AIDS and Substance Abuse: Issues for Health Care Providers

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The issue of AIDS and substance abuse raises critical clinical, ethical, and personal concerns for medical and mental health professionals. To develop effective strategies for coping with these concerns, health care providers need to consider first how substance abuse is linked to AIDS.

The most obvious connection is the direct transmission of the AIDS virus through the sharing of hypodermic needles, syringes, and paraphernalia while “shooting up” drugs. According to the Centers for Disease Control, intravenous (I.V.) drug use is the primary risk factor for 16 percent of people with AIDS. In addition, 11 percent of the gay and bisexual men with AIDS report a history of I.V. drug use. Thus a total of 27 percent of the people with AIDS have used I.V. drugs at one time or another.

Current statistics reveal that nearly 50 percent of the I.V. drug users with AIDS are black, 30 percent are Hispanic, and 20 percent are Caucasian. More than half of the women with AIDS in the United States are I.V. drug users; many of them are also sexual partners of I.V. drug users.

Another link between substance abuse and AIDS is the transmission of the virus by infected I.V. drug users to their sexual partners. Epidemiological data clearly reveal that the AIDS virus can be transmitted in this manner among heterosexuals as well as among homosexuals.

In addition, infected women who are I.V. drug users or who are sexual partners of users can transmit the virus during the neonatal period. There have been 217 pediatric cases of AIDS.

The connections between substance abuse and AIDS extend beyond the means of direct transmission. In recent cohort studies, a correlation was found between the use of volatile amyl and butyl nitrites (“poppers”) and the development of Kaposi’s sarcoma. Researchers have also established in laboratory studies the immunosuppressive effect of poppers. Earlier studies have confirmed the immunosuppressive role of alcohol, marijuana, cocaine, and amphetamines.

Being under the influence of alcohol or drugs can also affect a person’s resolve to follow AIDS risk reduction guidelines. In a recent report prepared for the San Francisco AIDS Foundation, the Research and Decision Corporation cited the following findings after polling a sample of gay and bisexual San Francisco men:

- While only 3 percent of the survey participants reported using I.V. drugs in the past six months, these men also accounted for a significant percentage of high-risk sexual activities. In addition, 61 percent of the participants agreed that they were more likely to have unsafe sex when using alcohol or drugs.

- Finally, alcohol and drug abuse can interfere with the medical treatment of AIDS. For example, the use of medication that is potentially hepatotoxic (toxic to the liver) is contraindicated in patients with a liver already damaged by alcohol or drug abuse.

Confronting the Patient with Substance Abuse Problems

Physicians and other health care workers often have difficulty in treating substance abuse disorders in persons who have AIDS or ARC.

Health care providers often feel that the patient will die anyway, that substance abuse treatment will take away a “coping mechanism,” and that treatment is too strenuous and confrontive. These concerns reflect a basic underlying question: “Why bother with substance abuse treatment?” Substance abusers themselves may provide the answer. Already troubled by the chaotic lifestyle that often accompanies substance abuse, many individuals find that the added crisis of an AIDS diagnosis prompts a careful look at the quality of their lives. Some may choose to get help to stop using drugs or alcohol. Others, of course, may continue current behavior, even at the risk of jeopardizing their eligibility for needed social services.

The choice to seek treatment or to remain actively addicted will be made by the client. Health care professionals often have trouble with this fact, yet it is basic to all effective treatment strategies.

Substance Abuse As a “Moral Issue”

Health care providers sometimes view substance abuse as a weakness or as a choice rather than as a disease. They may believe that treatment should consist of a lecture about “right” instead of offering effective strategies for coping with these concerns.
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or "wrong" behavior, and they may advise clients to control their impulses. However, substance abuse is not a weakness; it is a chronic and progressive disease for which there is treatment and hope. Clinicians who view it otherwise may be reluctant to develop treatment strategies or to make effective referrals.

Behavioral Manifestations of Addiction

Many behavioral manifestations of addiction such as flattery, intrusiveness, intimidation, or inflammatory remarks can be frustrating for the health care provider. Clients often attempt to turn one staff member or agency against another. These behaviors can be attempts to avoid confrontation, to deflect attention, and to justify ongoing abuse.

