

## Counseling Clients With HIV And Substance Abuse Disorders

The pandemics of substance abuse and HIV/AIDS are clearly moving along similar paths, and each continues to present unique, yet interrelated, challenges. First, both disorders are considered to be chronic--that is, lifelong diseases. Second, substance abuse is a primary risk behavior for HIV infection. Third, a diagnosis of HIV infection or related conditions can be a stressor for an individual already in recovery from a substance abuse disorder. However, the diagnosis of HIV infection may motivate a client to enter substance abuse treatment. Injection drug users who test positive for HIV are more likely to enter treatment than those who test negative (Bux et al., 1993; McCusker et al., 1994b). Also, studies have noted a reduction in risk-taking behaviors among injection drug users who test positive for HIV (Colon et al., 1996; MacGowan et al., 1997). The diagnoses of a substance abuse disorder and HIV/AIDS require extensive physical and mental health care and counseling in conjunction with extensive social services. To deal with the myriad issues surrounding substance abusers who are HIV positive, substance abuse treatment professionals must continually update their skills and knowledge as well as reexamine their own attitudes and biases.

### Staff Training, Attitudes, And Issues

Before conducting any screening, assessment, or treatment planning, counselors should reassess their personal attitudes and experiences in working with HIV-infected substance abusers. This section discusses several ways in which counselors can accomplish this, including formal training within counselors' programs, examining personal attitudes (e.g., countertransference and homophobia), examining fears of infection, and avoiding burnout. It is important to reassess comfort levels with each client because each client will vary in demographic and cultural background. For instance, a service provider may feel comfortable working with a young Asian American male with a history of alcohol use, yet the same provider may not be at all comfortable with a pregnant Hispanic woman who is an active injection drug user and wishes to have her baby. Figure 7-1 provides an example of a comfort checklist for counselors to use as a routine self-evaluation.

#### *Training*

Staff members must have the proper training to screen, assess, and counsel clients. Achieving staff competency is an ongoing process. The complexities related to people with HIV/AIDS and substance abuse disorders are constantly changing and do not allow staff members to defer learning or training or even to maintain a "status quo" attitude about their competency.

Examples of methods to help staff grow in the areas of assessment, screening, and treatment planning include the following (see also the section "Cultural Competency Issues" later in this chapter):

- *Model skills and competencies.* Less experienced staff can observe supervisors or more tenured staff who demonstrate desired qualities.
- *Peer training and feedback.* Peer teams can provide feedback through direct observation

of staff members' interactions with clients, as well as review of staff members' client charts.

- *Case presentations.* Weekly or monthly group case presentations conducted by a different staff member each time can be effective for building skills and monitoring quality. Case simulation, in which each staff member has an opportunity to ask the "client" a question, is a highly useful training tool. At the end of the presentation, everyone attending can provide feedback about the activity.
- *Experiential skills-building exercises.* Many activities can be used to sensitize staff to the client's experiences. Activities can include encouraging staff members to go to a confidential and anonymous HIV/AIDS test site, or anonymously sit in the waiting room of the local food stamp office, HIV/AIDS clinic, or county jail. Staff must use different avenues to maintain a keen sensitivity to and awareness of the client's issues.
- *Assessment instruments.* Use specific assessment tools, such as substance abuse and sexual history questionnaires (e.g., the Addiction Severity Index [ASI]).
- *Formal conferences, training, consultations with clinicians.* Often agency budgets are tight, and the first expense to be cut is staff development. This is a major problem for many programs. Programs must establish that improvement and excellence are serious goals and that attending treatment-oriented conferences is a part of building staff competency and moving toward these goals.

### *Attitudes*

It is important that counselors be aware of any of their own attitudes that might interfere with helping a client. By learning to put aside personal judgments and focus on client needs, staff members can build trust and rapport with the client. When a counselor can deal with a client in a sensitive, empathic manner, there is a much greater chance that both will have a positive and successful encounter.

*Countertransference* is a set of thoughts, feelings, and beliefs experienced by a service provider that occurs in response to the client. Although sometimes these beliefs and feelings are conscious, generally they are not. It is thus unrealistic to expect counselors, usually untrained in addressing unconscious mental processing, to be aware of countertransference. Regular clinical supervision, which should be integrated into the staffing of the program, can help raise their awareness. If such resources exist, counselors may, with caution, address this issue.

In order to deal with countertransference issues, counselors must be willing to examine their skills and attitudes. Working with clients who have HIV/AIDS and substance abuse disorders brings up issues for treatment staff that can be both physically and emotionally demanding. Counselors see a broad range of diverse clients from all walks of life. To work in both these fields, providers must learn to be comfortable in discussing topics they may never have talked about openly--sex, drug use, death, grief, and so on. To effect positive change, counselors also must be willing to seek additional specialized training and support.

### *Examining attitudes and skills*

Countertransference can manifest itself in many different ways. The key to seeing countertransference issues is awareness and consciousness-raising. The commitment to "do no harm" to clients and their families, along with a desire to provide quality services, should be the driving forces for willingly examining these issues.

Following are some common countertransference issues for providers working with substance abusers who are HIV positive (adapted from National Association of Social Workers, 1997):

- Fear of contagion
- Fear of the unknown
- Fear of death, dying, grief, and loss
- Stigmatization (e.g., of people with mental health problems, "addicts," people who are HIV positive, homosexuals)
- Powerlessness, helplessness, and loss of control
- Shame and guilt
- Homophobia
- Anger, rage, and hostility
- Frustration
- Overidentification
- Denial
- Differences in culture, race, class, and lifestyle
- Fantasies of professional omnipotence
- Burnout
- Measures of success and personal reward

### *Issues*

#### Homophobia

To be aware of homophobic responses among treatment professionals and of their own countertransference issues, it is important that counselors understand how the client is handling his homosexuality. The counselor should understand the possible link between substance abuse and gay or lesbian identity formation. Substance abuse can be an easy relief, can provide acceptance, and, more important, can mirror the "comforting" dissociation developed in childhood. The "symptom-relieving" aspects of substance abuse help fight the effects of homophobia; substance abuse can allow "forbidden" behavior, allow social comfort in bars or other unfamiliar social settings and provide comfort just from the dissociative state itself. For example, some men have their first homosexual sexual experience while drinking or being drunk. This connection is a very powerful behavioral link--the pleasure and release of substance abuse with the pleasure and release of sex--and is very difficult to change or "unlink" later in life.

In regard to the issue of homophobia, it is also critical to understand how stereotypes affect the treatment options offered. The professional should take an inventory of these stereotypes to assess her homophobia potential and should be aware of the roles countertransference can play.

The short assessment tool provided in Figure 7-2 can be used to examine where providers and clients alike might rank on a continuum of homophobic reactions. This tool is also useful in group supervision sessions or discussions with both gay/lesbian and heterosexual colleagues.

It is important that counselors have a working knowledge of some of the terminology and definitions pertaining to homophobia. Following is a brief list of terms and definitions.

- *Overt homophobia* includes violence, verbal abuse, and name-calling.
- *Institutional homophobia* describes the way in which governments, businesses, schools, churches, and other institutions and organizations treat people differently and less favorably based on their sexual orientation.
- *Cultural homophobia* includes social standards and norms requiring heterosexuality.
- *Internalized homophobia* is acceptance and integration by lesbians and gays of the negative attitudes expressed by society toward them.
- *Heterosexism* is the system of advantages bestowed on heterosexuals. It is the institutional form of homophobia that assumes all people are or should be heterosexual and therefore excludes the needs, concerns, and life experiences of lesbians, gays, and bisexuals.
- *Coming out* may possibly be the most important part of gay and lesbian development. This is the process, often lifelong, in which a person acknowledges, accepts, and in many cases appreciates his or her own lesbian, gay, bisexual, or transgender identity. This often involves sharing this information with others. Family members of gay and lesbian individuals go through a similar process.
- *Oppression* is the systematic subjugation of a particular social group by another group with access to social and political power, by withholding access to that power.
- *Lesbian/gay baiting* involves actions or words that imply or state that the presence of a gay man or lesbian hurts or discredits a social system. The purpose is to hurt, demean, intimidate, or control, and to stop social change or acceptance of lesbians and gays within the social system.

These definitions can help the counselor become aware of the added layer of discrimination felt by gay men and lesbians in treatment for HIV/AIDS and a substance abuse disorder. Following is a list of some "Do's" to keep in mind when working with homosexual clients (adapted from Storms, 1994).

- Identify the lesbian/gay client's strengths and accept them as you find them.
- Listen empathically and refrain from making judgments about the client's lifestyle.
- Remain aware of the client's sexual orientation and the possible effects of this orientation on the client's experience and world-view.
- Explore the client's sexual practices with an eye toward internalized homophobia.
- Be aware of your own preference and mindful of possible homophobia or confusion in your own sexual identity.
- Be knowledgeable about compulsive sexual behavior and sexual practices in the lesbian/gay community.
- Ask your lesbian/gay clients what terms they prefer when discussing their sexual orientation and those of others.

- Encourage self-empowerment, consciousness-raising, and participation in the lesbian and gay community.
- Encourage your program to hire openly lesbian and gay counselors/therapists.
- Educate others about internalized homophobia and heterosexism. Be gay- and lesbian-affirming rather than just gay- and lesbian-tolerant.
- Stay abreast of current information on resources and display this information in your office. Attend seminars and professional workshops about working with lesbian and gay clients.

#### Fear of infection

Fear of infection is one of the most challenging issues for counselors. It is essential that providers examine this issue without blaming or judging themselves and others. Most professionals who work with substance abusers and HIV-positive individuals have thought about becoming infected with HIV, hepatitis, or tuberculosis (TB) through their jobs (Sherman and Ouellette, 1999). Some fear that scientists are not aware of modes of infection or transmission that might put service providers and their families at greater risk of infection (Montgomery and Lewis, 1995). The key to dealing with this fear is to discuss it and vent the feelings with someone who is safe, trusted, and informed, *and* to practice universal precautions at all times.

Beyond this, it is essential for providers to have regular and frequent inservice training with updates on the latest research and data about transmission and treatment of HIV/AIDS, hepatitis, and TB.

#### Special considerations for counselors who treat HIV-infected clients

The challenges and stresses related to working with people with HIV/AIDS are in some ways unique. The fact that providers often deal with multiple and serial losses and see clients suffering on a daily basis clearly affects the providers' psychological health. In recent years, therapists have begun to examine and assess these service providers for symptoms of posttraumatic stress disorder (PTSD).

Burnout often is referred to as "bereavement overload." One definition characterizes burnout as lowered energy, enthusiasm, and idealism for doing one's job, that is, as a loss of concern for the people served and for the work (Hayter, 1999). Unlike fatigue, burnout does not resolve after a given amount of rest and recreation.

Burnout prevention and stress management techniques should be used both in the work setting and in counselors' personal lives. Working with HIV-infected substance abusers requires agencies and individuals to be more creative and flexible in finding new and different ways to support and nurture counselors to prevent burnout. Agencies that have taken on this challenge with integrity and commitment have seen highly effective staff function at optimal levels for many years.

Suggestions for ways in which agencies can take care of counselors at work include

- Assigning clearly specific duties
- Having clear boundaries on professional obligations
- Enlisting volunteer help from community organizations
- Allowing for "time out" activities
- Varying tasks and responsibilities
- Building in "mental health days"
- Providing for continuing education
- Holding staff retreats (with enjoyable activities planned)
- Holding discussion, process, and support groups
- Convening regular staff/team supervision meetings

In addition, it is important that agencies allocate time to discuss the deaths and losses faced by staff. This may mean supporting special memorial events at which those who have been lost to HIV/AIDS disease can be remembered. Agencies also can support staff through contracts with employee assistance program therapists and by providing an onsite therapeutic support group for staff members to attend as they wish.

## Screening

### *Client-Specific Needs*

A positive screen for HIV infection typically leads to a referral for formal assessment, usually to an HIV/AIDS case management service. Frequently, substance abuse treatment programs provide referrals to HIV/AIDS care services. Providers will want to identify substance abuse treatment programs and agencies with these networks. At a minimum, services should include the following client needs in priority order:

- Substance abuse treatment
- Medical care
- Housing
- Mental health care
- Nutritional care
- Dental care
- Ancillary services
- Support systems

Discussion of some of these needs appears below.

### [Interim substance abuse treatment for clients on waiting lists](#)

Because of an insufficient number of substance abuse treatment slots, clients often must wait for treatment. Risk-reduction efforts can be made, however, while the client is waiting for substance

abuse treatment.

