saddam Hussein. I don't care how big of a bastard he is. And I feel like I would really rather not take the chance of somebody else catching it from me, not to mention you can get thrown in jail for that."

"It's a hard thing to say and I discuss it with my friends all the time, but the less sex you have the better it is for you."

Unsafe Sex. Despite some of the sentiments expressed above, there is still evidence of occasional unsafe sex. The main reason cited for unsafe sex is that the partner wants to have unsafe sex. Also commonly cited was discomfort with or loss of sensation from condoms. However, most do not report problems with access to or use of condoms.

"Well, I just do what they want to do. I'm that kind of person. I can work with it. It's not going to kill me."

Barebacking. A variety of responses and feelings were expressed regarding the practice of barebacking. While some were quite clear that they do not feel that it is a good thing to do, others made a distinction between barebacking with serious vs. casual partners.

"I miss it terribly. I really do. It's like a funeral. And, I have done it. My last relationship was with somebody who was HIV-positive as well and that's the guy I wanted to use the female condoms with and the male condom and he didn't want to do it. He just wanted barebacking. So, we did. At the time we had an exclusive relationship."

"I think that, um, I think people are willing to take more risks now. That the idea of barebacking is becoming more popular. And I think that some of the, um, younger men have the attitude like, well this won't happen to me or there's treatment now so we don't have to be as concerned about it. It's...it's not a death sentence, diagnosis HIV positive."

Reinfection, STDs, and Undetectable Viral Load. Many of the MSMs interviewed seemed to have some knowledge of the possibility of reinfection and report being worried about STDs. There also appeared to be a fair amount of understanding that a person with an undetectable viral load can still transmit the virus.

"You have sex, you kiss him and you're doing all that stuff, you open up your system to a lot of opportunistic things. And, I've been very careful as far as sex is concerned. I'm actually not having sex. For the last year, I had very little sex outside my relationship and the relationship with my boyfriend after seventeen years became very, very little and the most masturbation and he's HIV-negative, by the way. And, comparing one year that I had very little sex outside, my CD4 went up..."

"And I think of, oh, I could pick up another strain and it interferes with my medications and I've already got enough problems."

"Same precautions, same warnings to everybody. Just because it's undetectable doesn't mean it's not there."

Disclosure. Though some have experienced rejection due to disclosing their HIV status, many say that they usually serodisclose to all sexual partners.

"When the point comes where if...obviously you're going to home, and you're going to get naked and you're going to have a good time, that's when I'll tell them. Before that time, they don't have a need to know."

"I...I wouldn't mind to tell everybody, but I have a lot of situations where when I say it, I never see that person again, you know...So sometimes I don't know when is the right time to tell. Because I don't know when they use that against you or when...when you open your feelings and say to somebody something so private and then, you know, thinking that, well, maybe I'll get a friend, or I can get a boyfriend (and) poof! They don't care."

Rape. As in the other populations interviewed, MSMs, too reported a significant amount of rape during childhood, adolescence and adulthood, impacting on their lives, HIV status, sexuality/sexual preferences, emotional, physical and sexual health.

"I was young. I wasn't even in grade school yet...it happened for a while."

"But I feel that I never would have turned out to be gay if one of my cousins, when first got sex...circumcised at the age of thirty, would...two days after he got home from going to the hospital, got drunk, and I was at my auntie's house and he raped me."

"I was first raped when I was fifteen years old. I was gay already. I found out I was gay when I was seven. A psychiatrist told my mother."

"That always happened to me, that rape thing. It's like it follows me. You know. I couldn't believe it. It happened to me so many times in my life. If I would have been a woman, I would have been a suffering woman. Honestly. Because I live with stronger thinking about things like that. A woman takes that really to heart, do you understand?...and it bugs her out, understand? Also, we take it different. It's something that I couldn't enjoy. But it happened and I just have to forget about it."

"When somebody forces you to have sex with them, you don't want to do it, it's very disgusting. So, you know, everything is involved about doing something that you don't want to do."

- **Medication/Treatment Adherence and Non-Adherence.** MSMs identified many motivating factors regarding adherence to medication/treatment regimens, including wanting to live longer, survival, believing in the efficacy of the drugs, medication as a priority, medication as a responsibility, feeling as though one is "doing something" about having HIV, and others. Obstacles included feeling like a "medication guinea pig," severe side effects, forgetfulness, dosing regimens and scheduling, drug and substance use/abuse, and others.

"I found myself lucky because when I got tested they had ways of trying to make you live longer, so I think there's a way you like grab this hope, this medication and try to survive..."

"So I do believe...at first I didn't believe in the modern medicine but it does work."

"...back when I was young, if you were told you had AIDS, you were pretty much going to die. Now, people are living longer."

"I had went—four-hour horrible diarrhea, nausea, vomiting and then a skin rash—to a point where I was so uncomfortable and sick that I stopped taking the medication."

