



HIV/AIDS Prevention for MSM Latino Men: A Campus-Community Collaborative Needs Assessment

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The following CSUS graduate students actively participated and assisted with the development, implementation and completion of this pilot study:

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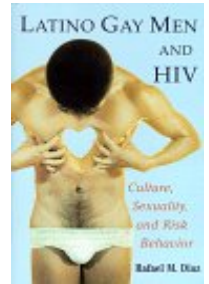
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Ψ

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To Learn More About HIV/AIDS

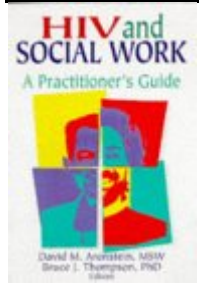
Please refer to pp. 20-27 of this study for helpful websites and related professional articles from peer-reviewed published scholarly journals



Mortal Secrets: Truth and Lies in the Age of AIDS

by Robert Klitzman, Ronald Bayer

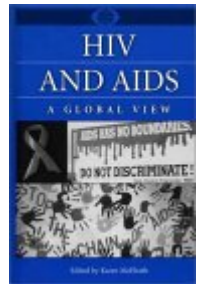
Based on qualitative interviews with AIDS patients and discusses how they dealt with telling their partners, family, and friends about their illness. Highlights their dilemma of disclosing their diagnosis and confronting intimate questions about truth, lies, sex, and trust.



HIV and Social Work: A Practitioner's Guide (Haworth Psychosocial Issues of HIV/AIDS)

by David M. Aronstein, Bruce J. Thompson

Experienced social workers share their knowledge and insights on such topics as psychosocial intervention, clinical issues, and helping people cope with the changing expectations brought on by promising but complex treatment options. They consider basic information and skills, multicultural competence, practice in health and mental health settings, services for children and families and for special populations, economic supports and housing, and caring for the professional caregiver.



HIV and AIDS : A Global View (A World View of Social Issues)

by Karen McElrath

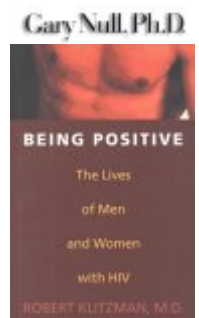
Book covers the following topics: 1. AIDS & HIV 2. AIDS (Disease) 3. Cross-cultural studies 4. Health Care Delivery 5. Medical / Nursing 6. Social Science 7. Sociology 8. Sociology - General 9. Social Science / Sociology / General



AIDS: A Second Opinion

by Gary Null, James Feast, Gary, Ph.D. Null

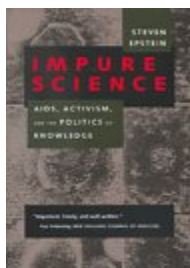
Provides an overview of the controversies and differing opinions surrounding AIDS, with a discussion on the inability to isolate HIV from everything else in a white bloodcell. The authors focus on science more than social factors but do address social factors by analyzing how they can unconsciously influence scientific thinking.



Being Positive : The Lives of Men and Women with HIV

by Robert Klitzman

In-depth interviews with a broad cross-section of people with HIV. A compassionate portrait of their losses, strengths, and attitudes, and their ability to finding meaning in life. Looks at patterns of spiritual beliefs, work and volunteer activities, and family relations through perspectives from anthropology, existential psychiatry, and depth psychology.



Impure Science: AIDS, Activism, and the Politics of Knowledge (Medicine & Society, No 7) by Steven Epstein

Book covers the following topics: 1. AIDS & HIV 2. Aids (Psychosocial Aspects) 3. Diseases - AIDS & HIV 4. Medical 5. Medical / Nursing 6. Public Policy - General 7. Research 8. Sociology