If substance abuse treatment slots remain unavailable, alcohol and drug counselors should refer clients who need medical care to primary medical care services. Clients who display more acute symptoms or conditions should probably be referred to an emergency department. However, emergency department care typically is limited to wound care and provision of nutritional supplements. Clients who do not have acute symptoms or conditions but need medical care should be referred for primary medical care, either to their own physicians or to primary medical care clinics or services.

#### [Primary medical care](#)

Primary medical care should consist of a comprehensive physical exam, treatment for HIV/AIDS (e.g., combination therapy), and treatment for opportunistic infections. In particular, chronic substance use can result in significant weight loss, lack of appetite, poor digestion, substandard elimination, kidney and liver dysfunction, and weakened immune system functioning.

See [Chapter 2](#) for more information about medical care of clients with HIV/AIDS. [↑ TOP](#)

#### [Mental health care](#)

A diagnosis of mental illness may reflect the client's affective and mood responses to this medical judgment, may be a consequence of self-medication, or may reflect neurological complications of HIV/AIDS, as well as an underlying mental health disorder. Mental health care should consist of both a neuropsychiatric workup and full mental health status examinations ([see Chapter 3](#)). Service providers should be alert to and notify clients and psychiatrists that complications may arise from the use of prescription medication for mental health problems and interactions between drug residue in the body and medications for HIV/AIDS and opportunistic infections.

#### [Nutritional care](#)

Substance-abusing clients living with HIV/AIDS are typically mal- or undernourished because of street lifestyles, the effects of HIV disease, and the physical effects of substance abuse. This combination typically results in diminished appetite, weight loss (especially of lean muscle mass), poor hygiene, immune suppression, protein deficiencies, vitamin and mineral exhaustion, and anemia. In addition, providers should be aware that apparent lack of nutrition is not associated with digestive disease or parasites.

Good nutrition is a fundamental part of overall medical care. It improves strength, energy, longevity, and quality of life; increases muscle mass and body weight; decreases likelihood of hospitalization and length of stay; and slows progression of HIV to AIDS.

Without adequate nutrition, HIV/AIDS clients can easily develop malnutrition. Various causes of malnutrition and weight loss include

- Inadequate intake of food
- Anorexia

- Malabsorption of food
- Altered metabolism
- Food and drug interactions
- Androgen deficiency
- No cooking facilities
- Limited income
- Reliance on community food programs

With the onset of malnutrition, the client loses weight and experiences several body composition changes. *Starvation* results in loss of body fat and muscle. *Wasting syndrome* produces a loss of a serious percentage of body weight, with accompanying diarrhea and fever, and has been considered a defining symptom of AIDS since 1987. The degree of loss of lean body mass can indicate the length of time that the client has left to live.

### Lipodystrophy syndrome

Lipodystrophy syndrome occurs in early end-stage AIDS and produces altered body composition and various hormonal and physiological changes. The cause of the syndrome and its relationship with HIV and protease inhibitors are unknown. Because of the disfiguring nature of some symptoms, lipodystrophy can be particularly distressing for women. Symptoms include

- Redistribution of body fat
- Increase in waist size
- Thinning of the arms and legs
- Increased facial wrinkling
- Weakness and muscle wasting
- Gastrointestinal symptoms
- Increased triglycerides and cholesterol
- Decreased testosterone levels
- Hypertension
- Diabetes

To determine body composition changes, provider staff should recommend that clients be measured on a bioelectrical impedance analysis machine. This noninvasive machine sends a weak electrical current through electrodes placed on the client's hands and feet to measure fluid volume, blood cell mass, extracellular mass, and level of body fat. Repeated every 3 to 6 months, this procedure can provide an accurate gauge of the client's biophysiological status.

Providers can treat weight loss and malnutrition by prescribing a nutritious, balanced diet with plenty of fluids and a daily multivitamin, if needed. Protein and calorie supplements are recommended if the client is losing weight. The client should avoid toxic substances such as alcohol, tobacco, and recreational drugs and should practice a daily routine of moderate exercise. Pharmaceutical interventions that may be required include appetite stimulants, thalidomide, and growth hormones.

Treatment staff should also discuss integrative therapies with the client. These can include herbs,

acupuncture, meditation, massage, yoga, chiropractic, homeopathic medicine, megadosing, tai chi, qigong, and various religious practices.

#### *Dental care*

Substance-abusing clients typically have poor histories of routine dental care, which can lead to extreme physical pain and incapacitation. Persons living with HIV/AIDS usually require extensive dental care, up to and including tooth extraction, jawline reconstruction, and dental plate replacement.

#### *Ancillary services*

The steady increase in the number of women living with HIV/AIDS is creating a great demand for ancillary services such as child care, housing, and transportation. Families needing housing may face long waiting lists for Section 8 housing or may receive Section 8 certificates only to find few landlords willing to accept Section 8 housing payments. Another concern for substance abusers, whether currently using or in recovery, is the fact that most low-cost housing tends to be in areas known for high drug traffic and crime.

#### *Disclosure Issues*

Disclosure issues are difficult for all HIV-infected clients. For substance-abusing clients, these issues take on additional challenges. For example, disclosure of positive HIV status may lead to personal threats or harm to both client and family. A client's family may refuse to associate with him upon learning of his HIV/AIDS status. Particularly for clients whose culture reflects definition of self within a community or self in relation to a clan (as opposed to individual definition), separation from community can serve as a trigger for lapse or relapse into risky substance use and sex-related behaviors. Therefore, providers must use caution when notifying clients of test results and should comply with regulations to ensure that a client's confidentiality is preserved. Providers should refer to [Chapter 9](#) for guidance in this area.

Also, during group therapy clients often feel an obligation to reveal their HIV status to the rest of the group. Counselors should caution clients about the impact of such disclosure and consider discouraging them from making it. Clients who wish to disclose their HIV status generally do so in response to treatment themes of honesty and openness and are not completely aware of the consequences. Of course, in treatment settings where all patients are HIV positive, there is no need for this concern.

### **HIV/AIDS-Specific Substance Abuse Counseling Issues**

There are many counseling issues specific to HIV/AIDS that providers should be familiar with when treating HIV-infected, substance-abusing clients.

#### *Cultural Competency Issues*

Culture is the integrated pattern of human behavior that includes thoughts, speech, actions, and

artifacts. Culture depends on the capacity of humans for learning and transmitting knowledge to succeeding generations. It takes into account the customs, beliefs, social norms, and material traits of a racial, religious, or social group. With this type of definition, it is easy to see that there is indeed a culture of addiction, a culture of poverty, a gay culture, and even a recovery culture.

Cross and colleagues present a comprehensive discussion of culturally competent systems of care. Five essential elements contribute to cultural competence (Cross et al., 1989, pp. 19-21), which can briefly be described as follows:

1. **Valuing diversity.** Counselors value diversity when they accept that the people they serve come from very different backgrounds and may make different choices based on culture. Although all people share common basic needs, there are vast differences in how people go about meeting those needs. Accepting the fact that each culture finds some behaviors, actions, or values more important or desirable than others helps workers interact more successfully with different people.
2. **Cultural self-assessment.** When counselors understand how systems of care are shaped by dominant cultures, it may be easier for them to assess how these systems interface with other cultures. Care providers can then choose actions that minimize cross-cultural barriers.
3. **Dynamics of difference.** When cultural systems interact, both representatives (e.g., care provider and client) may misjudge the other's actions based on history and learned expectations. Both will bring dynamics of difference--culturally prescribed patterns of communication, etiquette, and problemsolving, as well as underlying feelings about serving or being served by someone who is different. Incorporating an understanding of these dynamics and their origins into the system enhances chances for productive cross-cultural interventions.
4. **Institutionalization of cultural knowledge.** Workers must have accurate cultural knowledge and information or access to such information. They also must have available to them community contacts and consultants to answer culturally related questions.
5. **Adaptations to diversity.** The previous four elements build a context for a cross-culturally competent system of care and service. Both workers' and systems' approaches can be adapted to create a better fit between needs of people and services available. For instance, members of certain ethnic groups repeatedly receive negative messages from the media about their culture. Programs can be developed that incorporate alternative culturally enhancing experiences, develop problemsolving skills, and teach about the origins of stereotypes and prejudice. By creating and implementing such programs, workers can begin to institutionalize cultural interventions as a legitimate helping approach.

Finally, becoming culturally competent is a developmental process for individual counselors.

It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and a willingness to risk. (Cross et al., 1989, p. 21)

Treatment providers and counselors must examine two essential factors when working with culturally, racially, or ethnically different populations: the socioeconomic status of the client or group and the client's degree of acculturation. A distinction should be made when discussing a population as a whole and a particular segment of that population. For example, when treating an HIV-infected substance-abusing Hispanic woman, the counselor should focus on the woman as an individual and on the particular circumstances of this individual's life, rather than seeing her as an abstract representative of her culture or race. More often, poverty is the relevant issue to be discussed, rather than specific ethnic or racial factors (Centers for Disease Control and Prevention [CDC], 1998).

The second factor, degree of acculturation, is important and should be part of the assessment process. How acculturated or assimilated are the family and client? What generation is this client? Assessing for this, and knowing that several generations with different values and levels of acculturation may all live in one household, can test the communication skills and counseling skills of the best service providers. When discussing acculturation/ assimilation and values, counselors should keep in mind that, in general, the more years a family has lived in the United States, the less traditional their values tend to be. Thus a fourth-generation Chinese-American client may not speak Chinese or hold traditional Chinese values. Knowing the values and beliefs of a client is crucial if treatment is to be effective.

Providers must also help develop culturally competent systems of care. A part of this is making services accessible to and often used by the target risk populations. Culturally competent systems also recognize the importance of culture, cross-cultural relationships, cultural differences, and the ability to meet culturally unique needs (Cross et al., 1989).

Aside from assessing cultural competence using the five elements discussed previously, it also is helpful to examine some ways in which providers can minimize cultural clashes and blocks that may exist when working with clients. The guidelines given in Figure 7-3 are adapted from a project conducted by the University of Hawaii AIDS Education Project.

One concern in providing culturally competent care is how to discuss values and differences around sex and sexuality. In many cultures, people avoid discussing sex because they find such discussions disrespectful. This is one reason why so many cultures avoid discussing homosexuality. A counselor should consider using a less direct approach when initiating discussion about issues related to sex and sexual orientation. Many providers believe that some of the public health problems faced in communities of color and the gay community are related to their inability to speak often and directly enough about safer sex practices, risky behaviors, and homosexuality. Even in the recovery culture and in many treatment settings, sex and sexuality are blatantly avoided. Service providers must acknowledge that they, too, in addition to their clients, are often uncomfortable talking about sexuality, sexual identity, and sexual orientation.

Providers also should be aware of the messages often given to communities of color and particularly women. The message, "stop having sex," often advocated by providers has been mixed with historical issues and fears of racial/ethnic genocide, thus making it difficult for most

groups to give any credence to those expounding this method of reducing HIV/AIDS. The value of sex and procreation in many cultures makes it difficult for someone from outside the client's culture, especially someone of a different gender, to tell people to not have sex or to have sex only with a condom.

Finally, it is important that the counselor recognize that much of what is asked of clients and their families is personal and private. Questions related to sex, dying, and substance abuse are not usual topics of conversation, and when asking these questions, the counselor crosses many boundaries. It often is considered disrespectful (and offensive to certain cultural values) to ask questions about these specific areas. One wise way to broach these subjects with clients, especially clients who are significantly older than the provider or from a more traditional culture, is to simply apologize

The most practical advice is for providers to (1) maintain an open mind, (2) use cultural consultants for training and support, and (3) when in doubt, defer to the concepts of health and stability over pathology and dysfunction.

Figure 7-4 presents the LEARN model developed by Berlin and Fowkes, an excellent cross-cultural communication tool that can be useful in all client encounters, especially with clients who are culturally different from the provider and who have HIV/AIDS and substance abuse disorders.

### *Special Populations*

#### *Gay, lesbian, bisexual, and transgender populations*

Providers wishing to serve the needs of particular ethnic or cultural groups have learned that communities must be understood, respected, and consulted in order to make effective interventions; this also holds true when working with gay men, lesbians, and bisexual men and women. This population is defined not by traditionally understood cultural and ethnic minority criteria, but by having a sexual orientation that differs from that of the majority. Transgender people also form a unique population, often linked to gay men, lesbians, and bisexuals, although they differ from the majority by gender identification rather than sexual orientation.