"...and the ones that they wanted to put me on, it's guinea pig material."

"Just seeing so many people do so poorly...and get so toxic. My friend who died in '89...looking back, we shouldn't have wondered why she got so sick so quick. Washing down those massive doses of AZT..."

"When I was doing drugs, I wasn't taking them. Now I stopped doing drugs and I'm taking them and I feel different. I feel like living. I feel more stronger. More power. They're working, they're good. Honestly."

SPECIAL ISSUES: IDUs

- **Major Life Crises/Turning Points in IDU Lives.** IDUs identified major turning points in their lives, which often took the form of major life crises. These included the HIV diagnosis as catastrophic, spiritual transformation following positive response to medication, improved quality of life after HIV diagnosis, and others.

"I was in denial—I didn't even want to listen to the doctor, to nobody. ...Finally it sunk into me that I was sick and that if I didn't do something about it I was gonna be a dead, sick man."

"My mental outlook is more positive. My spiritual outlook has been changed completely from being a non-spiritual, non-caring person to somebody that is more spiritually involved with my...my higher power, and more caring for other people, shall we say? Because before, I didn't give a shit about you or me, and now, with the medications and hope for my future, I have hope for other people's futures as well."

"...the standard of living that I have is better because of my HIV, considering I have no college diploma, I'm computer illiterate, you know, so the financial assistance and the counseling that I've been able to get and the psychiatric help I've been able to get and the free rehabs I've been in, I think that's really supported me. So, I think that my quality of life, because of the HIV, is better..."

- **Mental Health.** Quite a few mental health issues came up in the interviews, including the effect of drug use on mental health, which mental health problems existed before contracting HIV; having to fight both mental health problems and HIV, dual psychiatric diagnoses, effects of drug use on other emotional responses, and others.

"...They want to know if you're hearing voices and blah, blah, blah this and no, I'm not right now, but sometimes I do see shadows and stuff but it's probably my own little weird thinking. For a long time I tried to deny the fact that drugs did have an impact on me, mentally. And, they did because I was a big user."

"...besides my depression and all that, as far as anything else, you know, I've been shot at, stabbed, because I've done a lot of drugs and I'm not a bad person but you would think something like this would just...I thought I could handle it. But, I just can't."

"On welfare, I'm stuck in this hotel down in skid row that I stopped using drugs some time ago, like last August, when I was getting depressed and you're down with everybody that uses all the time. How are you going...you're going to fight my depression, then the drug use, living in the same area that you know you grew up dealing drugs in and then HIV comes along..."

"Well, I am bi-polar, hypomanic type two, how's that? At least it's what psychiatrist has diagnosed me as..."

- **Issues Surrounding Sex.** As in the other groups interviewed, many issues arose surrounding sex for the IDUs. These issues included the effect of drugs on sex, the importance and non-importance of sex, and changes in importance since the HIV diagnosis.

Importance of Sex. Some IDUs reported that sex remained an important part of life, while for others, it's importance had clearly changed since being diagnosed with HIV.

"I still have a very active sex life. It's still an important part of my life. I still value it. It's a good sensation, satisfying, gratifying. I love it—I just love it."

"I don't need sex as much as I used to, and it's changed the way I practice sex and the partners I practice with."

"...and it's cut down on the sexual partners I've had. I've only had three partners in the past two years versus where it would have been, you know, fifteen or twenty, or more. I've kind of cut down a lot in that."

Safer Sex. Many IDUs defined safer sex as condom use, though some cited withdrawal before ejaculation or oral sex as alternative safer sex methods. Motivations for safer sex included: protecting self from reinfection, protecting others from infection, protecting against STDs, avoidance of guilt, and others.

"Safer sex, I call 'Condom Man.' I say 'Condom Man' because he wears it to protect everybody. I practice safe sex."

"But the truth of the matter is that in most circumstances, the ability to pull out before you come in someone's mouth always presents itself."

"Safer sex means to me, protecting your life. And you're protecting hers at the same time..."

"I learned that I could reinfect the person that I'm with if they're already infected and if they're not infected I could infect them. I shouldn't have unprotected sex because there are a lot of STDs out there, too..."

"If I know that I infected you, what is going to happen is I'm going to feel guilty about it. And by feeling guilty, I'm going to get depressed, and by getting depressed, I'm going to end up getting sick."

Obstacles to Safer Sex. Condom problems, partner pressure to have natural sex and partner willingness to join their HIV seropositive partner in infection were all cited as obstacles to safer sex within the IDU group.

"I couldn't get used to condoms..."

"People aren't concerned with it the rest of the time, of the incident itself. I mean, it's so far off, you know, what's it matter? Not too many people are concerned with consequences or they don't think about them."

"You know, she start crying and then she say, 'Well, if I'm gonna get it, then I don't mind getting it like this with you...'"