A Neighborhood Divided: Community Resistance to an AIDS Care Facility

by Jane Balin

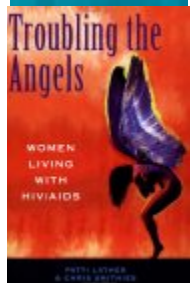
Book covers the following topics: 1. AIDS & HIV 2. AIDS (Disease) 3. Diet / Health / Fitness 4. Gay Studies 5. Health Care Delivery 6. Hospice care 7. Lesbian Studies 8. Location 9. Nursing homes 10. Patients 11. Popular Culture - General 12. Social Science 13. Social aspects 14. Sociology



The Endangered Self: Identity and Social Risk

by Gill Green, Elisa Janine Sobo

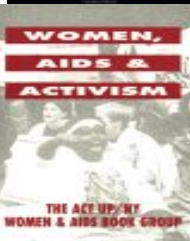
Book covers the following topics: 1. AIDS & HIV 2. AIDS, Disease) 3. Diseases 4. General 5. Health Care Delivery 6. Medical 7. Medical / Nursing 8. Psychological aspects 9. Social aspects 10. AIDS: social aspects 11. USA



Troubling the Angels: Women Living With HIV/AIDS

by Patricia Ann Lather, Chris Smithies, Patti Lather

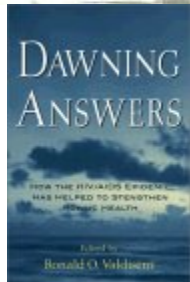
Qualitative interviews complemented by statistics and facts about the epidemic of AIDS; a series of interviews and follow-up interviews with women infected with HIV reveals the impact of the disease on their lives, exploring their feelings of blame, regret, and fear.



Women, AIDS and Activism

by Act-Up Women's Caucus Staff, Marion Banzhaf

These 44 essays bring a feminist, activist perspective to bear on the AIDS crisis, examining the impact of sex-ism, racism, class-ism, age-ism, and homophobia on its management. The voices include diverse ethnic groups; lesbians, bisexuals, and heterosexuals; incarcerated prisoners, sex workers, substance abusers; and women with HIV+ and AIDS.



Dawning Answers: How the HIV/AIDS Epidemic Has Strengthened Public Health (Medicine)

by Ronald O., Md. Valdiserri

Text offers information on the effects of the global HIV/AIDS epidemic to the theory and practice of public health. Describes how advances in techniques and policy, help set funding priorities, mobilize communities, support the adoption of safer behaviors, and ensure access to needed prevention and treatment services.

INTRODUCTION



While the global problem of HIV/AIDS continues to expand among men ages 25 to 44, the problem has become an epidemic of mostly ethnic minority men for the first time in the United States (Aboud, 1998; Centers for Disease Control, 1993, 2000; Mays, 1993; Webb & Truax, 2002). The term MSM has been applied to this population; that is “Men Who Have Sex with Men” but who self-identify as heterosexual. MSM is considered a more precise and sensitive term. MSM may be heterosexual or bisexual in orientation, since it is the sexual act rather than the sexual orientation that increases the chances of infection.

According to the Centers for Disease Control, (2000) MSM is the leading exposure category for persons with HIV/AIDS, representing 66% of all persons living with HIV/AIDS in the United States today. As an overlapping member of two high-risk groups: Latinos –and—MSM, Latino men have been highly and inexplicably affected by the HIV/AIDS virus (Chang & Geliga-Vargas, 1999; Lehner & Chiasson, 1997; Myers, et al., 2003; Wohl, et al., 2002). While Latinos comprise 12% of the U.S. population, they make up 18% of diagnosed AIDS cases (Centers for Disease Control, 1999). In California, HIV/AIDS continues to disproportionately impact the MSM male population, with subpopulations of Latino and African-American MSM experiencing particularly dramatic increases in rates of new infections (Centers for Disease Control, 2000; Lehner & Chiasson, 1997; Valleroy, et al., 2003; Webb & Truax, 2002).