Until recently, there has been no solid agreement about the amount of substances used or the incidence of substance abuse in the gay, lesbian, bisexual, or transgender populations. Most studies (Beatty, 1983; Diamond and Wilsnack, 1978; Lewis et al., 1982; Lohrenz et al., 1978; McKirman and Peterson, 1989; Mosbacher, 1988; Pillard, 1989; Saghir and Robins, 1973), reports (Fifield et al., 1975; Lesbian and Gay Substance Abuse Planning Group, 1991), reviews of surveys (Morales and Graves, 1983; Weinberg and Williams, 1974) and the experiences of most clinicians working with gay men and lesbians (Cabaj, 1989; Finnegan and McNally, 1987) have estimated an incidence of substance abuse of all types at approximately 30 percent, with ranges of 28 to 35 percent (contrasting with an incidence of 10 to 12 percent for the general population). The CDC's biannual report on HIV/AIDS clearly indicates a subgroup of gay and male bisexual injection drug users, and one of the routes of HIV infection for lesbians is via

IDU.

A careful review of these reports, however, has demonstrated significant and persistent methodological problems, ranging from poor or absent control groups and nonrepresentative population samples (some studies gathered subjects only from gay and lesbian bars) to a failure to use uniform definitions of substance abuse or of homosexuality itself. Nevertheless, a recent study was conducted using data from the 1996 National Household Survey of Drug Abuse (NHSDA), a yearly population-based survey that applies standard epidemiological methods to determine the prevalence of substance use in the U.S. population. This study has concluded that homosexually active women are indeed more likely than heterosexually active women to evidence drug or alcohol dependency (Cochran and Mays, in press).

A sudden increase in the use of methamphetamine, known as "speed," "crystal," "ice," or "crank," by gay and bisexual men has become a matter of grave concern. A primary route of administration for this drug is injection. Combined with its disinhibiting and sexually stimulating effects, gay male injectors of methamphetamine are at extremely high risk for HIV exposure: The drug causes the abuser to suspend all judgment and leaves him often impotent but extremely sexually aroused and often an anal-receptive partner in sex (Gorman, 1996;Gorman et al., 1995).

Men who have sex with men (or MSMs--the CDC category used to report its data) may self-identify as gay (men with homosexual sexual orientations), bisexual (men who feel sexually drawn to both men and women), or heterosexual (men having sex with men as a purely physical act and not a reflection of innate sexual orientation). No matter what their sexual orientation, unprotected sexual contact puts MSMs at risk for HIV. In most reviews of gay men and safer sex practices, most men who were knowledgeable about safer sex failed to practice it while under the influence of some substance (Calzavara et al., 1993; Leigh, 1990; Leigh and Stall, 1993; Paul et al., 1994;Stall, 1987; Stall et al., 1986). Many men from minority backgrounds who have sex with other men do not self-identify as gay or bisexual, so interventions should be based not on sexual orientation, but on sexual behavior.

Some women who have sex with women continue to have sex with men. A number of these women may be injection drug users and share syringes; consequently, they are prone to HIV infection. Although it is unlikely that female-to-female transmission of the virus will occur, lesbians have been urged to use safer sex precautions, such as using dental dams during oral sex (White, 1997).

Lesbians present some specific issues that must be highlighted. Compared with gay men, they are more likely to have lower incomes (as do women in general when compared with men); are more likely to be parents (about one-third of lesbians are biological parents); face prejudice as women as well as for being gay, including the stronger reaction against and willingness to ignore females with substance abuse disorders; are more likely to come out later in life (about 28 years of age versus 18 years of age in men); and are more likely to have bisexual feelings or experiences, so that they are still at sexual risk for HIV infection as well as possible IDU risk (Banks and Gartrell, 1996; Bell et al., 1981; Bradford and Ryan, 1987; Mosbacher, 1993).

Gay youth also present treatment challenges. Special sensitivity and understanding are needed to

work with youth of any background, especially youth who are gay or lesbian or from an ethnic minority background. Young gay males in particular may be subjected to harassment at home or school, and they are prone to alcohol use, dropping out of school, running away, and getting involved in sex for drugs or money (Ku et al., 1992; Rotheram-Borus et al., 1995; Savin-Williams, 1994). Many young gay male streetworkers abuse amphetamines, "tweaking" to have a sexual experience, and may exchange sex for drugs.

In general, gay men, lesbians, bisexuals, and transgender people are wary of the medical establishment and may resist seeking health care, distrust the advice given, or question the treatment plan suggested if the provider displays evidence of homophobia or heterosexism.

### Transgender individuals

Some substance abuse treatment clients are transgender. The following definitions have been provided to clarify the confusion some providers may feel when working with transgender clients (CSAT, in press [b]).

Transgender people are a diverse group of individuals who cross or transcend culturally defined categories of gender. They can include the following:

- Male-to-female (MTF) and female-to-male (FTM) *transsexuals*--those who desire or have had hormone therapy or sex reassignment surgery
- *Cross-dressers* or *transvestites*--those who desire to wear clothing associated with another sex
- *Transgenderists*--those who live in the gender role associated with another sex without desiring sex reassignment surgery
- *Bigender persons*--those who identify as both man and woman
- *Drag queens* and *kings*--usually gay men and lesbian women who "do drag" and dress up in, respectively, women's and men's clothing
- *Female* and *male impersonators*--males who impersonate women and females who impersonate men, usually for entertainment

Gender identification is different from sexual orientation. *Gender identity* refers to a person's basic conviction of being male, female, or transgender. *Sexual orientation* refers to sexual attraction to others (men, women, or transgender persons). For example, many cross-dressers are heterosexual men who have active sexual relationships with women. Many homosexual men, although historically considered effeminate, identify strongly as men and appear very masculine.

Substance use plays a significant role in the high HIV prevalence in MTF transgender individuals (Longshore et al., 1993, 1998). One study that investigated 519 transgender individuals in San Francisco found high rates of substance abuse among both MTF and FTM individuals (Clements et al., 1998). The study reported that 55 percent of the MTF sample indicated they had been in substance abuse treatment at some time during their lifetime. The study also found that HIV prevalence was significantly higher among MTF individuals (35 percent) than FTM individuals (2 percent), and among the MTF individuals, HIV prevalence for African Americans was 61 percent. Although the HIV prevalence rate was low in the FTM

individuals, they commonly reported engaging in many of the same HIV risk behaviors as the MTF individuals (Clements et al., 1998).

Counseling transgender individuals who are HIV positive and in substance abuse treatment can involve many different issues. Some of these issues are obvious: lack of family and social supports, isolation, low self-esteem, and internalized transphobia, to name a few. Some issues are not so obvious; for example, transgender clients currently undergoing hormone therapy often experience emotional and physical changes that can make treatment for substance abuse more difficult and relapse more likely. Although medically managed hormone treatment should not be interrupted, both the clinician and client must be aware that estrogen and testosterone therapies are mind- and mood-altering substances, particularly when incorrectly taken. Improper administration of estrogen mimics the premenstrual symptoms of nontranssexual women, which can have a deleterious effect on recovery (CSAT, in press [b]). These premenstrual symptoms can trigger or exacerbate Post Acute Withdrawal Syndrome, which is believed to be the leading cause of relapse.

Additional relapse triggers or clinical issues may include the following: (1) inability to find, engage in, or maintain gainful employment due to employer prejudice against transgender individuals; (2) lack of formal education or training because the client was forced to leave school or home before completing his or her education; (3) the fact that HIV-positive transgender clients may be denied sex reassignment surgery due to their HIV status, even if they are asymptomatic and healthy; and (4) the general lack of substance-free role models and widespread social support for transgender individuals.

Clinicians, particularly those in rural areas, may have had little experience in treating transgender clients. Figure 7-5 lists some guidelines that clinicians may find helpful in working with this population. Some resources providers may also find helpful include the Lambda Center in Washington, D.C. (202-965-8434), which provides behavioral healthcare programs for transgender clients and others with HIV/AIDS and substance abuse problems, and the Center Gender Identity Project in New York City (212-620-7310), which provides HIV/AIDS and substance abuse counseling and referral services exclusively for transgender clients. [↑ TOP](#)

## Women

The needs of women have always represented a unique challenge to health care and substance abuse treatment systems. Traditionally, these challenges have not been well met and are being exacerbated by the growing number of substance-abusing women infected with HIV. The diseases of substance abuse and HIV/AIDS present differently in women than in men and progress at different rates for a variety of reasons, including the fact that women usually present later in the HIV/AIDS disease process than men.

Gender-specific services for women should include the following:

- Medical and substance abuse treatment that is accessible, available, and incorporates
  - General health (including reproductive health) and wellness across the life span
  - Mental health counseling (particularly for PTSD)

- Parenting skills and support
- Family-focused support
- Relationship issues
- Trauma/abuse support
- Educational/vocational services
- Legal services
- Sexuality and sexual orientation issues
- Eating disorder support
- Women-only support groups
- Empowerment--that is, holistic programming that emphasizes the development of a partnership with a female service provider, one in which there are mutual respect and many opportunities for positive role modeling
- Transportation services
- Child care, both onsite and supervised
- Woman-sensitive women working with women
- Long-term case management services that extend to the client and her family

A woman's identity as caregiver/caretaker must be recognized as an extremely powerful factor in how she accesses care and treatment and how successful she is in her recovery and health maintenance. There is no question that this identity/role can explain why a woman seeks treatment ("for the kids") or why she leaves treatment ("to get home to my husband/partner/kids"). This is also a factor in a woman's sense of guilt and shame from becoming HIV infected--a societal stigma that only "bad girls" get HIV or are addicts or alcoholics, and the stigma of being an unfit mother if she has lost custody of her children.

Providers must be open and prepared to discuss safer sex and drug and alcohol abuse from a risk-reduction perspective. They must be well informed about and comfortable in discussing sexuality. Risk reduction is an ongoing type of intervention that goes beyond assertiveness training and teaching women how to put condoms on men. It recognizes the need to "start where the client is" and use appropriate interventions, which may help a woman reduce her risk of getting reinfected or of infecting a partner. This includes instructing female injection drug users about how to use bleach to "clean their works," how to use a female condom, or how to use a vaginal spermicide foam (not the safest risk-reduction method, however) to lower their risk of HIV infection when having intercourse. It also involves making referrals to substance abuse treatment and instruction for male partners on how to use a condom correctly.

### Reproductive decisionmaking

Reproductive decisionmaking is an important area for providers to examine with both female and male clients. Providers must be prepared to discuss pregnancy and family planning with respect and without judgment. This is a difficult task for providers and clients; counselors may have many judgments about "right" and "wrong" and many opportunities for countertransference. One way providers can interact with clients is to help them openly and honestly consider various factors when making reproductive decisions. Figure 7-6 is adapted from an article written by Rebecca Dennison, director of a women's health advocacy organization based in San Francisco, who is HIV positive and considered these issues with her husband in her own reproductive

decisionmaking.

The questions listed in Figure 7-6 are extremely helpful, but it is also important to remember that many clients have never made reproductive decisions. Their substance abuse problems have been at the forefront of their lives for so long that they may find it difficult, even in recovery, to "own" their decisionmaking responsibilities. One way to provide support in this area, and help build coping skills, is to encourage women to talk with other women--to become part of a support group that is based on empowerment and women helping women. Counselors should see reproductive decisionmaking as a very high priority and move toward this goal in small, incremental steps.

At present, no one knows exactly how to predict which mothers will transmit HIV to their infants. Although there is some speculation that a mother's viral load, measured through viral load assays, may indicate whether her infant becomes HIV infected. Much is still unknown, and controversies abound, but providers must understand and respect the importance of self-determination and the right of women to make their own decisions. Ultimately, it is the woman's choice.

Today, HIV-positive women are looking at the prospect of pregnancy differently than they did in 1989. HIV-positive women who think about becoming pregnant have access to information about viral load testing and the possibility of artificial insemination. Also, HIV-positive women can consider a natural rhythm method, identifying fertile days and limiting unprotected intercourse to those times to decrease their partner's risk of HIV infection. There is no question that even today, facing pregnancy while HIV positive, examining the options related to terminating or continuing a pregnancy, deciding about medications, examining the woman's health and the infant's health, and addressing the long-term implications are all complex issues.

It is essential that providers examine these issues with clients within the context of a biopsychosocial framework. Counselors and health care providers must work together, along with the female client, to stay aware of the latest research and information regarding HIV/AIDS treatment. It is also important to remember that data and information on HIV/AIDS are constantly changing and that the "facts" provided to clients today may be very different tomorrow.

#### Parents who are HIV positive

More and more resources have been developed for single- and two-parent households in which one or both parents are HIV positive and/or the children are HIV positive. There must be a continued awareness of the needs of these families.