"I guess that...I guess you don't care...(about having safer sex, while using drugs)."

Disclosure. Concerns in this area centered around whether to disclose to a potential sexual partner, whether to ask the status of a partner and the clear decision not to disclose.

"We were having foreplay already...and then I froze because she told me she was trying to pull the condom off. She asked me why did I freeze and then I told her the truth. After that, she got dressed and left."

"If someone is really making it clear to me that we're going to fuck, I'll tell you right up front that I'm positive and if that means you're going to skit away because you're a freak, then, fine, save me the time and energy. Save the boner."

"It shouldn't be a thing where only I have to share my part, why not them tell you? I make it a point to let every woman that I go to bed with know that I am HIV positive. Because I do not want to carry this in my conscience. I do not wish to have something that's detrimental to my well-being anyway..."

"Yeh, but...it's...if I gotta lie, I'll tell them that I got an infection...No, I'll say something that 's why I'm using a condom."

"Of I don't know the person is safe, I wear a condom. If they've got HIV, I figure it doesn't matter..."

Rape. As in the other two groups, rape was very much a part of the life experience of this group, as well.

"I got raped by my babysitter and by some...some boys..."

"I didn't choose to use drugs. Some guy, he raped me and he shot drugs into me when I was 13, guy named Kenneth..."

"...When I was raped and turned on to heroin, that impacted my life..."

- **Medication/Treatment Adherence and Non-Adherence.** Substance use or history of substance use affected IDUs in their attempts to adhere to a medication or treatment regimen—in both negative and positive ways.

"For 10 years I completely ignored I had it, and didn't take care of my body, lived on the streets, didn't care about nothing, and was depressed. And now the most traumatic thing that's happened is my complete turn around and recovery from substance abuse, and the work I have to put in to, you know, putting my life back together. It's very, very traumatic because you know, I'm worried that I'm not going to be able to make it, that my health might fail me, or that I might go back out and use again, but, you know, it's a constant, daily struggle..."

"...I think anytime you have to take medications and live with the side effects, it's more of a hassle. I'm one of these people that I would rather have a short, quality life than a long, un-quality life. So, to me, it's more of a hassle. But I do..."

"Medication—the regime of taking the medication kind of was a hassle—adherence to it. But, other than that, I think the main problem with taking care of my health would be the transportation to and from medical appointments."

"The first thing is getting up, taking my medicine, eating breakfast, and going to the program...drug rehabilitation program that I am in. Those are the first three things that's on my agenda for the day."

"I had such a bad experience with (AZT) that I stopped it altogether. My hair started thinning out. I caught shingles from the anxiety. I went back to negative thinking for awhile. I was really on a down thing—I hit bottom first before I—meaning depression, drugging again. I had spurts of drugging—at one point, one day I got high and I fucked it all up. Then I regretted it and I had mixed feelings about everything."

VI. PROCEDURAL ISSUES

FACILITATOR PREPARATION

It is important that Facilitators be prepared prior to each intervention session. Preparation entails training, reviewing information about the Client, and reviewing the Intervention Manual for instruction for session goals, materials, and protocol.

Information about the Client that is available to the Facilitator will be contained in the Client File. The Participant File contains activity worksheets needed for each session, a Goal Recording Sheet for each session, 15 Quality Assurance Check Sheet/Notes, 15 Session Notes forms, and a storage envelope of the Goal Cards. It will be important for the Facilitator to review the Client's progress documented within this file before each session.

The Intervention Manual is a session-by-session guide that outlines the activities to be conducted in each of the 15 sessions. For each session, the first page is an overview that contains the goals and objectives, an agenda and timeline, and a list of the materials. This page is followed by a detailed outline of the session content, divided into four components: Check-In/Life Context, Skills-Building, Problem-Solving, and Wrap-Up. Interspersed in the Intervention Manual are the session-specific worksheets.

Prior to attending centralized training, each Facilitator must read the Intervention Manual, Reference Guide, and supplemental articles (see section VIII, "Required Readings), and watch videotapes and mock sessions.

DOCUMENTATION OF PATIENT CONTACT

At the conclusion of each session, Facilitators record the details of the session in two places. First, in the Client File, there is a "Session Notes" page for each of the 15 sessions. Session Notes remain in the Client Files during the course of the project and are designed to help re-orient you to the Client prior to each session. This information will be especially important when beginning Modules 2 and 3, after a three-month break, or if for some reason a different Facilitator begins working with the Client. Session Notes should generally include behavioral observations, the mood of the Client, the Client-specific content of the session (i.e., current stressors, Life Project goal, etc.), and progress on and deviations from the study protocol.