Using a mixed methods approach, participants in this pilot study were recruited from a local multi-service mental health agency servicing Latinos. While this agency has traditionally provided outreach, education and referrals for substance abuse treatment, it is responding to the increased needs of the community by providing more HIV/AIDS services. Data was collected from 42 adults attending one of three court mandated counseling groups at this agency. All subjects participating in this pilot study were identified as “high risk” – that is experiencing problems in one or more of the following areas: (1) MSM, (2) engaging in unprotected sex, (3) arrested for DUI, (4) drug possession/convictions, (5) alcohol/substance, and/or (6) domestic violence/child abuse. Recommendations are made regarding HIV/AIDS education (awareness & knowledge), literacy, and advocacy-based counseling approaches among the identified population.

LITERATURE REVIEW

Defining & Understanding HIV/AIDS

A person can become infected with the Human Immunodeficiency Virus (HIV) from anyone who's infected, even if they don't look sick, and even if they haven't tested HIV-positive yet. The blood, vaginal fluid, semen, and breast milk of people infected with HIV has enough of the virus in it to infect other people. Most people get the HIV virus by: 1) having sex with an infected person; 2) sharing a needle (shooting drugs) with someone who's infected; 3) being born when their mother is infected, or drinking the breast milk of an infected woman (Hacki, Somali, Kelley, & Kalichman, 1997). There are no documented cases of HIV being transmitted by tears or saliva, but it is possible to be infected with HIV through oral sex or in rare cases through deep kissing, especially if a person has open sores in their mouth or bleeding gums (Miner, 1998).

A person may not know if they are infected by HIV. Some people have no symptoms. However, the virus will multiply in the body for a few weeks or even months before the immune system responds. During this time, a person won't test positive for HIV, but they can infect other people. When their immune system responds,

it starts to make antibodies. When this happens, they will test positive for HIV. During this time, HIV is damaging their immune system. One way to measure the damage to the immune system is to count the CD4+ cells. These cells, also called "T-helper" cells, are an important part of the immune system. A person might start having signs of HIV disease like fevers, night sweats, diarrhea, or swollen lymph nodes. Infection with the HIV virus leads to changes in the immune system that can result in a cluster of symptoms recognized as AIDS. According to the definition, a person's T-helper lymphocyte blood count must be below 200 and the person must have had one or more opportunistic infections associated with AIDS.

In the United States, a person is not considered to have AIDS until he or she meets a definition adopted by the Centers for Disease Control and Prevention (1998). AIDS stands for Acquired Immune Deficiency Syndrome (Bartlett & Finkbeiner, 1996):

- ACQUIRED: a person becomes infected.
- IMMUNE DEFICIENCY: a weakness in the body's system that fights diseases.
- SYNDROME: a group of health problems that make up a disease.

A person doesn't actually "get" AIDS. Rather, one might get infected with HIV, and later might develop AIDS. If the person gets an opportunistic infection, they have AIDS. There is an "official" list of opportunistic infections overseen by the Centers for Disease Control (1998). The most common ones are: 1) lung infection; 2) skin cancer; 3) an infection that usually affects the eyes; and 4) a fungal infection that can cause thrush (a white film in your mouth) or infections in the throat or vagina. AIDS is different in every infected person. Some people die soon after getting infected, while others live fairly normal lives for many years, even after they "officially" have AIDS. A few HIV-positive people stay healthy for many years even without taking anti-HIV medications. There is no cure for AIDS. There are drugs that can slow down the HIV virus, and slow down the damage to the immune system. Moreover, there are other drugs that one can take to prevent or to treat opportunistic infections (OI). In most cases, these drugs work very well. The newer, stronger anti-HIV drugs have also helped reduce the rates of most OIs. However, there are some OI's that are still very difficult to treat (Centers for Disease Control and Prevention, 1998; Kalichman, 1999).