These families experience the need for a variety of services, both child-centered and adult-centered. Concerns about guardianship for children after the parent is unable or unavailable to care for them must be a major focus for the parent and the service provider. Unfortunately, many clients who have long histories of substance abuse may have "burned many bridges," and the family support they need for permanency planning and establishing an appropriate guardian for their children is no longer available. All too often, there is only a tired, abused, and used

grandparent who is dealing with chronic ailments, limited resources, and little emotional energy to raise more children.

If a child also is HIV positive, there will be special needs that the parent may not be able to address while facing her own issues. The already demanding dynamics of childhood, school, and growing up become more challenging for an HIV-infected child and parent. Even if the child is not HIV positive, the demands of parenting can prove rigorous for single parents with HIV/AIDS. Although the parent experiences the relief of knowing the child is all right, the poignant realization that he may not live to see that child grow up can still be painful.

The HIV-infected single parent with a substance abuse disorder is at risk of losing custody of her minor children if convicted of drug possession or substance abuse. If family members disapprove of the single parent's lifestyle, they may seek custody of the active substance abuser's minor children. The counselor may facilitate a plan encouraging the single parent toward goals that support the parenting relationship. This enables the recovery process to take place while the parent and child are working out their own version of permanency planning.

It is difficult for a child to witness the effects of a substance abuse disorder on a parent; surely the difficulty increases enormously when the child is told that the parent has HIV/AIDS. Children whose parents are in recovery from substance abuse disorders or who are maintaining some stability despite periodic substance abuse may experience some changes in their relationships with their parents.

There are support groups and programs for children whose parents are affected by HIV. Although not available in all communities, these groups offer children a chance to talk about their fears regarding their parents' health, learn more about the disease, and socialize with others who are facing these problems. At the same time, the programs can provide the parent with some respite time. In addition, groups like Al-Anon and Alateen can provide children with support and education about the recovery process.

If service providers work in a large urban area, chances are there will be an AIDS Service Organization (ASO) listed in the phone book. This agency is likely to have lists of support groups of all kinds. Single parents with substance abuse disorders who are HIV positive should also have a support group.

### Hispanics

The Hispanic population in the United States is diverse, composed of a wide range of racial, indigenous, and ethnic groups. The following are important statistics related to the U.S. Hispanic population that affect how outreach, prevention, and treatment planning should be conducted:

- Hispanics have the highest labor force participation rate of all groups.
- Hispanic men have the highest fertility rate of all groups across all ages.
- Hispanic men have the lowest divorce rate of all groups.
- Hispanic men are on average younger than other men in the United States (with median age of 26.2 years).

- Hispanic women seek detoxification and treatment for substance abuse disorders in lower numbers than women from any other ethnic/cultural group.
- 90 percent of Hispanics are Catholic.
- 36 percent of Hispanic children live below the poverty level.
- There is a clear increase in substance abuse as Hispanics become more acculturated (i.e., in second and third generations, and so on).
- Hispanics are overrepresented among HIV/AIDS cases for men, women, and children.
- Hispanics as a group may include aliens who are undocumented or carry immigrant visas (green cards) and who avoid contact with the health care system because they fear possible deportation.

Within the context of acculturation and socioeconomic status, providers should be aware of specific cultural issues that can support interventions and improve a provider's ability to engage Hispanic clients, such as the role of the family, the values of interdependence, respect, and "personalismo" (i.e., importance of personal contact). Understanding these concepts will help establish rapport and trust.

The Hispanic family is generally extended and has many members. A Hispanic client's support system may be composed of siblings, godparents, aunts, and uncles who are all very involved with the client. The family as a whole is of great importance, and often what is best for the family will override what is best for one of its members. Because the family is so important to most Hispanics, children are highly valued. This makes it easier to see how some Hispanic women who are HIV positive grieve deeply about the decision not to have children and may feel unfulfilled and inadequate as a result. This also sheds some light on the challenges of involving Hispanics in substance abuse treatment. Leaving their children behind while in treatment or turning guardianship over to a State agency may be unacceptable and create more conflict.

Often, families are aware of homosexual family members, but usually this is not discussed openly. The reality is that many Hispanic men who prefer sex with other men do marry and have children. This partly explains why Hispanics are at such high risk for HIV/AIDS. If the man has married and fathered a child, he has been congruent with the values relating to family; if he then goes out with men, or even with other women, this behavior may be tolerated as long as he continues to provide for his family. Figure 7-7 offers additional considerations for working with Hispanics.

#### African Americans

As is the case with members of other minority groups, the health and social repercussions of substance abuse problems are magnified in the lives of African Americans (CSAT, 1999b). In terms of past-year prevalence rates of illicit drug use, the 1998 NHSDA (SAMHSA, 1999) found that the rate for African Americans (8.2 percent) was somewhat higher than for whites (6.1 percent) and Hispanics (6.1 percent). In addition, HIV/AIDS disproportionately affects African Americans, and from July 1998 through June 1999, injection drug use accounted for 26 percent of AIDS cases among African American males and 26 percent of cases among African American females (CDC, 1999b). (See Chapter 1 for more information about the epidemiology of the

## AIDS pandemic.)

African American women in particular have special needs. Minority women represent the fastest-growing segment of the U.S. HIV/AIDS pandemic. One study (Kalichman and Stevenson, 1997) examined the psychological and social factors related to HIV risk among 153 African American inner-city women. The women completed measures of HIV risk history, sexual and substance use behaviors, perceived risk for HIV infection, self-efficacy to reduce risk (i.e., the belief that one can effectively perform specific behaviors), and perceived social norms supporting risk reduction. Fifty-five percent of the women reported at least one factor that had placed them at known risk for HIV infection. Results showed that HIV risk history was associated with a self-perceived risk for HIV infection and low self-efficacy to perform risk-reducing actions, suggesting that HIV risk-reduction interventions targeting inner-city women should focus on skills training approaches to build self-efficacy and empower women to adopt risk-reducing practices (Kalichman and Stevenson, 1997).

Many African Americans have a deep-seated mistrust of the health system. This dates back to the pre-Civil War period when, because they were considered property and had no legal right to refuse, slaves were sometimes used in medical experiments (Gamble, 1997). A collective memory thus exists among the African American community of their exploitation by the medical establishment (Gamble, 1997). More recently, the syphilis study performed at Tuskegee University from 1932 to 1972, during which 400 African American men infected with syphilis were deliberately denied life-saving treatment, has fostered in some African Americans the belief that contact with health care institutions will automatically expose them to racist administrators and policies. Several articles point to the Tuskegee study as a significant factor in the low participation of African Americans in clinical trials and organ donation efforts and in the reluctance of many African Americans to seek routine preventive care (AIDS Weekly Plus, 1995; Karkabi, 1994; Thomas and Quinn, 1991). As one AIDS educator said, "so many African American people that I work with do not trust hospitals or any of the other community health care service providers because of that Tuskegee experiment. It is like \_ if they did it once, then they will do it again" (Thomas and Quinn, 1991).

A study (Longshore et al., 1992) that compared the use and perceptions of substance abuse treatment services among African American, Hispanic, and white substance-abusing arrestees confirmed that African American substance abusers were more likely than white substance abusers to hold unfavorable views of treatment. Another study (Gary, 1985) examined the attitudes of African Americans in a northeastern city toward mental health treatment and found that only 34 percent of the sample felt positively toward community mental health centers. The study also revealed that women and married persons demonstrated more positive attitudes than did men and unmarried persons and that participants with a high tolerance of substance abuse possessed more negative attitudes than did others.

Counselors should be aware that the issues of slavery and institutional racism are constant and prevalent facts in the lives of many African Americans and should be addressed early in treatment so they are acknowledged, validated, and brought into the treatment process (CSAT, 1999A). In order to provide effective substance abuse treatment for African American clients, providers need to take into account the social, economic, political, and cultural contexts of their

lives (Pena and Koss-Chioino, 1992).

Spirituality is very important for many African Americans. The relationship between an individual and the faith community is a critical source of strength that can help prepare clients to succeed in substance abuse treatment. In addition, many African Americans have strong social networks. They may have friends or a pastor with whom they might share information they would not share with a substance abuse counselor. These confidants might act as "co-therapists" for the client. It can be helpful for clients if counselors can identify and integrate clients' co-therapists into their substance abuse treatment plans (keeping in mind clients' rights to confidentiality and the need for signed consent forms--see Chapter 9 for more information).

Along these lines, for African Americans with substance use disorders and HIV/AIDS, support groups of friends may be more likely to be helpful and less undermining than support groups of families. This is perhaps due to the lingering stigma of the ways in which HIV/AIDS is acquired--both intravenous drug use and homosexual activity are still highly stigmatized acts within many African American communities. Thus, activating family supports may be difficult, and providers should encourage clients to participate in support groups composed of their peers. [↑ TOP](#)

#### Asian Americans

Asians and Pacific Islanders are a culturally and linguistically diverse people from the Asian continent and the Pacific Islands. In the United States, they include nearly 40 different nationalities, 50 different ethnic groups, and more than 100 languages and dialects. Asians and Pacific Islanders comprised 4 percent of the total U.S. population in 1999. From July 1998 through June 1999, they accounted for 0.7 percent of all adult and adolescent HIV cases (these include only persons reported with HIV infection who have not developed AIDS), and 0.4 percent of adult and adolescent AIDS cases. Of the total AIDS cases reported for this population through December 1998, 89 percent were in men; 79 percent of those were reported in men who have sex with men (CDC, 1999b). Among women, nearly half the cases (48 percent) are associated with sex with an infected or high-risk partner, and 17 percent are reported from IDU (CDC, 1999b).

The increasing size and diversity of the Asian and Pacific Islander population make it difficult to discuss group norms regarding substance abuse. Norms for alcohol and tobacco use vary by culture and there appear to be no norms governing the consumption of narcotics or other substances.

Service providers also should shed the notion of the "model minority," which often typecasts Asians and Pacific Islanders and limits treatment access. Often, Asians and Pacific Islanders believe the model minority myth and feel isolated when they test positive or report substance abuse disorders. They may also feel they have let down their families and communities.

Despite differences in cultural norms and mores among Asians and Pacific Islanders, cross-cultural beliefs in the importance of group and collective identity, service, and responsibility suggest the use of treatment strategies that incorporate biological or constructed families and communities rather than a focus on individual behavior change. Moreover, treatments that emphasize nonverbal or indirect communication skills, not confrontation, may be more culturally

appropriate and more effective. Most American treatment modalities rely heavily on verbal therapies that require direct verbal emotional expression and a high level of personal disclosure. Many substance abuse treatment programs favor a confrontational approach, and many HIV/AIDS programs favor support groups and psychotherapy. These treatment approaches, unless modified for Asian and Pacific Islander clients, are often unsuccessful because they violate Asian and Pacific Islander cultural norms. By American standards, Asians and Pacific Islanders tend to communicate more indirectly, often by telling stories and discussing what happened to themselves and others. Their feelings and opinions are implied rather than directly stated. Asians and Pacific Islanders are also less likely to provide direct verbal expression of their feelings by using "I" statements than are members of other groups. Providers should expect to reveal personal information about themselves if they want clients to disclose their own problems. Asians and Pacific Islanders may prefer to keep strong feelings under control so that they will not become disruptive. Caring is often demonstrated by physical support such as by giving money, cooking favorite foods, or giving advice rather than by verbal expression or physical affection.

A problemsolving approach rather than an intrapsychic one is more effective with Asian and Pacific Islander clients. Problemsolving enables a counselor to provide information, educational materials, and referrals without probing for more personal information and pushing a client to express feelings. For Asian and Pacific Islander clients with somatic complaints, suggest relaxation and breathing techniques, meditation, qigong, yoga, massage, acupuncture, tai chi, or biofeedback. It is generally not helpful to discuss underlying feelings because it is not only culturally unacceptable, but many Asian and Pacific Islander clients do not see the emotional-physical connection. In problemsolving, providers should actively give suggestions and if necessary, be directive rather than let Asian and Pacific Islander clients struggle to figure out what options are available to them.

Asking personal questions about substance abuse and sexual risk factors, especially early in the helping relationship, could be viewed as intrusive and disrespectful. Asian and Pacific Islander clients may not answer truthfully, if at all, and may not return. It is best to start with the least intrusive or nonthreatening questions during the intake and explain why the information is needed. If clients seem uncomfortable with certain questions, ask them at a later date.