The second place that you will record details of each session is on the "Quality Assurance Check Sheet/Notes" form. These notes should be more general in nature (i.e., those that anyone doing across-site quality assurance could read without breaking confidentiality). Fifteen session-specific forms are included in the Client File; each lists the required components of the session. Facilitators will need to simply check off which components were completed, and at the bottom of the form, record the reason that any of the components were not completed. At the end of each session, this form is to be turned in to the study coordinator, who will copy the form and return it to the Client File.

SESSION TAPING

Facilitators are responsible for audiotaping all sessions. Audiotapes will be used for quality assurance and may be used in supervision.

FACILITATOR SUPERVISION

Facilitators are expected to participate in at least one hour of clinical supervision per week regarding their contact with HLP participants. A licensed clinical psychologist or psychiatrist at each research site will provide regular supervision regarding clinical issues. This supervision may be either in an individual or group format. Individual supervision will also be available on an as-needed basis for urgent matters. Facilitators need to be familiar with the Emergency Protocol for their site to know who to contact in case of a clinical crisis.

FACILITATOR TEAM MEETINGS

In addition to weekly clinical supervision, Facilitators will meet regularly as a team with their site coordinator to discuss and make decisions regarding procedural issues. Questions about premature termination, alcohol and drug intoxication during sessions, tardiness, etc. should be discussed on a case-by-case basis during Facilitator team meetings.

ABSENCES

If a Client misses a session without contacting you, contact him/her to attempt to reschedule the session. If a Client misses repeated scheduled appointments, he/she may be attempting to withdraw from the study. In this case, try to engage the Client in a discussion of his/her reservations about coming to sessions, with gentle pressure to return for an additional session where this can be discussed further. Also see "Premature Termination" section at the end of this section.

TARDINESS

It is important that Clients arrive in time to complete each session. In the event that a Client is too late for a meaningful session (i.e., more than 30 minutes late), reschedule the session. It will be explained to Clients in advance that to receive the financial incentive for a session they must attend the complete session. If a Client is repeatedly late for sessions, this should be addressed directly and empathically, with an emphasis on determining the reasons for tardiness and providing options for improving attendance.

EXTRA SESSIONS

We will strive to adhere to the study protocol of 15 sessions as closely as possible. However, it is likely that Clients will occasionally come to us in crisis, and will need to discuss issues other than the intervention during that appointment. In general, this is fine. However, financial incentives cannot be given for general support sessions, and Facilitators should mention this briefly early-on if a session needs to be devoted to support or crisis management. Participants will be aware that they are in a research study (as opposed to therapy) and that emphasis is placed on completing intervention sessions. In these cases, assessment (e.g., for suicidal or homicidal ideation) should be conducted regarding whether the Client needs services beyond your capabilities and expectations as a Facilitator. If indicated, a referral for additional services should be made by following the Emergency Protocol procedures at your site.

DRUG AND ALCOHOL USE

We expect that some Clients will come to sessions under the influence of drugs or alcohol. Participants will have been told in the informed consent phase that the study protocol discourages them from coming to sessions when intoxicated, and that they should call to reschedule appointments if they are too intoxicated to participate. They will also have been told in advance that if they come to a session and are unable to participate in a session due to intoxication, they will be asked to reschedule and will not receive the financial incentive for that session.

For Clients who have long-standing drug or alcohol abuse problems, Facilitators should attempt to schedule appointments during a time of day when drug use is least likely to interfere with the session. In the case of a Client who comes to a session intoxicated, the Facilitator will need to assess whether the Client is capable of participating meaningfully. If the Client is not able to participate, the Facilitator should suggest that the appointment be rescheduled. It is also important that Facilitators not confront Clients in even a remotely hostile fashion regarding their intoxication, as this could result in an escalation of the situation.

CONCURRENT TREATMENT

It is completely permissible, and in some cases highly desirable, that Clients receive other mental health services (e.g., psychotherapy, drug or alcohol treatment) while they are enrolled in the HLP. We will ask Clients about their specific involvement in other services during assessments.

PREMATURE TERMINATION

Participants have the right to withdraw from the study at any point. If a Client expresses the desire to do so, attempt to engage him in a discussion of the reasons for termination. Offer solutions if he brings up reasons that are changeable (e.g., session appointments conflict with another regular appointment). If no suitable solutions can be generated, provide the Client with resources for obtaining services elsewhere and inform him/her that if he/she reconsiders prior to the next scheduled session (i.e., either in two weeks or three months; see Figure 1 on page 1 of this Guide), he/she can continue participating in the study. A list of HIV/AIDS and mental health resources should be given to each Client who withdraws from the study.

VII. BIBLIOGRAPHY

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VIII. REQUIRED READINGS

COPIES OF REQUIRED READING JOURNAL ARTICLES FOR EACH POPULATION

COPIES OF REQUIRED READING JOURNAL ARTICLES FOR INTERVENTION COMPONENTS

SUGGESTED "OTHER READINGS"

Current Medications:

Agenerase (Amprenavir): A protease inhibitor. Most frequently reported side effects: nausea, vomiting, fatigue, headache, rash, anemia, colitis, bruising easily, prolonged bleeding, and circumoral paresthesia (tingling around the mouth). Recommended dosage: Eight 150mg capsules twice a day.