Cultural Aspects

Latinos in the United States are disproportionately affected by HIV, accounting for 18% of the total AIDS cases while comprising only 12% of the population (Klevens, Diaz, Fleming, Mays, & Frey, 1999; National Commission on AIDS, 1999). Similarly, Latino children under the age of 13, make up 24% of U.S. pediatric AIDS cases (Centers for Disease Control and Prevention, 1998). At present, MSM and gay men now account for the majority of existing cases of HIV/AIDS infections in the United States with 25% of new infections annually (Centers for Disease Control and Prevention, 2000; Guarnaccia & Fasina, 2002). As a result, these life threatening illnesses have become a major threat in Latino communities, many of which were already disadvantaged even prior to the HIV epidemic due to ethnic minority status, economic disparities, and language barriers (Klevens, Diaz, Fleming, Mays, & Frey, 1999).

Interestingly, HIV prevalence among Latinos in the United States varies strongly by region. For example, a high rate of HIV exists among Latinos in the Northeast where many Latinos from Puerto Rico and the Dominican Republic live, reflecting the geography of injection drug use (53%) in the United States (Roldan, 2003). Consequently, the majority of cases among Puerto Rican adult women occur because of heterosexual contact with an injection drug user (Roldan, 2003). Interestingly, much lower rates are reported for Latinos in the West and Southwest regions, where many Latinos are of Mexican and Central/South American origin (Koblin, Chesney & Husnick, 2003). In 1997, 34% of all AIDS cases among Latino men occurred in men who have sex with men, and 30% among injection drug users (Centers for Disease Control and Prevention, 1998). In the same year, 46% of AIDS cases among Latino women were due to heterosexual contact (being infected by their male partners), while 29% were due to injection drug use.

Among Latino gay/bisexual men, rates of HIV infection are increasing faster than among White gay/bisexual men (National Commission on AIDS, 1994). These rates are likely underestimates because many Latino men who have sex with men do not self identify as gay/bisexual.

Alcohol use has been identified as a probable factor related to unsafe sexual behaviors (Boulton, McLean, Fitzpatrick & Hart, 1995; Parsons, Vicioso, Punzalan, Halkitis, Kutnick, & Velasquez, 2004). Previous studies have examined ways in which gay, bisexual, and MSM men use alcohol to engage in sexual encounters. First, alcohol results in a person focusing his attention on the present context, thereby decreasing his awareness of the social norms or what is perceived as acceptable behavior (Steele & Josephs, 1990). Alcohol mutes self-monitoring and therefore increases the impact of environmental stimuli.

Studies of HIV-positive MSM have found this connection between alcohol use and unprotected sexual practices (Dolezal, Meyer-Bahlburg, Remien & Petkova, 1997; Purcell, Parsons, Halkitis, Mizuno & Woods, 2001). Others have found that other variables, such as outcome expectancies and sensation seeking, may play a role in predicting both unsafe sex and alcohol use (Kalichman, Kelly, & Rompa, 1997; Leigh & Stall, 1993). Although alcohol use may not be causally related to unsafe sex, drinking may play a role in sexual scripts. Sexual scripts are the narrative ways in which people organize their beliefs and expectations regarding sexual behaviors. One way in which a sexual script can be examined is from a cultural level, in which scripts are constructed by cultural and social groups for the purpose of contextualizing acceptable sexual activity (Gagnon & Simon, 1999). A few studies have used sexual script theory to frame behavior involving the use of alcohol and drugs (Fordham, 1995; McKirnan et al., 1996; Mutchler, 2000). These studies have helped us in our understanding of the context of substance use for socializing and engaging in sexual behavior, since these scripts involve expectancies for alcohol or drugs within specific social contexts. Contexts may involve a bar with loud music, a club where people go to dance and meet potential partners, or a bathhouse where men have anonymous sex with other men. Therefore, alcohol may be involved in scripts for different occasions, including factors related to choice of partners, types of occasions, types of sexual acts, and decisions on whether or not to use condoms (Parsons, Vicioso, Punzalan, Halkitis, Kutnick, & Velasquez, 2004).