Staff members should avoid expressing anger, blame, or disappointment toward clients who continue to use drugs or alcohol. At the same time, staff can encourage clients’ constructive expressions of feelings. Staff can help prevent a sense of helplessness by holding clients responsible for their actions and by maintaining their own values, their commitment to quality care, and their professional standards.

Substance Abuse Assessment

An accurate and specific assessment of a client's substance abuse is essential to the clinician's understanding of the concerns and difficulties to be encountered. This assessment should include the amount, frequency of use, duration of use, and last use of all classifications of illicit drugs, mind-altering prescription medication, and alcohol. The following factors are helpful in determining the extent of a substance abuse problem:

(1) Emotional, social, relationship, employment, legal, or other difficulties that can be linked to the use of alcohol or drugs;
(2) Loss of control of frequency or amount of use;
(3) Preoccupation with drugs of choice or alcohol;
(4) Self-medication for anxiety or sadness with drugs or alcohol;
(5) Drinking or using drugs while alone;
(6) Rapid initial intake of drugs or alcohol;
(7) Protection of drug or alcohol supply — stocking or hiding supply;
(8) Tolerance to large quantities of alcohol or drugs;
(9) Withdrawal symptoms;
(10) Blackouts.

Once the health care provider has determined the extent and the effects of substance abuse, it will be helpful to assess the clients' awareness of the problem and their willingness to follow treatment strategies.

People who actively pursue their addiction often feel little motivation for treatment, especially if they have not felt the painful consequences of their drinking or drug use. They may feel that the problem "is not bad enough yet" to seek treatment. Even if clients display limited motivation for treatment, it is important for clinicians to educate clients about specific AIDS risk reduction practices and to support changes in these areas.

It is natural for a person to engage in denial at the onset of a life-threatening illness. The denial usually continues until a person begins to absorb the impact of the diagnosis. Substance abusers, however, regularly employ denial as a chief defense against seeing the problems and effects of their addiction. Thus, health care providers can be most effective by challenging the denial of these clients and by helping them accept their AIDS diagnosis.

Priority Issues

Clinicians recognize so many other physical, emotional, financial, and legal concerns confronting their clients with AIDS that frequently they do not consider substance abuse as a priority to be addressed aggressively. However, not dealing with substance abuse issues can undermine other efforts to cope with the many problems that come with AIDS.

Current epidemiological data confirm the connections between substance abuse and AIDS. Projections for the future suggest that substance abuse will command even more attention from health care providers, educators, and health policy officials. While there are many problems associated with dual diagnoses of substance abuse and AIDS, health care providers can intervene effectively by first recognizing how their own values and anxieties impact upon treatment approaches. Next, they can accept substance abuse as a problem that can be ameliorated by treatment interventions. And, finally, they can stay informed of community resources to help them make accurate assessments and to develop effective treatment strategies.

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Diagnosis/Treatment AIDS and Substance Abuse Counseling with Gay Men

Tom Smith, MD

Counselors who work in the field of substance abuse confront a frequent challenge to meet new and unmet needs. The newest challenge comes from the need to provide services to gay men who have two problems: difficulties with substance abuse and a diagnosis of AIDS. To assist these clients and to educate them about avoiding exposure to the AIDS virus, counselors need to recognize the special issues relevant to working with gay men.

Substance abuse is a major health problem for the gay population in this country. A 1983 San Francisco study (Morales and Graves) revealed extensive drug use among gay men from a variety of backgrounds: 9% reported I.V. drug use, 58% volatile nitrite (poppers) use, 15% daily marijuana use, and 83% alcohol use (with a problematic use rate of 20%).

Counselors who encounter a client with these problems should first obtain an adequate drug use history and appraise the gay client's strengths and motivation. They must also be prepared to assess the client's attitudes and value systems, participation in the general society and in the gay subculture, and his stage in the "coming out" process. Essential for the counselor is an awareness of basic components of the gay experience; these include knowledge of gay milieus, homophobia, internalized homophobia, the great variety of gay
sexual expression and its relationship to substance use, and gay language and sensibility.

Particularly important is an awareness of those symptoms related both to substance abuse and to the oppression of gay people: depression, low self-esteem, paranoia, and "double lives."