Combivir (Lamivudine/Zidovudine): Combination tablets containing lamivudine (Epivir, 3TC) and zidovudine (Retrovir, azidothymidine, AZT, or ZDV). Most frequently reported side effects: headache, fatigue, nausea, diarrhea, nasal signs and symptoms. One tablet (containing 150 mg of lamivudine and 300 mg of zidovudine) twice daily.

Crixivan (Indinavir): A protease inhibitor. Most frequently reported side effects: kidney stones, breakdown of red blood cells, liver problems, diabetes and high blood sugar, increased fat appearing in areas such as the neck, breasts, abdomen, and back. Recommended dosage: Two 400 mg capsules every 8 hours taken without food but with water one hour before or two hours after a meal. It is recommended that the patient drink at least 48 ounces of non-alcoholic liquids during the course of 24 hours.

Epivir (3TC): A synthetic nucleoside analogue with activity against HIV. Most frequently reported side effects: headache, fatigue, nausea, nasal signs and symptoms. Recommended dosage: 150 mg. twice daily, keep in tightly closed bottle.

Fortovase (Saquinavir soft-gel): A protease inhibitor. Most frequently reported side effects: diarrhea, nausea, abdominal discomfort or pain, flatulence, indigestion, headaches, insomnia, fatigue, and taste alteration. Recommended dosage: Six 200 mg. capsules three times daily with food or within 2 hours after a meal.

Hivid (ddC, zalcitabine, dideoxycytidine): A nucleoside analog reverse transcriptase inhibitor. Most frequently reported side effects: a rash, chest pain, fever, nausea, changes in liver function and mouth sores. The most serious side effects include peripheral neuropathy, and in rare cases, pancreatitis. Recommended dosage: One 0.75 mg tablet three times daily.

Hydrea (Hydroxyurea): A cancer drug commonly used as an HIV antiviral. Most frequently reported side effects: anemia, nausea, vomiting, anorexia, diarrhea, constipation, fatigue, hair loss,, drug-induced hepatitis. Recommended dosage: One 500 mg. capsule twice a day.

Invirase (Saquinavir hard gel): The first protease inhibitor approved for the treatment of HIV. Most frequently reported side effects: diarrhea, stomach discomfort and nausea. Recommended dosage: Three 200-mg tablets three times daily within two hours of a high fat meal.

Norvir (Ritonavir): An inhibitor of HIV protease with activity against HIV. Most frequently reported side effects: nausea, diarrhea, vomiting, anorexia, abdominal pain, and neuropathy. Recommended dosage: Six, 100 mg twice daily preferably with food.

Rescriptor (Delavirdine): Contains a synthetic non-nucleoside reverse transcriptase inhibitor of HIV. This medication should always be administered in combination with appropriate antiretroviral therapy. Most frequently reported side effects: skin rash. Recommended dosage: Four 100 mg. tablets, three times daily.

Retrovir (zidovudine, AZT): A pyrimidine nucleoside analogue active against HIV. Most frequently reported side effects: severe headache, nausea, insomnia, and myalgia. Recommended dosage: 600 mg per day in divided doses.

Stavudine (d4T, Zerit): A nucleoside analog anti-HIV drug. Most frequently reported side effects: stomach upset, peripheral neuropathy, and elevated liver function tests. Recommended dosage: 30-40mg every 12 hours.

Sustiva (Efavirenz): An HIV-a specific, non-nucleoside, reverse transcriptase inhibitor. Most frequently reported side effects: skin rash, central nervous system symptom (dizziness). The medication was discontinued for one or more of the following psychiatric symptoms: somnolence, insomnia, abnormal dreaming, confusion, abnormal thinking, impaired concentration, amnesia, agitation, depersonalization, hallucinations and euphoria. Recommended dosage: Three 200 mg capsules once daily, preferably at bedtime, in combination with a protease inhibitor and/or nucleoside analogue reverse transcriptase inhibitors. May be taken with or without food, but high fat meals should be avoided.

Videx (Didanosine, dDI): A nucleoside analogue anti-HIV drug (a new mandarin orange flavored tablet is now available that is smaller and dissolves faster in water). Most frequently reported side effects: Stomach pain, diarrhea, and painful and persistent peripheral neuropathy at high doses. Recommended dosage: 250 mg to 600 mg daily, taken in two doses. Should be taken on an empty stomach.

Viracept (Nelfinavir): A protease inhibitor. Most frequently reported side effects: severe diarrhea, stomach pain, weakness, nausea, flatulence, and rash. Recommended dosage: Recently approved five 250 mg tablets twice daily.