Cultural influences such as *machismo*, and *familismo*, coupled with homophobia may be internalized by Latino gay men and make safer sex practices difficult (Miller, Guanaccia & Fasina, 2002). Culturally, *machismo* dictates that sexual intercourse is a way to prove masculinity. For MSM Latinos, *machismo* and *familismo* can create conflict because families perceive homosexuality as sinful. As a result, familial support is virtually non-existent because of the silence about one's sexual preference or shame about one's secretive behavior -which in turn- reinforces shame, self-loathing and low self-esteem among these Latino men. Not surprisingly, many of those subsequently infected with HIV/AIDS face challenges of living with a chronic terminal disease, feeling alone, rejected, and ostracized by both family and community (Roldan, 2003).

Many ethnic minority women living in poverty are disproportionately affected by HIV. For these women, the struggle for daily survival may take precedence over concerns about HIV infection, whose impact may not be seen for several years (Needle, Trotter, Singer, Bates, Page, Metzger & Marcelin, 2003). In a study of unmarried Latina women across the United States, Arredondo (1999) found that 20% reported a history of sexual abuse or rape. Traditional interpretations of cultural values and gender roles may also serve as barriers to maintaining safer sex practices for many Latino women. For example, in a survey by Needle, Trotter, Singer, Bates, Page, Metzger and Marcelin (2003), 67% of Latino women reported never using condoms with their steady male partner. Culturally, in a traditionally *machista* society, women often do not talk to men about sex because it suggests promiscuity; and within a traditional framework, frequency and type of sex is most often determined by men. Public health agencies need to raise public awareness about

sexual coercion and help women and men develop the skills needed to prevent it. For women to protect themselves from HIV infection, they must rely on their own skills, attitudes, and behaviors regarding condom use as well as their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making. Women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives (Díaz, 1995).

In this vein, a greater understanding of and respect for Latino culture will lead to better HIV prevention efforts. Prevention programs for Latinos must take into account cultural characteristics including *familismo*, *simpatía*, and *personalismo* (Díaz, 1995; Needle, Trotter, Singer, Bates, Page, Metzger & Marcelin, 2003). *Familismo*, or the importance of the family as a social unit and source of support, can be a barrier to educators, with whom Latino clients may not share their concerns. On the positive side, family support can be a powerful factor to motivate behavior change. *Simpatía* refers to the importance of polite social relations that shun assertiveness, negative responses and criticism. With regards to therapeutic practice, counselor educators need to be aware that because of cultural variables such as this, Latinos may appear to agree with a counseling directive or educational message that they may not understand or intend to follow. *Personalismo* refers to the preference for relationships that reflect familiarity and warmth. Similarly, HIV information and service delivery may be most effective when helping professionals establish warm and trusting relationships and ask questions about family and shared experiences (Needle, Trotter, Singer, Bates, Page, Metzger & Marcelin, 2003).

Policy & Politics

HIV infection is a highly stigmatizing disease. AIDS-related stigmas result in discrimination, prejudice, and isolation. Social stigmas are a major factor in limiting social support and assistance for coping with HIV (Frale, Wortman & Joseph, 1997). Homosexuality, drug abuse, poverty, and ethnic minority group status are all characteristics that carry significant social adversities. The social construction of HIV/AIDS in the United States has made it among the most stigmatizing medical conditions in modern history (Fernandez, Perrino, Bowen, Royal, & Varga, 2003; Miller, Guarnaccia & Fasina, 2002). AIDS is viewed as much more than a transmissible and lethal disease. In some cases, the fear of a positive test result and/or the social stigma around HIV testing keeps some people from seeking it. In other cases, individuals who are tested for HIV antibodies do not return for their results. Approximately 37% of people who were tested at publicly funded clinics in 1990 did not return for their results. Using Goffman's (1993) dimensions of stigma, the stigmatization of HIV/AIDS as follows: although undetectable early in its course, later stages of HIV infection and AIDS are rarely hidden from others; HIV infection interferes with social relationships; the disease physically disables and disfigures and is therefore aesthetically repellent; its origin is often, although not always, blamed on behaviors and choices; the course of HIV infection is degenerative and not alterable; and, HIV is a high-peril condition in that it poses risks to others. Important advances in the study of stigma have occurred in AIDS research. For example, Herek's (2000) work has suggested that social discrimination and prejudice against people with AIDS is explained by traditional models of social stigma and has led to important public information intervention strategies. Penner and Fritzsche (1994), for example, found that brief videotape presentations of people with HIV under various conditions can significantly manipulate negative attitudes and associated behaviors toward people with HIV/AIDS. This and related research by various social psychologists have used AIDS-related phenomena to advance an understanding of the social stigmatization process.