Making an effort to connect with clients outside actual treatment appointments when they come to the agency for other activities or via followup calls is also helpful. Asian and Pacific Islander clients may not initiate contact when they have a problem because of cultural tendencies to minimize problems to reduce stigma and because they do not want to be intrusive and bothersome. In all interactions, it is helpful to minimize the stigma Asian and Pacific Islander clients attach to their HIV/AIDS status and substance abuse disorders. Counselors should not refer to themselves as HIV/AIDS, mental health, or alcohol and drug counselors unless they know the client is comfortable with this. These titles imply the client has an unacceptable condition and can increase stigma. Clients may be more receptive to treatment for HIV/AIDS and substance abuse issues if they are combined with other, less stigmatized health issues.

Group interventions can be effective if everyone speaks the same language well enough and if the group is centered around an unstigmatized activity, social gathering, or education session.

Providing refreshments also facilitates bonding. Asian and Pacific Islander participants will look to a facilitator to provide direction and guidance. Rather than be assertive in talking, Asian and Pacific Islander clients will more likely wait for a space to open up for them to speak and consequently will rarely have the opportunity to do so when in a group with predominately non-Asians and Pacific Islanders. Should this happen, the group leader needs to facilitate opportunities for Asian and Pacific Islander clients to participate. [↑ TOP](#)

#### [Native Americans](#)

Native Americans and Alaskan Natives comprised 0.9 percent of the total U.S. population in 1999. From July 1998 through June 1999, they accounted for 0.4 percent of all adult and adolescent HIV cases reported (these include only persons reported with HIV infection who have not developed AIDS) and 0.6 percent of adult and adolescent AIDS cases. The largest percentage of HIV and AIDS cases in women was from heterosexual contact (39 percent and 23 percent, respectively). The largest percentage of HIV and AIDS cases in men was reported in men who have sex with men (43 percent and 47 percent, respectively).

The CDC found that Native Americans have high rates of STDs and substance abuse, which in turn raise their risk of HIV/AIDS. They also lack access to diagnosis and treatment. Gay men and substance abusers run the highest risk of HIV/AIDS among Native Americans and Alaskan Natives, just as they do among white Americans.

The combination of high rates of cofactors for HIV/AIDS, limited access to health care, lack of information and education about HIV/AIDS issues, substantial numbers of Native Americans who are already infected with HIV, and the flow of Native Americans between urban centers and reservations all lead to an HIV/AIDS crisis for Native American communities.

Limited treatment services for HIV-infected substance abusers exist on and outside tribal lands. In 1991, the American Indian Community House, which ministers to the health, social service, and cultural needs of Native Americans in the New York City area, created the HIV/AIDS Project, the first Native American program east of the Mississippi River to provide culturally sensitive legal services, HIV/AIDS treatment information, emergency assistance, and prevention education. The Friendship House Association of American Indians in San Francisco provides another example of treatment (drop-in centers). This program provides comprehensive treatment to Native Americans living with HIV/AIDS as well as treatment for substance dependency. Services target the gay, lesbian, and bisexual communities. HIV/AIDS is presently underreported for Native Americans and is based on the high incidence of sexually transmitted diseases (STDs) in general, and thus substance abuse treatment centers will be faced with more and more HIV-infected Native Americans.

#### [Clients involved with the criminal justice system](#)

Many persons with substance abuse disorders receive treatment only after arrest and are offered treatment as a diversionary service or receive treatment while they are in jail or prison. The racial and class patterns characterizing arrest, adjudication, and sentencing in the United States skew more white Americans (regardless of social class or income) to treatment trajectories and more persons of color to jail or prison trajectories. Access to treatment within the criminal justice

system is thus highly associated with ethnicity and social class. Only a handful of correctional facilities in the United States have instituted some type of therapeutic community treatment program in prison with a parallel transitional program for new parolees (for more information on these programs, refer to TIP 30, Continuity of Offender Treatment for Substance Use Disorders From Institution to Community, [CSAT, 1998d]). Unfortunately, many HIV-infected individuals who are in treatment for HIV find it impossible to remain on their medication schedules after being arrested because their medications are often confiscated for days at a time.

The population in prisons and jails tripled between 1987 and 1997. Overcrowding and understaffing are common in prison facilities and can increase inmates' risk of contracting HIV. In 1992, HIV/AIDS cases for people in State and Federal prisons reached 195 per 100,000 compared with 18 per 100,000 for the general U.S. population.

Risky behaviors that lead to HIV infection are not eliminated when a person is imprisoned but may actually increase in frequency and availability. This occurs for several reasons. First, drug offenses count for the single largest number of Federal and State crimes for which people are arrested and incarcerated. In 1996, 79 percent of State inmates reported at least one use of illicit drugs during their lifetime. Therefore, high rates of HIV infection are not surprising in a population so closely characterized by heavy substance abuse involvement. In addition, many people enter jail or prison already infected with HIV. A 1993 study of 46 correctional facilities found people entering these facilities had an average infection rate of 1.7 percent. In some facilities, however, rates for women were as high as 21 percent and 15 percent for men. Among injection drug users, rates ranged from less than 1 percent to 43 percent.

Injection drug users face particular risk in prison settings as clean syringes are all but impossible to secure. Although syringes are not officially available, they can be acquired through illicit prison markets at exorbitant prices (\$34 in one Canadian facility) or through risky exchange of syringes for unprotected sex. Syringes are typically not new or sterile. As a result, injection drug users have as their only recourse used or shared syringes, which increases their chances of HIV infection. Tattooing is also common practice among prisoners and is another source of HIV infection. To date, there have been at least two documented cases of HIV/AIDS related to tattooing with unsterile needles in a correctional facility.

Only six prison systems in the United States distribute condoms: Mississippi, New York City, Philadelphia, San Francisco, Vermont, and the District of Columbia. Distribution strategies range from receipt of a single condom per medical visit to receipt of multiple condoms during HIV/AIDS education workshops. Furthermore, condom distribution programs send mixed messages because sexual activity in some facilities is illegal and a punishable offense. In other facilities, correctional medical and social service staff may advocate condom availability while administration and security officers oppose it.

Sixteen prison systems mandate HIV testing, and although 77 percent make testing available to inmates on request, few inmates request it for several reasons. First, confidentiality of results is not guaranteed. Second, mandatory testing may result in the segregation of those who test positive from those who test negative or who do not test. Third, prisoners do not wish to acknowledge activities that could subject them to further sanctions. Fourth, confidentiality on

discharge is eliminated because the Federal Bureau of Prisons requires HIV testing for all inmates on their release. HIV-positive inmates are asked to directly notify sex partners and significant others of the results. However, the Bureau of Prisons handles only a small percentage of inmates, and its policy is not the norm.

Treatment for HIV-positive inmates is often inadequate when available. Primary medical care may be limited to *Pneumocystis carinii* pneumonia prophylaxis and HIV monotherapy. Combination therapy may not be available or accessible to inmates, given the cost of medications, limited storage, refrigeration requirements for some medicines, and the strict adherence regimen required by combination therapy, which would require round-the-clock monitoring and assistance by typically unwilling and suspicious security staff.

Although there are large numbers of substance abusers within correctional facilities, less than 15 percent participate in treatment programs. This is partly because of lack of program availability and the common type of program offered (i.e., 12-Step, abstinence-based.) A 1991 study reported that only 1 percent of inmates with moderate to severe substance abuse disorders received appropriate treatment. Many of these treatment programs advocate sexual abstinence during recovery. Often, these programs offer no or little information about safer sex practices or advocacy around changing sexual behaviors. When persons with substance abuse disorders in treatment relapse, as is often the case, they may also engage in risky sexual behaviors. They are most likely to engage in risky sexual behaviors with sexual partners from similar treatment networks. These partners may include people who have used syringes, traded sex for money or drugs, or been victims of trauma. All of these populations are likely to have higher rates of HIV infection, making transmission likely.

Inmates who do complete or participate in treatment programs often rapidly relapse on discharge. For inmates who do complete treatment, there are often no aftercare programs to help them remain substance free. A 1995 study of Hispanic inmates in California State prisons found that 51 percent reported having sex within the first 12 hours after release, and 11 percent reported injection of drugs during the first day after release.

#### Adolescents

Adolescents are another group that is experiencing an increase in incidence and prevalence of HIV. Since 1994, findings from the Monitoring the Future surveys have revealed a dramatic and sustained increase in consumption of licit and illicit drugs among adolescents--this after nearly two decades of sustained decrease in drug consumption. Studies also note that teens are having sex earlier than ever before, often with multiple partners and inconsistent use of condoms, putting them at greater risk for HIV/AIDS. Beyond this, young people find themselves marginalized in U.S. society; this is especially true for young gay and bisexual youth, sexually active young women, and young people of color.

According to the CDC, AIDS is the fifth leading cause of death for Americans between the ages of 25 and 44 (CDC, 1999f). At greatest risk are young, disadvantaged females, particularly African American females, who are being infected with HIV at younger ages and higher rates than their male counterparts (CDC, 1998j). Because of the long and variable time between HIV

infection and AIDS, surveillance of HIV infection provides a clearer picture of the pandemic in young people than surveillance of AIDS cases. From the States for which HIV is a reportable condition, young people ages 13 to 24 accounted for a much greater proportion of HIV than AIDS cases (17 percent versus 4 percent). Of these HIV infections, 38 percent were reported among young females, and 56 percent were among African Americans (CDC, 1999b).

Adolescents may benefit from treatment that is developmentally appropriate and peer oriented. Addressing educational needs may be particularly important as well as involving family members in the planning of treatment and therapy.

Substance abuse among adolescents is frequently associated with depression, eating disorders, and sexual abuse history. Histories of familial sexual and substance abuse are predictive of serious adolescent substance involvement and subsequent treatment needs. For a discussion on adolescents and substance abuse disorders, see TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999A), and TIP 32, *Treatment of Adolescents With Substance Use Disorders*, (CSAT, 1999b).

#### Older adults

The last few years have witnessed greater increases in the number of HIV/AIDS cases among middle-aged and older individuals than in those under 40 years of age. Through June 1999, people over the age of 50 account for 11 percent of cumulative AIDS cases and 5 percent of cumulative HIV cases in the United States. Women comprise a greater percentage of all AIDS cases as age increases, ranging from 13 percent of AIDS cases among people aged 50-59, 15 percent of AIDS cases among those aged 60-69, and 21 percent of those 65 and over. For women with HIV, 22 percent of this group is in the 50-59 age bracket; 24 percent is aged 60-64; and 31 percent aged 65 and older. The rate of HIV infection in older women reflects the greater incidence of surgeries (such as hysterectomy) that require blood transfusions.

Although many of these AIDS cases are the result of HIV infection at a younger age, many people become infected after age 50. Rates of HIV infection among older adults are difficult to ascertain because very few people over 50 years of age routinely test for HIV. Because older adults are diagnosed with HIV/AIDS at advanced stages, older adults are less amenable to treatment, become sicker, and die faster than their under-50 counterparts. In addition, retroviral treatments and opportunistic infection prophylaxis may interact with medications the older person is taking to treat other preexisting chronic illnesses and conditions. Also, the vast majority of medication studies are done on much younger subjects. There is little research on the metabolism of anti-HIV drugs in older adults.

There is, as well, little research on the substance-abusing behavior of older adults, and very few substance abuse treatment programs address the needs of older adult substance abusers (see TIP 26, *Substance Abuse Among Older Adults* [CSAT, 1998a]). Unfortunately, many medical professionals do not consider older patients to be at risk for either substance abuse (with the exception of alcohol use) or HIV infection. A study in Texas found that most doctors never asked patients older than 50 years questions about substance abuse or HIV/AIDS or discussed risk factor reduction. Doctors were much more likely to rarely or never ask patients over 50

about HIV/AIDS risk factors (40 percent) than to rarely or never ask patients under 30 (7 percent). Older persons may not be comfortable disclosing their sexual behaviors or substance abuse to others, since their generation or culture may not encourage such disclosures. This can make finding treatment programs and support programs especially difficult.

Certainly, there is a need to educate service providers about the sex- and substance-related behaviors of older persons. At the very least, service providers should conduct thorough sex and substance abuse risk assessments with their patients over 50, and challenge all assumptions that older people do not engage in these activities or will not discuss them. [↑ TOP](#)

#### [Sex industry workers](#)

Among sex workers, street prostitutes are the most vulnerable to HIV infection, given the coexisting features of poverty, homelessness, history of childhood sexual abuse, and alcohol and drug dependence. Comparatively, male and female sex workers who work in massage parlors, escort services, their own apartments, or brothels rather than on the street are far less likely to be at risk for infection, less likely to depend on substances, and more likely to control sexual transactions and insist on condom use.