Viramune (Nevirapine): A non-nucleoside reverse transcriptase inhibitor. Most frequently reported side effects: skin rash. Recommended dosage: 200 mg once a day for first two weeks, then increased to 200 mg twice a day thereafter.

Ziagen (Abacavir Sulfate): A nucleoside reverse transcriptase inhibitor. Most frequently reported side effects: nausea, vomiting, diarrhea, fatigue, headache and abdominal pain. A hypersensitivity reaction can be fatal if Ziagen is stopped and then taken again. Recommended dosage: One 300 mg tablet twice a day.

Cytomegalovirus (CMV): See “HIV-Related Illnesses: Viral Infections”

CMV Neurological Disorders: See “HIV-Related Illnesses: Viral Infections”

Drug Cocktail: See “Medication Categories”

Ecstasy: See “Illicit Drugs and Common Street Names”

Epivir (3TC): See “Current Medications”

Emotion-Focused Coping: See “Coping”

Emotional Support: See “Support”

Fortovase (Saquinavir Soft-Gel): See “Current Medications”

Genital/Oral Herpes: See “Sexually Transmitted Infections”

Genital Warts: See “Sexually Transmitted Infections”

Gonorrhea: See “Sexually Transmitted Infections”

Hairy Leukoplakia: See “HIV-Related Illnesses: Viral Infections”

Hepatitis—A, B, and C: See “HIV-Related Illnesses: Viral Infections”

Hepatitis B: See “Sexually Transmitted Infections”

Heroin: See “Illicit Drugs and Common Street Names”

Heroin/Cocaine Mix: See “Illicit Drugs and Common Street Names”

Herpes (Herpes Simplex Virus I and II); Shingles (Herpes Zoster): See “HIV-Related Illnesses: Viral Infections”

HIV: See “Sexually Transmitted Infections”

Hivid (ddC, Zalcitabine, Dideoxycytidine): See “Current Medications”

HIV-Related Illnesses:

Bacterial Infections:

Mycobacterium Avium Complex (MAC): Persistent fever, night sweats, fatigue, weight loss, chronic diarrhea, low blood platelets, nausea, dizziness, abdominal pain, soft-tissue masses; swollen lymph glands, kidney or spleen.

Salmonella: Persistent diarrhea, cramping, fever, weakness, and loss of appetite.

Tuberculosis (TB): Night sweats, cough, fever, weight loss, swollen lymph glands, fatigue, organ-specific symptoms.

Cancers

Kaposi’s Sarcoma: Cancer of the skin and organs associated with a new herpes virus, HHV-8; small, purplish lesions visible on skin. Bronchoscope used for diagnosis in lungs.

Non-Hodgkin’s Lymphoma (NHL) or B Cell Lymphomas: Cancer of lymphocytes; may also affect bone marrow and central nervous syndrome; B-cell lymphomas linked to Epstein-Barr virus (EBV).

Fungal Infections

Candidiasis (Thrush): White patches on gums, tongue; pain and difficulty swallowing; loss of appetite; vaginal itching, burning, discharges.

Cryptococcal Disease: Meningitis: Mild headaches, intermittent fevers, malaise, nausea, fatigue, loss of appetite, altered mental status, seizures (rare). Skin ulcers, pneumonia (concurrent with PCP).

Histoplasmosis: Skin infections, fever, swollen lymph glands, weight loss, anemia, difficulty breathing; also pneumonia.

Gynecological

Cervical Cancer: Cervical lesions and cellular abnormalities caused by sexually transmitted viruses, including herpes and HPV; detected by abnormal Pap smear; confirmed by coloscopy.

Human Papilloma Virus; Genital Warts: Genital warts can be felt if external; internal requires exam. HPV linked to cancers of anus, penis, vagina, and cervix.

Pelvic Inflammatory Disease (PID): Vaginal discharge, pain, internal ulcers, ectopic pregnancy, linked to chlamydia; screening, early detection critical.

Protozoal Infections

Cryptosporidiosis: Diarrhea with watery stool, abdominal cramping, nausea, vomiting, fatigue, and flatulence, weight loss, poor appetite, dehydration, electrolyte imbalances.

Microsporidiosis; Isosporiasis; E. Intestinalis: Watery diarrhea, abdominal pain, cramping, nausea, vomiting, and weight loss, fever.

Pneumocystis Carinii Pneumonia (PCP): Fever, dry cough, weight loss, night sweats, difficulty breathing, elevated liver enzymes.

Toxoplasmosis Gondii (Toxo): Encephalitis (brain disease); also fever, pneumonia, severe headaches, confusion, lethargy, altered mental state, dementia, seizures, coma.

Viral Infections

Cytomegalovirus (CMV): Fever common: affects different parts of body. In eyes: blurry vision. In esophagus: pain, ulcers, difficulty swallowing. In colon and gut: diarrhea, abdominal pain, wasting. In lungs: pneumonia.