Social stigmas are a source of chronic stress for people living with HIV and AIDS. Victim blame is common because people often contract the virus through behaviors that are socially sanctioned. Also, people

infected with HIV can internalize blame, believing that they "should" have known better and should have taken precautionary steps against getting infected. A serious outcome of social stigmatization experienced by people with HIV is their reluctance to disclose their HIV status to others. Fears of being ostracized, isolated, and abandoned create a shroud of secrecy around having HIV (Diaz, Ayala, Bein, Henne & Marin, 2001). An inability to disclose being HIV positive to others limits the resources and supports that is available to a person living with HIV. Acts of discrimination against people with HIV/AIDS are frequent. People have been denied services, residence, and employment because they are HIV infected. Although laws that protect people against discrimination exist in many areas, these problems still persist. According to Cadwell (1994), support groups and group psychotherapy can be vital forums for addressing stigmatization. Group facilitators can help members to identify the social function of stigmatization, examine their own internalized stigma, and experience the catharsis of their pain and shame. These groups also provide HIV positive people with an empowering sense of belonging. Counseling can help HIV-positive clients cope with job-related discrimination (distinguishing between realistic paranoia (fact based) and exaggerated paranoia (fear based) with regards to discrimination). Leaving work on disability can be another recognition that HIV has encroached upon their life. People who are strongly tied to their careers for self-identity may experience profound despair upon taking disability leave. Many people rely on employers as their sole source of health insurance. Thus, for many clients, work-related issues become intricately intertwined with issues of health care. Those who do migrant work or day labor receive no health insurance, benefits and disability. For them, not working may not be an option. Hiding their HIV status may be crucial and working paramount, even when it means destroying their health. The Americans with Disabilities Act (ADA) requires employers to make reasonable accommodations to a work environment or in the way things are customarily done for disabled workers. These accommodations must permit a person with HIV/AIDS to apply for a job, perform essential functions of a job, gain access to a work site, and enjoy equal privileges and benefits of employment.

For counselors helping individuals who believe they may have HIV/AIDS, the decision to get tested involves four main counseling tasks: (1) helping clients overcome any ambivalence regarding testing; (2) reviewing options and the consequences of receiving a positive/negative test result; (3) support while waiting for results by discussing/validating fears; and (4) preparing clients for results of the test. Acute distress in response to a positive HIV test is universal. People may experience many reactive psychological symptoms including depression, anxiety, and preoccupation with illness (Stoskopf, Kim & Glover, 2001). These symptoms often take the form of adjustment disorders. However, it is often observed that depression and other aspects of the initial shock of learning one is infected decline over the first few weeks. According to Stoskopf, Kim and Glover (2001), a wide range of personal reactions might include:

- Numbness accompanied by an inability to take in the news that they are HIV positive-or-an immediate rational acceptance of their positive status without any exploration of possible emotional reactions;
- Intense fatalism, a belief that they have only a short time left to live. Despite knowledge of promising new drug treatments, these people often believe the treatments won't work for them;
- Guilt and remorse for past behaviors (Lynch & Palacios-Jimenez, 1993) observed that many of their clients began taking inventory to determine what they did to deserve AIDS-resulting in feelings of self-blame & intense anger directed at the people believed to be responsible for transmission);
- People may receive a positive test result and go into denial for years until they become symptomatic;
- Suicidal ideation (Rabkin, 1994) notes that although many believe they might choose suicide at some future point, they often discover new strengths;
- Hopefulness regarding new treatment options such as protease inhibitors.