Seroprevalence rates among sex workers vary dramatically. A 1990 study of nearly 1,400 sex workers in six U.S. cities yielded a seroprevalence rate of 12 percent, ranging from 0 to 47 percent as a function of the city and the level of injection substance abuse. Most alarming was the high association of injection substance abuse and HIV infection rate.

Among female sex workers, IDU continues to be the major cause of HIV infection. Female injection drug users who trade sex for money or drugs are more likely to share syringes than injection drug users who do not exchange sex for money or drugs. Drug use also increases the likelihood of sex work and risky sex. Studies of crack cocaine abusers in three urban neighborhoods found that 68 percent of the women who were regular crack smokers exchanged sex for drugs or money. Of those, 30 percent had not used a condom in 30 days. Recent research has also demonstrated an association between HIV infection, heavy crack use, and unprotected fellatio. This is likely due to the combination of poor dental hygiene, damage to the mouth from hot crack stems or pipes, high frequency of fellatio, and inconsistent or marginal condom use. Street-based sex workers may agree to unprotected sex if clients offer more money, if workers themselves are desperate for money to buy drugs, or if activity has been slow.

HIV treatment challenges may occur given the sex workers' more immediate needs for drugs, food, and housing. These needs overshadow future concerns about living with HIV/AIDS. Beyond this, sex workers with HIV/AIDS may continue to work routinely for the purpose of exchanging sex for drugs or money. Sex workers thus run risks of spreading HIV/AIDS as well as reinfection of HIV and the acquisition and transmission of other diseases such as hepatitis and STDs.

There are many examples of effective treatment programs for sex workers with substance abuse disorders, including the California Prostitutes Education Project (CAL-PEP); Sisters Helping Each Other in Chicago, Illinois; Second Chance in Toledo, Ohio; the Threshold Project in

Seattle, Washington; Alternatives for Girls in Detroit, Michigan; and the On the Streets Mobile Unit-Options Program in New York City. Most of these programs use former sex workers as outreach staff, use a risk-reduction model of care, and establish linkages with organizations in the treatment continuum.

#### Homeless people

Homeless people suffer higher rates of many diseases, including HIV/AIDS and substance abuse disorders, than the general population. No national statistics exist, but studies within major U.S. cities are illustrative. In a 1990 survey of homeless adults in St. Louis, Missouri, 40 percent of men and 23 percent of women reported substance abuse, and 62 percent of men and 17 percent of women reported alcohol abuse. Another 1993 study of homeless adults in Mississippi revealed that 70 percent of respondents engaged in at least one of the following high-risk behaviors: unprotected sex with multiple partners, injection substance abuse, sex with an infected partner, and exchanging unprotected sex for drugs or money. Of these respondents, nearly half reported two risk factors, and 25 percent reported three or four risk factors. Homeless people--especially women and youth--may engage in risky behaviors for survival reasons.

#### *Developing New Substance Abuse Treatment Goals*

##### Altering admission requirements

A "one-size-fits-all" abstinence-based approach to admission effectively serves only a small number of clients. Insisting that clients detoxify and remain substance free prior to admission to substance abuse treatment programs assumes a homogeneity of substance abuse and substance abuse behavior that does not exist.

Providers should realize that some clients use substances as a way to control mood, monitor affect, and adhere to a schedule of activity. Drug use as a life management strategy may seem dysfunctional but is not necessarily a personal deficit. Eliminating substance abuse without understanding the context and role it plays in the lives of clients may, in counter-intuitive fashion, increase the chances of lapse and relapse among clients. Stopping substance abuse without substitutes or proxies for its socially constructed meaning is fraught with risk.

Removing substances of abuse without acknowledgment of the psychological benefits perceived by abusers is also laden with risk. Providers should appreciate (without necessarily agreeing) that many people use substances because they like the way substances make them feel. Many substance abusers find replacement of this feeling extremely difficult, if not impossible, to obtain. Breaking, changing, or altering a chronic cycle of substance abuse is difficult under optimal circumstances where clients have social, psychological, and material supports and services. Changing chronic cycles of substance abuse without these supports and services is not impossible but very nearly so.

Programs should include a harm-reduction treatment track that can accommodate the retention in treatment of clients who are active substance abusers but willing to control their substance use (i.e., agreeing not to consume substances on the premises and agreeing not to participate in programs when under the influence). Admission requirements might be altered depending on

level of care, motivation and coping resources of client, and treatment agency and philosophy.

This program flexibility is crucial to improving treatment outcomes. Because HIV is a pandemic that has spread across the globe over the past two decades and remains a public health crisis of epic proportions, an "abstinence-only approach" will not be effective. The goal for treatment programs that serve HIV-infected substance abusers must be to initiate treatment--HAART, if available--for these individuals as soon as possible. Awareness of and education in HIV-related issues can help treatment providers recognize potential barriers to effective treatment, such as homophobia and irrational fears of infection, that can occur in both counselors and clients.

What programs should try to achieve in treating the HIV-infected substance abuser is a base of clients who are as healthy as available treatment can make them. A client who has stabilized his illness has a better chance of decreasing his substance use than one who has not.

### *Continuum of Care: Different Treatment Strategies for Different Levels of Care*

#### Detoxification

Most of the client work during this stage of care is directed to surviving the physical and psychological traumas of separation from addictive substances. The degree and range of trauma will vary greatly depending on the substance used. Often clients will benefit from an initial placement in a 12-Step program to begin the long process of breaking through denial, consciousness raising, and discussing feelings.

Medical supervision during this process is critical. Detoxification of HIV-infected clients presents considerations not usually encountered in other clients. Many HIV-infected clients either are on, or will soon be on, a complicated schedule of medications to which strict adherence is necessary. These clients may also suffer from medical conditions that have occurred as a result of the disease, which can interfere with the detoxification process. Thus, while the counselor focuses on the client's psychosocial issues, it is imperative that an experienced physician monitor her closely and supervise treatment during this process.

#### Inpatient and residential treatment

Care strategies during inpatient treatment consist of consciousness raising, contemplation of behavior and personal changes around risky behaviors, and developing plans for action. It is recommended further that clients begin to discuss the problems of relapse and interaction of competing problems from sex and drug domains.

Individual therapy is often used to clarify comments and observations raised by clients who participate in group therapy, which in turn usually reinforces personal gains achieved in individual sessions. Group therapy is optimal for consciousness raising and convincing clients to move toward a more consistent level of safe behaviors. During this initial period, efforts should be made simply to get the client to begin thinking about safer behaviors and activities.

#### Individual therapy strategies

Clients may raise several issues in therapy that then become clinical issues. Following are common issues that clients raise during the inpatient treatment process along with suggested responses from the counselor during individual therapy:

- Feeling the problem (of HIV infection or living with AIDS) has not "hit them" yet. The counselor can provide the client with education about risky behaviors, living with AIDS, and so on. Presenting the client with future scenarios and life trajectories if behaviors remain unchanged may be helpful. Sharing success stories about positive changes in peers may also be a helpful strategy.
- Expressing the need to make their own decisions and choices regarding care, treatment, and their lives. Counselors should underscore the fact that clients must decide what is in their best interests, taking care to define "their best interests" within the client's definition of self as either an individual, a provider, a parent or caregiver, a member of a family or community, or a combination thereof. Counselors should balance this by letting clients know that no one has all the answers to their problems, and reassure clients that their feelings are valid, not unusual, and realistic. Changing one's life is hard work.
- Knowing how to change behavior, yet not making these changes. The counselor should support client efforts to reduce risk behaviors but educate the client as to why risk remains. Exploring what the client is willing to consider changing provides an outline of possible actions. Working together with the client on strategies to resolve barriers to change in small steps may be a useful tactic as well.
- Giving up hope for change or feeling overwhelmed by problems. Workers should reassure clients that their feelings are typical and that change is hard. Telling clients about positive role models who have successfully changed after facing many difficulties along the way is another useful approach.

Service providers should know that this initial phase of client change is the longest and most difficult for many clients. It is not uncommon for clients to spend a lot of time in inpatient treatment weighing the pros and cons of their behavior. Clients may have invested much energy in intentionally not thinking about the problem. Thinking about the problem may release painful issues (real or perceived) for clients that they have not allowed themselves to reflect on. Service providers should be acutely aware of the power of denial for many substance-abusing clients living with HIV/AIDS.

It is often difficult for the client to anticipate potential problems, interactions, and pitfalls, particularly those that will be faced in the external community. The counselor must help the client examine the barriers that may arise and develop strong responsive coping skills and activities. A weak plan of action can lead to quick lapses and relapses. This level of client activity (preparing for action) is characterized by switches in both personal external cues for behaviors and the ways in which clients perceive and cope with internal situations. This is a time for counselors to develop specific plans and identify individuals in a person's social environment who may provide support or information to the client upon discharge.

The idea of self-liberation can be used to influence a client to choose to act in a specific manner or believe in his ability to change. Clients can benefit from thinking about what may change once

the new behavior(s) have begun so they can be prepared for those changes. Questions similar to the following can be used to facilitate self-liberation:

- Is this what you want to do? Are you prepared for the risks involved?
- What are your reasons for changing your behavior?
- When do you want to make your change?
- What problems do you think you may face in the future?
- Whom have you discussed this with?
- How do you feel the environment is going to affect your change?
- Are there any support groups you could join in the area? Would you like to join any?

### Group therapy strategies

The gains made in individual treatment can be consolidated in well-designed and well-facilitated group therapy. Consciousness-raising techniques may help when talking with a client who seems to lack basic information about behaviors or topics, such as HIV transmission. Questions such as the following can determine how much consciousness raising is needed:

- What are your concerns about HIV/AIDS?
- What do you think about "cleaning your works" in order to protect yourself?

Dramatic relief strategies can be used when talking with a client who knows something about topics like HIV/AIDS but still engages in unsafe behavior. Questions such as the following are helpful in determining the level of dramatic relief strategies:

- Do you feel you are at risk for HIV/AIDS?
- Do you worry about getting an STD?

Group therapy also can be used to present role models (peers) who have successfully addressed many of the issues clients in inpatient treatment may face. Peer programs can provide support for substance recovery and other psychosocial services. There are many resources in the community for these interventions; all a program must provide is a meeting place. It is helpful if the peer group facilitator has some training, even if this consists solely of the orientation that all substance abuse treatment program volunteers receive. Because they are not led by professionals, peer groups may be limited in what they can achieve. However, the absence of professional involvement may give peer groups greater credibility with hard-to-reach clients.

Self-reevaluation (or self-reflection) and environmental reevaluation are good activities to use in group settings during inpatient treatment when clients might be motivated to change behavior. Self-reevaluation occurs when clients think about their behavior, and environmental reevaluation occurs when they think about the impact of their behavior on others. A counselor can initiate self-reevaluation by asking questions such as the following:

- How would you feel about bleaching all the time?
- Are there times you are willing to take risks by not using a condom? Why or why not?

- How often do you think about HIV/AIDS?
- Do you ever worry about getting something from your partner? What do you worry about? Why do you worry?
- Do you ever worry about giving something to your partner? What do you worry about? Why do you worry?

Environmental reevaluation can be facilitated with questions such as the following:

- How does your partner (partners) feel about using condoms?
- How would your partner (partners) feel if condoms were used?
- Do people close to you ever talk about your addiction? What do they say?
- Do people close to you ever talk about HIV/AIDS? What do they say?
- How does your addiction affect people who are close to you?

Group therapy in inpatient settings can be very helpful in setting the stage for actual behavior change. It is challenging for clients who have started to change behavior within a structured setting to continue the change when they return to the less structured environment from which they came. This environment may not necessarily support newly acquired lifestyle changes.

#### Stage of HIV infection

Segregating groups by stage of HIV infection presents difficulties, but not doing so can also be problematic. Clients who are HIV positive but asymptomatic and attending a support group for the first time may be uncomfortable when encountering clients in the late stages of AIDS. Such a meeting may force them to confront fears about their own mortality before they are ready to do so.

Because treatment programs have limited resources, separating groups by stage of HIV infection may be impractical. Programs able to support separate groups may wish to use the three-group model, with groups consisting of

- Clients newly aware of their positive HIV status
- Those who are asymptomatic or mildly symptomatic
- Those with more advanced disease

The interplay between substance abuse disorders and HIV infection in groups can be complicated. As clients move further into substance abuse recovery, they may be getting progressively more ill from HIV disease. In a mixed group, healthier clients may provide support to sicker ones.