CMV Neurological Disorders: Infections of the central nervous system, encephalitis (brain disease), dementia, apathy, delirium, confusion, and lethargy.

Hairy leukoplakia: White, raised patches in mouth and on tongue. Also skin rash, thirst, light-headedness, nausea. May be confused with thrush.

Hepatitis—A, B, and C: Liver infections, fever. Chronic progressive disease is seen for B and C. Co-infection with hepatitis C has been linked to higher HIV viral loads.

Herpes (Herpes Simplex Virus I and II); Shingles (Herpes Zoster): Ulcers, painful blisters and/or itching on lips (caused by herpes simplex I), anus and/or genitals (caused by herpes simplex II). Shingles on body caused by herpes zoster.

Progressive Multifocal Leukoencephalopathy (PML): Neurological problems: gross dementia, paralysis, loss of all senses in late-stage disease.

Other Conditions

AIDS Dementia Complex (ADC): ADC is not a true opportunistic infection. It is one of the few conditions caused directly by the HIV virus. Those with ADC have HIV-infected macrophages in the brain (i.e. HIV is actively infecting brain cells). Early symptoms are similar to those of depression (apathy, loss of interest, etc.). Advanced symptoms include cognitive and motor problems. AZT is effective in treating and preventing HIV activity in the brain.

Idiopathic Thrombocytopenia Purpura (ITP): Excessive bleeding from nosebleeds and cuts; easy bruising; small and large red spots on skin. Due to HIV-related low platelet count.

Lipodystrophy (Progressive): A condition characterized by a complete loss of the subcutaneous fat of the upper part of the torso, the arms, neck, and face, sometimes with an increase of fat in the tissues about and below the pelvis.

Neuropathy: Tingling "pins and needles" in feet and legs, hands and fingers; numbness, pain. Similar symptoms can also result from drug-related toxicity.

Wasting Syndrome: Rapid severe weight loss, loss of appetite, chronic diarrhea, fever. Tumor necrosis factor and glutathione levels linked to wasting. Check for other opportunistic infections.

Histoplasmosis: See “HIV-Related Illnesses: Fungal Infections”

Human Papilloma Virus; Genital Warts: See “HIV-Related Illnesses: Gynecological”

Hydrea (Hydroxyurea): See “Current Medications”

Idiopathic Thrombocytopenia Purpura (ITP): See “HIV-Related Illnesses: Other Conditions”

Illicit Drugs and Common Street Names:

Cocaine: A bitter alkaloid that is obtained from coca leaves, is used as a local anesthetic, can result in psychological dependence, and produces intoxication (Coke, "C", Snow, Blow, Toot, Leaf, Flake, Freeze, Happy dust, White girl, Peruvian lady, Cola, Nose, Pearl, Stardust)

Crack Cocaine: Rocks, Roxane, Ready-rock, Gravel

Ecstasy: A "designer" drug that belongs to the methylated amphetamine family. Causes a mild euphoria accompanied by openness and lack of defensiveness. Also called MDMA, XTC, and Adam. Other methylated amphetamines are DOM (also called STP), MDA (i.e., love drug, mellow drug of America), and MDE (i.e, Eve)

Heroin: A strongly physiologically addictive narcotic more potent than morphine used illicitly for its euphoric effects (Black tar, Tootsie roll, China white, Junk, Smack, Scag, "H", Hard Stuff, Horse, Brown Sugar, Harry, Dust)

Heroin/Cocaine Mix: Speedball, 8-ball

Methamphetamine: A stimulant for the central nervous system (Crystal, Crank, Ice, Speed)

Morphine: A bitter crystalline addictive narcotic used as an analgesic and sedative (Big M, Miss Emma, White stuff, "M", Excel, Hocus, Unkie, Hard stuff, Morph)

Poppers: Slang name for Amyl and Butyl Nitrite, an inhalant that causes dialation of blood vessels. Causes a euphoric "head rush" and is used in conjunction with sex to enhance and intensify orgasm and to facilitate relaxation of anal musculature to allow penetration. Also called snappers, rush, and locker room

Informational Support: See “Support”

Invirase (Saquinavie Hard-Gel): See “Current Medications”

Kaposi's Sarcoma: See "HIV-Related Illnesses: Cancers"

Lipodystrophy (Progressive): See "HIV-Related Illnesses: Other Conditions"

Medication Categories:

Drug Cocktail (combination drug therapy, Highly Active AntiRetroviral Therapy—HAART): Suggested initial regimens of two nucleoside reverse transcriptase inhibitor and a protease inhibitor (or two protease inhibitors) or two nucleoside reverse transcriptase inhibitors and a nonnucleoside reverse transcriptase inhibitor are recommended.