- Helping clients adjust to the multiple tasks they face upon testing positive such as forming a medical team, treatment decisions, and disclosing their status to third parties;
- Finding developmentally appropriate messages to convey information about HIV disease and to dispel fears;
- Helping patients' understand and manage their emotional reactions to testing positive and to manage their symptoms. Counselors may use a crisis counseling model, some clients may need psychotropic drugs;
- Assessing patients' support networks and making referrals to resources when necessary;
- Managing the balance between duty to protect confidentiality and duty to warn HIV-positive clients' partners.

Social Support

The majority of U.S. AIDS cases to date have been in the populations of marginalized groups which have been historically underrepresented and/or stigmatized. In addition, even though the public is now better informed about how unlikely transmission of HIV through casual contact is, many people feel uncomfortable in the presence of someone with a life-threatening, infectious illness. Therefore it is harder for those with HIV/AIDS, who may feel "toxic," to establish and maintain social support networks that it is for persons with other illnesses. Feelings of isolation, alienation, and depression have been linked to a lack of social support (Hoffman, 1996). For many, revealing that one is HIV-positive involves a double disclosure in which one's sexual orientation, sexual activities, and/or drug use are also revealed (Green, 1989). Therefore care must be taken when choosing sources of support. Latino MSM is less likely than other populations to seek support from family (Hays, Catani, McKusick & Coates, 1990). Research has found that MSM men often have conflicted relations with their family and are hesitant to seek social support from them pertaining to their HIV/AIDS needs (Nott, Vedhara, & Power, 1995). Instead, they are more likely to seek support from professionals and peers. Factor analysis has identified four sources of support (friends, relatives, partner, and organization) for gay men (Schwarzer, Dunkel-Schetter, & Kemeny, 1994). Blame and fear are barriers in providing social support (Collins, 1994). Ethnicity is an important variable in help-seeking behavior. For example, in one study Spanish-speaking Latino men were more likely than either English-speaking Latino or Whites *not* to disclose being HIV-positive and being gay or bisexual to their significant others (Mason, Marks, Simoni, Ruiz, & Richardson, 1995). Of course, non-disclosure reduces the likelihood of engaging in safer-sex practices and seeking medical help. A positive relationship between social support and psychological well-being in HIV-positive persons has only been established for White gay men (Hoffman, 1996). Social support has been studied in homes with spouses and/or children. For example, in married couples with an HIV-positive husband, an avoidant coping style by either spouse was associated with poorer family functioning (Klein, Forehand, Armistead, & Wienson, 1994). Many scales have been developed to improve our understanding of social support networks for the HIV-positive person and to measure them better. Examples include 1) the Social Support Inventory for People with AIDS; 2) the Mental Attitude to HIV Scale Health Related Quality of Life Battery for HIV Positive Individuals; 3) Adjustment to AIDS Scale; and, 4) Healthcare Needs Scale for Patients with HIV/AIDS. Social support networks have been studied extensively and have been associated to stress management and to the following coping styles: action-oriented, cognitive, emotional, and avoidant. Both the quality and the quantity of social support are considered important. There is no clear causal direction in the relationship between social support and health. It is possible that "good social support promotes psychological well-being which in turn promotes good health" (Green, 1993); but it is also possible that those with good health find psychological adaptation easier, which then attracts a wider support. Some evidence exists that lack of good support precedes the onset of depression, although depression may then lead to changes in the quality of support. In sum, cyclical relationships may be operative. The unclear causal direction between social support and health is unclear for health conditions in general is a particularly intractable puzzle with AIDS/HIV, with its many biological markers and opportunistic infections. It is possible that social support is a beneficial mediating

variable, but that the causal paths among stress, coping, social support, and disease progression have not yet been clearly delineated.