In a group consisting solely of clients symptomatic with AIDS, members are vulnerable to becoming involved in a process of continual grieving. Sometimes groups have to discontinue for a period of time when too many members become sick or die. For this reason, it may be helpful to establish support groups for time-limited periods.

#### Outpatient treatment

Outpatient treatment consolidates the gains made in the detoxification and inpatient and residential treatment levels of care. Typically, clients may still need to think about change or begin to plan for change on their discharge from inpatient or residential treatment. On entering outpatient treatment, clients may have actually begun some behavior change, but the novelty of the change can lead to relapse as the client moves away from the controlled and structured environment.

Clients in outpatient treatment usually need support from at least one other person who cares about them. This can be a time when clients are vulnerable because as they change, others around them may change in response. Friends and significant others may feel threatened, abandoned, jealous, or angry and may try to sabotage the client's efforts. This puts tremendous pressure on clients because they are experiencing new feelings and new, difficult ways of life. Although many of these life changes may be positive, they are also unfamiliar for many clients.

During outpatient treatment, group therapy could focus on the use of successful peers in modeling helpful but difficult strategies such as stimulus control and counterconditioning. Individual therapy will involve helping the client balance and coordinate recovery with other issues, such as assessing client responses and concerns with case management, care coordination, and child and family issues when relevant.

Stimulus control and counterconditioning are two strategies clients may find helpful. Stimulus control helps clients restructure their environment so they can avoid circumstances that elicit problem behaviors. There are three methods for managing tempting stimuli:

- Develop a plan for managing the situation.
- Manage the situation so the temptation does not occur. For instance, a person who knows alcohol puts her at risk for unsafe sex will not drink when sex may occur.
- Restructure the environment so that stimuli for more positive events occur and so clients remain aware of people, places, and things that cause relapse.

In developing stimulus control strategies, consider developing questions such as the following:

- What are the situations where you may be at risk of not using a condom?
- How can you avoid them?
- How do you stay safe when you have sex?
- Where do you keep your condoms?
- What are the situations in which you find yourself using substances?
- Do you keep your own "works" with you?
- When are you tempted not to bleach?

Counterconditioning involves exchanging risky behaviors with less risky alternatives in situations that are not amenable to stimulus control. To develop counterconditioning strategies, questions such as the following can be used:

- If you found yourself in a situation where you were tempted to have sex without a

- condom, how could you deal with it so that you could have safer sex?
- How would you deal with a situation where you insisted on having safer sex and your partner got angry?

A major risk during outpatient treatment is the involvement of the client in sexual networks and sexual mixing. Many clients in treatment may select sexual partners from similar networks (recovery programs, 12-Step meetings, and so on). These partners might include persons who have used syringes, traded sex for drugs or money, been victims of trauma, or been incarcerated. All of these populations may have higher rates of HIV infection, making transmission more likely, and clients should be counseled about these risks.

#### Drop-in centers

Drop-in centers are an excellent way to engage homeless people in treatment. These centers offer a needed service for substance-abusing individuals who are homeless. As individuals start dropping in, they begin to interact with staff and form trusting relationships, which builds a necessary foundation for beginning treatment. The use of maintenance strategies characterizes treatment in drop-in centers. At this phase, service providers must work to prevent relapse and bring together the gains achieved during inpatient and outpatient treatment. During this time, clients may have learned to adjust their new behavior to the environment in which they live, and the behavior has perhaps become habitual.

Also during this time, many clients relapse and may return to earlier treatment levels and milestones. As discussed elsewhere, there are many factors leading to client relapse. Situations such as breaking off relationships, starting new ones, severe temptation, or lack of environmental support may contribute to relapse. In addition, the client can easily choose not to try again due to the negative feelings associated with relapse such as shame, embarrassment, guilt, failure, regret, anger, or denial.

Service providers may work with clients so that they can realize that their past successes indicate better chances of success in the future. They should underscore the fact that clients have learned new ways of coping with old behaviors and have developed supportive relationships. Service providers may find the use of reinforcement management a helpful strategy that can be facilitated in either individual or group level modes. Reinforcement management helps clients develop internal and external reinforcers and rewards that increase the chance of new behaviors continuing.

Workers can also reassure clients that relapse encounters are part of an ongoing process. Helping clients determine what caused the slip can be useful in helping them develop strategies to avoid lapses in the future. Workers can also work with clients to help them learn more about themselves, their environment, and their addiction and risky behaviors.

Questions similar to the following can help determine if clients need better or more reinforcement management:

- Do you feel good about your new behavior?

- What kind of things do you tell yourself, knowing you are practicing safer sex?
- What kind of things do you tell yourself, knowing you are controlling your substance abuse?

### *Counseling Terminally Ill Clients*

The counseling of ill and dying clients should be supportive and nonconfrontational, addressing issues relevant to the client's illness at a pace determined by the client. However, clients are not the only ones to be affected by the approach of death; counselors too may need assistance in dealing with clients' deaths. This section addresses the issues of denial, planning for death, pain management, unfinished business, and bereavement. A five-stage bereavement and loss model, based on Elisabeth Kubler-Ross' book *On Death and Dying*, also is presented.

#### Denial

Denial about a client's HIV/AIDS diagnosis can be experienced by both clients and counselors. Denial is a natural response and should be confronted only if it causes harm; for example, when a client in denial about his illness delays in making arrangements for medical and nursing care or procuring assistance with daily living activities. Counseling can play an important role in helping clients accept their illness and the eventual need for home health or hospice care.

Denial can also affect counselors. For example, because of the advances being made in the medical treatment of HIV/AIDS, a counselor may be in denial that a client will die of AIDS. Counselors must recognize and confront their own denial issues so that they are able to discuss death and dying and realistically explore these issues with their clients. Programs need to have inservice education and proper supervision for counselors who work with terminally ill clients. Proper supervision will help the counselor confront her denial and help lessen her stress. [↑ TOP](#)

#### Planning for death

It is often difficult for a counselor to know how or when to talk to a client about planning for death. It is optimal, if possible, to begin a discussion of the client's future, including death, before the client is extremely ill. Questions that often lead the counselor into a discussion of death and dying, and also are centered on contingency planning, include, "if you were to become too ill to care for yourself any longer, what would you do, who would help, where would you go?" The counselor and client should also consider where the client would like to die because different arrangements may be required.

Counselors who will be working with clients at the end stages of AIDS should examine their own beliefs about death and dying. In addition to this, counselors may need to learn about the physical and biological process of dying so that it can be explained to clients. It is also important to keep in mind that clients' perspectives on death and dying are deeply rooted in their personal histories, religious practices, ethnic customs, family traditions, and community standards.

Many clients fear dying alone or in pain, or of losing control of their bodily functions, and thus having to rely on others for care. If clients want to talk about this personal and often frightening

experience, the counselor should listen and help the client locate answers to any questions concerning the process of dying. Counselors should ask their clients how much they want to know and make sure that clients know what to expect physically. Understanding the process and planning the details within their power can give clients a sense of control.

In addition, clients may ask counselors to share their own beliefs about death and dying. Minimal sharing can be reassuring, but counselors should focus on the clients' perspectives, beliefs, and needs. As counselors listen, valuable information and insight into possible resources and support needed by clients will come to light.

#### Pain management

Pain management is often a difficult struggle with those who are in the end stages of AIDS. The issue of pain is complex because many medical conditions related to a client's HIV/AIDS can cause her pain. Clinicians may be concerned that pain medications may reinforce an addiction. Also, clients who have achieved abstinence from drugs may not wish to use medications for pain relief. Another concern of clients is the appropriateness of pain management when it might hasten death. If a client raises this issue, the counselor should be prepared to discuss it, however, the counselor does not initiate discussion on this topic. If the topic arises, clients should be encouraged to discuss pain management issues with their physicians and, if appropriate, their significant others. Pain management is discussed (i.e., from a medical perspective) in [Chapter 2](#).

#### Unfinished business

One important area that counselors should explore with their clients is "unfinished business." For example, a counselor might suggest that a client make a will. But there may remain other issues to be addressed. Should a client consider making an advance directive or a living will? Will the client want to appoint a health care proxy? Should he consider granting power of attorney to a significant other? Should he appoint a guardian for his children? Are there family issues that he wants to address?

Some counselors express a desire to be there at the time of a client's death, or a client may request that someone be there until death. Counselors and health care providers may also spend more time counseling the client's significant others or support people during this time than they spend counseling the client. Here again, a little information can go a long way to reduce fear and anxiety in clients and their significant others.

#### Bereavement

Bereavement is a particular problem for programs with large numbers of HIV-infected clients. Bereavement can affect clients (who may grieve at the deaths of other clients, friends, or loved ones from HIV/AIDS); clients' significant others; and counselors who work with dying clients. The following strategies may be helpful in supporting those clients who are dealing with bereavement.

- Acknowledge the reality of the bereavement in supportive individual counseling.
- Encourage the expression of grief both verbally and nonverbally (e.g., art therapy,

- expressive movement, psychodrama).
- Provide group support for clients and their significant others who are experiencing grief and bereavement.
  - Acknowledge deaths with memorial services, flowers, photographs, and participation in commemorative projects such as The NAMES Project Foundation's AIDS Memorial Quilt, which attempts to include the names of everyone who has died of AIDS.

#### Kubler-Ross bereavement and loss model

One of the best and most often referred to models of bereavement and loss comes from physician and psychiatrist Elisabeth Kubler-Ross. In her book, *On Death and Dying*, she provides a five-stage theory that has become common language when dealing with death and dying. Her model of bereavement is essentially a series of defense mechanisms, or coping strategies, that are used by an individual confronted by death. These stages can also be observed as individuals are confronted with other traumatic circumstances or information, such as a positive HIV test, an HIV/AIDS diagnosis, or the death of a friend or peer. The five stages are denial, anger, bargaining, depression, and acceptance.

Individual interpretations of and responses to death and dying vary greatly, not only between people, but between cultures and religions. Yet, as this model eloquently describes, adjusting to death is a process, not an event that occurs seamlessly and in a logical sequential order.

The coping strategies and stages described below are not a recipe for health. Acceptance may not be the goal for everyone. Emotional processing is made more challenging when survival needs such as shelter, food, and medical care are not being met. Many clients are used to surviving with "street smarts" and not by psychoanalytical parameters and discussions about childhood. This model is included merely to help providers understand and relate to their experiences and their clients' experiences.

#### Denial

This is a time of terror management, an effort to psychologically buy some time while adjusting to the information or situation. It is here that people can feel the most isolated and the most suspicious and doubtful of the information that they are receiving. Denial is a natural and healthy response. It is not necessarily something that counselors must feel compelled to confront and rid clients of at the earliest possible moment. Allowing clients to have denial can be challenging, and for the caregivers and support staff it can be anxiety producing, but it is important to remember that above all else, this is the client's experience. Denial is not always negative. The times that denial must be confronted are when it causes a danger to self or others. [↑ TOP](#)

#### Anger

This stage emerges as the person accepts the diagnosis and begins to strike out. The most common targets for this anger are the people closest and safest to him, especially caregivers and service providers. Anger can also be a test. The person facing death may want to know who can

be counted on as the end nears. This can sometimes be indirectly demonstrated by the client who may test the counselor's tolerance of anger; if the anger can be tolerated, perhaps the counselor can be trusted to tolerate the client's death and feelings of fear. [↑ TOP](#)

## Bargaining

Bargaining is the stage at which the individual commits to an uncommonly generous or humanitarian act with the belief that she will be spared or miraculously cured if deemed "good enough." The goal is a miraculous correction of the wrongs she has done, or possibly to buy some valuable time for treatment or dealing with end-of-life issues. The obvious danger is that most are not "cured" in that sense of the word, so what can happen is a loss of belief or faith.

## Depression

Depression represents a loss of denial, and an acknowledgment that the information is accurate and the situation and its consequences are unavoidable. As with clinical depression, the depth and severity depends on the specifics of the situation, mitigating factors, available resources, and the individual. This stage is marked by surrender to sadness; it is appropriate and adaptive. It is a time to collect resources and energies so that more processing can occur at a later time.

## Acceptance

This is the stage in which some come to terms with their situation and feel a welcomed release from struggle and strife. Option formation and reality-based planning, given the circumstances, become the focus. Acceptance occurs when there is agreement between the physical body, the emotional heart, and the cognitive mind, that death will eventually be the outcome.

### [No code or do-not-resuscitate orders](#)

The responsibilities for determining when, how, and under what circumstances to evoke or effect no code or do-not-resuscitate (DNR) orders are properly the role of the family, or those with power of attorney, and the physician. The order itself comes from the physician or from the client through the physician. Although alcohol and drug counselors do not initiate discussion of this topic, they should be aware of these terms and what they mean so that they can help prepare and inform the client and his family of these options.