Counselors must also realize that the gay male population is very diverse and spans all ethnic and socioeconomic groups. There are also a large number of "hidden" members. Thus, counselors must develop individualized treatment plans and not rely on just one approach. For example, some clients may need encouragement to come out of the closet as part of their recovery process while others might feel great stress at the prospect of increasing their identification with gay men. A push to self-disclosure could lead them to relapse.

Counselors can help clients by presenting a sex-positive approach. In addition, they should question how the behaviors of their gay clients relate to their drug compulsion. Do clients abuse substances to cope with oppression, peer pressure, and beliefs about drugs and sex?

Counselors for gay males should be well-acquainted with psychosocial and physiological effects of legal and street drugs and "poly-drug" treatment. A number of community resources exist to help the health care professional become knowledgeable about these issues.

Overall Strategy

Counseling should be filled with the concepts of client involvement in planning, hope, and personal growth, even in the face of approaching death. Messages should be clear, current, easily understood and repeated at the client's pace so that he can hear. The counselor should impart an attitude that positive actions will be beneficial and effective. Techniques should be designed for the person as a whole being, not focusing on just one drug or one sex act.

Specific Approaches and Techniques

Counselors should note the variety of experiences with AIDS for gay men. Some may be among the worried well; some may test positive, and others negative, with the AIDS antibody test. Other gay men may be positive but asymptomatic, and still others may have been diagnosed with AIDS or ARC. Even clients within these groups often face differing sets of problems. For example, the needs of a bed-bound drinker with pneumocystis pneumonia is quite different from a drinker who has Kaposi's sarcoma, feels well, and goes to work every day. To facilitate these differences, client categories for designing treatment plans might include the dying patient, the bed-ridden, the informed yet ambulatory, the weak but not sick, the able-bodied, the actively using, the motivated (for recovery efforts), the unmotivated, and the detoxing client ill from AIDS/ARC or not ill from AIDS/ARC.

Presenting AIDS Information. The bottom line approach in counseling gay men about AIDS is to provide information that explains the connections between AIDS, substance abuse, and sexual activity and also to develop a personalized plan of action for risk reduction.

Messages about the spread of AIDS through needle use should be given in an hierarchical order, congruent with client's strengths, motivations, and degree of drug abuse. Whereas a high-functioning speed user may internalize advice about total abstinence, a recalcitrant client may only be able to hear a message about not sharing needles.

The next message should be "don't use needles," with the following level suggesting "if you use needles, don't share them." The latter should advise users to "clean your works"; instructions on how to do so should be included. Many of these clients are distrustful; to increase compliance, messages must be individualized, non-authoritarian, and couched in language understandable to the client.

Disinhibition. One very difficult problem caused by the disinhibiting effect of drugs occurs in individuals who are out of control in many areas of their lives. Clients are often unable to control sexual behavior until they become sober, no matter how many ploys they make to eliminate unsafe sex. They need increased social support and the benefit of solid rapport with counselors. Interventions which include significant others and health care providers, especially in a "united front," is another effective approach for the "resistant" substance abuser with AIDS.

Sexuality Counseling. Although the AIDS epidemic has opened up gay men's most private lives as subject matter for media coverage, this exposure has not been accompanied by an understanding of male-to-male intimate feelings and values. Many counselors assume an innate ability to offer advice about sexuality; however, gay male sex counseling, especially in light of changes brought about by the AIDS epidemic, has become a complex art involving an appreciation of the full range of gay male sexual expression.

Group therapy intervention is often the best way to impress upon the client that poly-drug abuse is prevalent among gay men and that alternative drug-free social events have become popular in the gay community. In group sessions clients can also be introduced to methods of tension reduction and to non-chemical ways of altering consciousness to replace a dependency on drugs.

Substance Abusers With AIDS or ARC. Heavy drinking or drug use as a coping mechanism may occur at different times in the course of illness: prior to or immediately after diagnosis, during waiting times for test results, upon death of friends, after developing signs of further deterioration of the immune system, as a result of financial and social losses, when realizing that death is imminent, and when treatments fail. Often clients have not received enough information about substance abuse and recovery for them to make valid decisions about further use of substances during these stressful periods.