Nucleoside (nukes) and non-nucleoside (non-nukes) analog reverse transcriptase inhibitors: These drugs stop HIV from multiplying by blocking the step in its life cycle where the reverse transcriptase enzyme changes HIV's genetic material (RNA) into the form of DNA. This step has to occur before HIV's genetic code gets combined with an infected cell's own genetic codes.

Protease Inhibitor: These drugs work by blocking a part of HIV called protease. When protease is blocked, HIV makes copies of itself that can't infect new cells.

Methamphetamine: See "Illicit Drugs and Common Street Names"

Microsporidiosis; Isosporiasis; E. Intestinalis: See "HIV-Related Illnesses: Protozoal Infections"

Morphine: See "Illicit Drugs and Common Street Names"

Mycobacterium Avium Complex (MAC): See "HIV-Related Illnesses: Bacterial Infections"

Neuropathy: See "HIV-Related Illnesses: Other Conditions"

Non-Hodgkin's Lymphoma (NHL) or B Cell Lymphomas: See "HIV-Related Illnesses: Cancers"

Norvir (Ritonivir): See "Current Medications"

Nucleoside: See "Medication Categories"

Pelvic Inflammatory Disease (PID): See "HIV-Related Illnesses: Gynecological"

Pneumocystis Carinii Pneumonia (PCP): See "HIV-Related Illnesses: Protozoal Infections"

Poppers: See "Illicit Drugs and Common Street Names"

Problem-Focused Coping: See "Coping"

Progressive Multifocal Leukoencephalopathy (PML): See “HIV-Related Illnesses: Viral Infections”

Protease Inhibitor: See “Medication Categories”

Rescriptor (Delavirdine): See “Current Medications”

Retrovir (Zidovudine, AZT): See “Current Medications”

Salmonella: See “HIV-Related Illnesses: Bacterial Infections”

Scabies: See “Sexually Transmitted Infections”

Self-Efficacy: Belief that one is personally capable of successfully implementing behavior changes

Sexually Transmitted Infections:

Chancroid: Bacterial sexually transmitted disease; symptoms may include pub-filled bump around the genital area and painful lymph glands in the groin. Treatment: antibiotics

Chlamydia: A bacterial sexually transmitted disease; symptoms include discharge from the penis or vagina and burning sensations while urinating. Treatment: antibiotics.

Crabs: Parasitic sexually transmitted disease; symptoms include itching, a rash or bluish spots. Treatment: chemical solution.

Genital/Oral Herpes: Viral sexually transmitted disease; symptoms may include blister like sores. Treatment: no cure currently available, medication to keep virus in check is recommended.

Genital Warts: Viral sexually transmitted disease; symptoms may include small lumps on the genital area. Treatment: creams or cauterization.

Gonorrhea: Bacterial sexually transmitted disease; symptoms may include burning during urination, thick, yellow or yellow-green, cloudy discharge. Treatment: antibiotics.

Hepatitis B: Viral sexually transmitted disease; symptoms may include flu-like symptoms, yellowing whites of the eyes, and abdominal pain. Treatment: A preventive vaccine now available, no treatment or cure once infected.

HIV: Viral sexually transmitted disease; symptoms include body aches, fever, weight loss, sleeplessness, nausea, thrush, fatigue, swollen glands, diarrhea, pneumonia. Treatment: No cure, medication available to enhance the immune system.

Scabies: Parasitic sexually transmitted disease; symptoms include rash around the thighs, armpits or waist. Treatment: medicated cream.

Syphilis: Bacterial sexually transmitted disease; symptoms may include painless sores around the genital area. Treatment: antibiotics.

Trichomoniasis: Parasitic sexually transmitted disease; symptoms include discharge from vagina or penis and burning with urination. Treatment: antibiotics.

Stavudine (d4T, Zerit): See “Current Medications”

Stress: A psychological stress is a particular relationship between a person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being.

Support:

Emotional Support: Words or actions that make a person feel cared about, understood, and affirmed (i.e., empathy, caring, love, trust).

Informational Support: Information, advice, and suggestions.

Tangible Support: Money, labor, assistance, and aid in kind.

Sustiva (Efavirenz): See “Current Medications”

Syphilis: See “Sexually Transmitted Infections”

Tangible Support: See “Support”

Trichomoniasis: See “Sexually Transmitted Infections”

Tuberculosis (TB): See “HIV-Related Illnesses: Bacterial Infections”

Videx (Didanosine, ddI): See “Current Medications”

Viracept (Nelfinavir): See “Current Medications”

Viramune (Nevirapine): See “Current Medications”

Toxoplasmosis Gondii (Toxo): See “HIV-Related Illnesses: Protozoal Infections”

Wasting Syndrome: See “HIV-Related Illnesses: Other Conditions”

Ziagen (Abacavir Sulfate): See “Current Medications”

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