No code and DNR are terms used while a client is receiving care at an inpatient facility to identify a client who does not wish to receive medical intervention to save his life. For example, if a client has a DNR order and his heart stopped, he would not receive electric shock or cardiopulmonary resuscitation. It is the framing of these decisions and the terms used to help clients understand them that make all the difference. A counselor can help clients and their families talk about these concerns by first normalizing the process. That is, to present issues as no codes or DNRs, wills, and guardianship of minor children as decisions each person or family must come to grips with--whether they are ill or not, HIV positive or not. Counselors can approach and begin to discuss these issues within a context of "hoping for the best and planning for the worst." The discussion, then, is not related to being terminally ill, but rather to choosing,

taking control, and making difficult, responsible decisions.

It also is helpful for the client or the family to discuss with the physician changing the goal of medical treatment. For example, at some point in the treatment process, when death is imminent and further aggressive medical intervention will be futile, the goal of treatment could be changed to "comfort care" from "no code."

Some States also permit a person who has been discharged from a hospital to home to have a DNR, which can be tacked to the door. The drawback of home DNRs is when a client dies and emergency medical personnel arrive, in most places they are required to try to revive the client. A counselor should be familiar with State laws about home DNRs so that a client who wants to die at home can be given the best information about this option.

Health care providers and counselors must maintain a sense of how their communication efforts are affecting the people they are trying to help. A specific and practical example of this is in discussions around no code or DNR orders. As health care providers discuss treatment options with clients and their significant others and the possibility of changing the goal of treatment to comfort care, one distinction that can be helpful for some people is the difference between "life support" and "death prolonging."

The current standard of care as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) states that providers should develop a framework for decisionmaking in situations that may require the withholding of resuscitative services or the foregoing or withdrawing of life-sustaining treatment. Decisionmaking in such cases should reflect the following priorities (JCAHO, 1999):

- Enhancing the client's comfort and dignity by addressing treatment of primary and secondary symptoms
- Effectively managing pain
- Responding to the client's and his family's psychosocial, spiritual, and cultural needs

Many believe that decisions about medical treatment should not be based on "heroic" or "extraordinary" measures, or on medical complexity. They should be based on the potential outcomes and the benefits and burdens to clients and their support systems. An open and honest dialogue with the client, followed by a similar meeting with the entire care team, can facilitate decisions and move people to a place of comfort and resolution. Many States allow an individual to designate someone to serve as their "Durable Power of Attorney" for health care. Staff and clients should know what the State's regulations are.

### *Assisting Clients in Preparing Their Children for the Loss of a Parent*

It is estimated that the number of children orphaned by HIV/AIDS will increase by 200 percent in the next 20 years. Parents living with HIV/AIDS face a multitude of issues in preparing both seropositive and seronegative children for the loss of their parents. Fortunately, the child care system is developing credible guidelines on working with children with parents living with HIV/AIDS. In addition, placing a focus on providing for the future care and maintenance of the

children can serve as a cause for personal motivation and empowerment. Pragmatically, clients should be assisted in preparing their children for the loss of parents in the following areas:

- **Legal guardianship.** Workers should help clients identify significant others or friends within the client system who could serve as legal guardians for their children. By stressing that children without legal guardianship become wards of the State, clients sometimes find the motivation to search for and secure guardians for their children. Workers should understand that the search for guardians for children of clients with substance abuse and HIV/AIDS-related issues can be difficult because clients often have exhausted their support system of family and friends well before involvement in formal treatment systems or programs.
- **Standby guardianship.** A standby guardian is someone who agrees to stand ready to assume guardianship (legal responsibility) for a minor when the parent of that child dies or becomes incapacitated. A parent will use the procedure when there is significant risk that he will die or become incapacitated within a certain period of time (e.g., in New York, this period is 2 years). The parent must usually petition a court for the appointment of a specific individual to be the standby guardian. The standby guardian can assume responsibility when the parent becomes incapacitated and then relinquish it when and if the parent recovers. The standby guardian's authority is effective when she receives notification of the parent's incapacity or death.
- **Leaving a legacy of living memories.** An approach often used in agencies is working with parents to create living legacies for their children. For instance, families may be encouraged to make videotapes or audiotapes of themselves for their children. The National Hospice Organization has an excellent library of grief and bereavement materials, including some very good age-appropriate materials for children.
- **Dealing with survivor guilt.** The issue of survivor guilt is relevant for all family members but particularly so for the infected parent whose infant dies first. The problem of guilt must be brought forth, discussed, and processed so that clients can take a more proactive approach to their other problems.

### *HIV and Risk of Relapse*

Declining health as a result of HIV disease is a recognized risk factor for relapse into substance abuse. Physical and psychological stresses associated with HIV disease include pain, decreased functional ability, fatigue, and weakness, as well as fear, anxiety, grief, and possibly increased isolation and separation from loved ones, all of which increase individuals' risk of resuming substance abuse.

HIV/AIDS milestones are significant for the client, her significant others, and her support network. Counselors often can anticipate crisis, upset, or a readiness for change when a client reaches an HIV/AIDS milestone. Counselors who know and understand these milestones have an opportunity to prepare clients through the development of coping skills and strategies. It is a time of great opportunity for change (becoming clean and sober) or for relapsing. Milestones can create the impetus for a new way and learning new behaviors, or they can serve as an impetus for

clients to act in self-destructive or harmful ways.

Following are some of the milestones of HIV infection that counselors should learn to recognize.

- Taking an HIV test
- Receiving positive or negative HIV test results
- Experiencing the first symptoms
- Experiencing the first opportunistic infection
- Experiencing the first AIDS-related hospitalization
- Being diagnosed with AIDS
- Losing a friend, or significant other who dies from AIDS
- Beginning the medication regimen
- Experiencing little or no response to various medication regimens
- Decreasing CD4+ T cell count or increasing viral load

Alcohol and drug counselors may wish to suggest the following strategies to clients who are at risk of relapse because of HIV-related stress:

- Individual counseling
- Participation in a peer support group
- Medical attention to relieve physical discomfort and alleviate anxiety
- Relaxation and stress management techniques
- Recreational activities

#### Dealing with client relapse

The most successful relapse counseling is nonjudgmental. However, clients should understand that preventing relapse is their responsibility. If a client relapses into a risk behavior for substance abuse or HIV, the counselor's role is to help the client to understand the conditions that caused the behavior to occur and to identify alternative behaviors that could have been substituted to prevent the relapse. Relapse should be viewed as a learning experience and part of the recovery process. Clients should not be dismissed from substance abuse treatment or HIV/AIDS support groups because of a relapse. Rather, peer pressure may be constructively used to help clients acknowledge the reasons for and the consequences of their actions.

However, if the client's relapse includes the risk of nonadherence to HIV medications, these medications should be stopped entirely to prevent the emergence of resistance. Once the client is recommitted to therapy, the regimen should be reevaluated.

## Case Studies

### *Case Study 1*

Frankie is a 21-year-old, self-admitted gay man. He has been injecting "crystal meth" off and on for 3 years. He has also been a chronic marijuana and alcohol abuser since he was 12 years old. He uses these substances particularly when he can't afford the "rig" and other drugs. He has sold

his body for drugs but claims that he only has sex with "nice businessmen types." Frankie is new to the area and has been in town for about 9 months. He says his family does not approve of his lifestyle, so they made him leave home. He is in phone contact with his sister occasionally but only to let her know that he is "alive." Frankie lives in shelters and on the streets with other homeless adults and youth.

Frankie decides to enroll in an outpatient program because he has been hassled by the police lately and he went on a bad run using something called "fry" (marijuana soaked in formaldehyde, then smoked). He ended up in the emergency psychiatric unit at the county hospital and the staff there suggested that he seek some help. In addition, Frankie does know about HIV/AIDS and STDs and is concerned about his sexual behavior.

[Issues for the alcohol and drug abuse counselor](#)

### Referral and linkages

Frankie will need referrals for counseling and possibly testing for HIV and STDs if the facility does not provide these services. Referrals and linkages can be obtained by getting Frankie's written consent if the facility is communicating with another organization about services for its clients. However, if an outside agency is providing services to the facility, then a Qualified Service Organizational Agreement (QSOA) ([see Chapter 9 for more information about QSOAs](#)) or Release of Information form will be required in order for the substance abuse treatment facility to be compliant with confidentiality laws. Frankie will also need a risk assessment to help him determine just what his risks are and risk-reduction counseling regardless of his decision about any medical testing.

### Special population/cultural competency

The fact that Frankie is gay could be a concern if the treatment facility has not dealt with members of the gay population or has difficulty in dealing with this population. It will be important that Frankie is assigned to a counselor who is nonjudgmental and has had some experience with young gay men.

### Relapse

With Frankie, it may not be an issue of relapse as much as getting Frankie to discontinue or cut down his use. He is currently motivated for treatment but this "scare" may not last. A risk reduction model may work best with Frankie as this appears to be his first attempt at treatment and total abstinence may be unrealistic. This should be explored further with Frankie. [↑ TOP](#)

### Denial/anger

Although Frankie may not have shown any of these emotions yet, they probably should be explored with him (as well as others, such as depression, grief, loss) specifically as it relates to his family and their treatment of him, as well as his having to survive on the streets. [↑ TOP](#)

## Medical complications

There may be a need to further examine Frankie if he does not stop using fry or other substances. The medical complications to the heart, kidneys, lungs, and brain would be worse if he has HIV/AIDS or any other STDs. Because he has been on the streets, he probably has not seen a doctor for anything until he ended up in the emergency room.

## *Case Study 2*

Tina is a 29-year-old African American female. She has been using marijuana and alcohol since she was a teenager and progressed to using cocaine by her early 20s. Tina reports snorting cocaine for a couple of years when working as a dancer. She then discovered crack, which has been her drug of choice for the last 6 years.

Tina has been in and out of jail several times over the past few years, usually on prostitution charges. While in jail, she always tests for STDs and HIV/AIDS. She has repeatedly tested positive for chlamydia and has received treatment numerous times. Despite the treatments for the STD, she continues to test positive. During her most recent incarceration she was diagnosed with pelvic inflammatory disease, had an abnormal Pap smear, and tested positive for HIV. Other than being a little underweight she looks good and states that she feels fine with the exception of some abdominal pain.

Tina is very excited about her "new life" with her boyfriend, by whom she has been trying to become pregnant. Having HIV/AIDS does not seem to be a major concern for Tina because she knows that there is medication out there for the disease. She reports that she was already getting off drugs before the bust because she wants to get married and have a baby now that she's found the right man. She reports her main support to be her boyfriend of 2 months. She does have a couple of female friends but does not consider them close.

She has been court ordered to go to substance abuse treatment. She has made several treatment attempts before and states she doesn't understand why she has to go to treatment now when she was already planning to stop her drug use voluntarily. She is now being admitted to a 30-day inpatient treatment program; otherwise, she faces going to jail for a minimum of 1 year.

*Issues for the alcohol and drug abuse counselor*

## Relapse

This is the main area of concern. Tina has a long history of substance abuse. She reports little to no social support for her recovery. The nature of crack addiction suggests that a 30-day inpatient setting will "only be the beginning" of the treatment episode. The connection and consequences of high-risk activities need to be discussed and risk-reduction practices demonstrated and rehearsed. It appears that Tina is clearly in denial about her addiction and diseases and does not understand treatment and recovery. This may be exhibited through her either becoming a "compliant client" just to get along or a defiant, angry client because she doesn't think she needs

treatment.

## Medical

Tina has a number of medical issues that must be addressed and further explored. Tests and treatment for recurrent STDs, pelvic inflammatory disease, abnormal Pap smear, and HIV/AIDS are needed. With further exploration cervical cancer may be revealed, which could, in turn, give her an AIDS diagnosis. A pregnancy test may also be needed. The counselor needs to remember that it is Tina's decision about the issue of pregnancy. A counselor should watch for the issues relating to HIV/AIDS and pregnancy that can arise.

## Referrals and linkages

Tina will need medical referrals. She has so many issues in this area she would benefit by having an HIV/AIDS case manager to assist her in linking with and coordinating appointments, medication, and so on. She may also need all the "standard" services such as housing, transportation, and clothing.

## Compliance

There could be some compliance issues with this client. This is indicated by the good possibility that she was not taking her STD medication as directed and her statement that she doesn't understand why she has to go to treatment. This belief should be explored further because it could be a lack of information/education and not a compliance issue at all.

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