Many individuals with AIDS or ARC become absorbed with the pursuit of wellness. They may appear to be outwardly healthy yet be profoundly immunosuppressed. Marked and chronic fatigue in these individuals might be erroneously interpreted as substance abuse relapses. The client may need counseling about how to discuss his health status with friends.

Antibody Test Counseling. Many gay substance abusers are curious about the AIDS antibody test, and administrators of substance abuse programs have begun to advocate antibody testing as an admissions criteria. Counselors should become as informed as possible about the resources for performing the tests, the most current knowledge about the meaning of test results, confidentiality measures, and methods for processing emotional responses to the test.

Summary. For the therapist the good news is that basic substance abuse counseling techniques yield successful results in working with gay male substance abusers who have AIDS concerns or infection. Concepts of recovery, such as abstinence, hope, holism, socialization, spirituality, stress reduction, positive action, and positivism are essential components of effective strategies. On the other hand, counselors will find that fundamental substance abuse strategies, and even deeply held principles, must be modified to address the complex needs of this group. Concepts of personal responsibility, motivation, "cosmism", phase of addiction, personal actions, skills deficits, and specialness must be re-thought and made personal for the individual affected by AIDS.

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**RECENT REPORTS**

**Alcoholic Liver Disease May Trigger False Antibody Test Results.** A research team at the Cincinnati Veterans Administration Medical Center reported in *The New England Journal of Medicine* (April 2, 1986) that the blood of persons afflicted with alcoholism and liver-damaging hepatitis B may inaccurately test positive for the AIDS virus. The researchers tested stored, frozen blood serum from 95 patients who participated in a Veterans Administration study on alcoholic liver disease. They found that 13 percent of the serum samples tested positive for the AIDS virus, using the ELISA screening test. However, when the samples were subjected to the more definitive Western blot assay, all were found negative for AIDS virus infection.

The researchers concluded, “These findings demonstrate that patients with alcoholic liver disease have a high incidence of false positive results on tests for HTLV-III antibodies. This is important to recognize lest these patients be falsely labeled as having previous infection with the AIDS virus and suffer the socioeconomic consequences of this diagnosis.”

**New Classification System for AIDS Virus Infection.** The Centers for Disease Control (CDC) has announced a new classification system for persons infected with the AIDS retrovirus. CDC representatives explained that the new system attempts to provide a means of grouping patients infected with the AIDS virus according to the clinical expression of disease. As more information about infection has accumulated, researchers and health care professionals have needed more precise classifications for the spectrum of symptoms related to AIDS. This new classification addresses that need. The new system, however, does not imply any change in the definition of AIDS used by the CDC since 1981 for national reporting.

The system uses four principal groups based on chronology, presence or absence of signs and symptoms, and the type of clinical findings present. Group I notes transient signs and symptoms that appear at the time of initial infection. Group II includes those infected persons who are asymptomatic. Group III indicates persons with persistent generalized lymphadenopathy (PGL). Finally, Group IV, with five subgroups, includes those with constitutional disease, neurological disease, secondary infectious diseases, secondary cancers, and other conditions. Patients whose symptoms place them in the surveillance definition of AIDS are classified in Group IV. However, not every case in Group IV will meet the surveillance definition. Readers needing more precise descriptions of these classifications should refer to the May 23rd issue of *Morbidity and Mortality Weekly Report.*

**NEXT MONTH**

In June 3500 AIDS researchers, health care providers, and educators gathered in Paris for the International Conference on AIDS. The more than 1000 research papers presented reflected the rapid growth in the area of AIDS research. By comparison, researchers presented only one-third as many papers at the first such international conference, held in Atlanta in April of 1985. Of the total presentations in Paris, nearly 100 related to the psychosocial impact of AIDS.

In the September issue of *FOCUS,* Judy Macks, LCSW, will review the many psychosocial studies discussed at the conference. Macks presented in Paris a poster entitled “Life in the Grey Zone: Interventions Addressing the Psychological Needs of Persons with ARC.” She coordinates mental health training at the AIDS Health Project; she formerly coordinated the mental health services program for people with AIDS at San Francisco General Hospital’s Ward 86.

In addition, editor Michael Helquist, who also attended the Paris conference, will present a selection of abstracts that highlight some of the clinical, epidemiological, and public health papers delivered there.