Legal & Ethical Issues

Counselors have expressed considerable concern about meeting their legal and ethical responsibility to protect the confidentiality of professionally-obtained information and the possibility that one may have, under state or federal law, the responsibility to protect sexual or needle-sharing partners of clients who are HIV positive from contracting HIV disease (Woods, Marks & Dilley, 2000). In response to these concerns, the following suggestions are offered to counselors facing difficult situations involving clients who are HIV positive (Burriss, Dalton, Miller & the Yale AIDS Law Project, 2003; Simone & Fulero, 2001):

- 1) Counselors should abide by state laws and regulations, consistent with the Ethical Principles that address client confidentiality. Most state laws provide that professionally obtained information, including a client's HIV status, must be kept confidential unless the client consents to disclosure. If there is no legal exception to confidentiality for HIV status or for endangerment to third parties, and consent to disclose is not given, then the information should remain confidential.
- 2) Where appropriate, counselors should seek to assist clients who are HIV positive to adopt and maintain behaviors for preventing and reducing the risk of HIV infection. If the provider does not feel competent to assist a person with these issues, then he or she should seek consultation or refer the client to another resource.
- 3) Counselors are encouraged to work through and with public health officers who are experienced in confidential and anonymous contact tracing and partner notification strategies that may protect the identity of a client.
- 4) The determination that a known third party is at risk for HIV infection and the decision whether to act to protect the third party constitute difficult, complex professional judgment to be made by the provider on a case-by-case basis based on his/her assessment of the situation.
- 5) In making such judgments, the counselor may consider various factors, including the following:
 - Whether the counselor knows of an identifiable third party at risk;
 - Whether the counselor believes there is a significant risk of harm to the third party by virtue of the client/patient's conduct;
 - Whether the counselor believes that the third party does not suspect that he or she is at risk;
 - Whether the client has been counseled to notify the at-risk partner and has refused, or is considered unreliable in his/her willingness or competence to notify the partner;
 - Whether there is available public health officials engaged in contact tracing and partner notification strategies that the provider can lawfully notify third parties.

According to Britton, Rak, Cimini & Shepard (1999), counselor attitudes and biases are important in the impact on the process of counseling. Counselor's attitudes include beliefs reflected in emotional responses and behavior as well as cognitions. Because of the socio-cultural nature of the AIDS epidemic, counselors can be especially vulnerable to being influenced by their own attitudes and biases. It is important that they be cognizant of their own biases and attitudes and the subsequent impact of their work in counseling persons with HIV disease. Overall, the research suggests that counselors have demonstrated biases against persons with AIDS. Crawford (2001) found that counselor indicated that persons with AIDS were more responsible for their illness, less deserving of sympathy, and more dangerous to the general public than clients with leukemia. These workers reported less willingness to attend a party or work where a person with AIDS was present. Homophobic attitudes have been expressed by counselors working with clients with HIV disease and this attitude relates to their discomfort with gay clients. Hayes and Gelso (1995) found in their sample of male counselors that they experienced greater discomfort with HIV-infected clients than HIV negative clients, and counselors' homophobia predicted their discomfort with gay male clients. Homophobic attitudes in counselors may have an impact on their decision making around ethical issues. McGuire, Nieri,

Abbott, Sheridan & Fisher (1995) found a significant relationship between homophobia and likelihood of breaking confidentiality in situations where a client was perceived as dangerous to others. Counselor biases' can contribute or mediate counselors' ability to diagnose and plan interventions appropriately. Counselors may overlook indicated treatment interventions for their client with AIDS. Walker and Spengler (1995) found when assessing a client who had AIDS and endogenous depression, counselors may mistakenly overlook appropriate interventions. AIDS is such a salient issue for clients that counselors react with their own stereotypes, (e.g., depression is an understandable reaction to AIDS), and in so doing disregard indicated treatment options. Walker and Spengler (1995) also found that counselors may mistakenly fail to diagnose depression in AIDS patients or attribute symptoms of depression to an understandable reaction to a terminal and stigmatizing illness. Training and education can reduce counselor bias. There is a need for training that includes a focus on content and counselor attitudes. Carney, Werth and Emanuelson (1994) found that positive attitudes toward persons who are gay and toward persons with AIDS corresponded with high levels of knowledge. Results suggest the importance of training that includes knowledge based material as well as exploration of attitudes.

Preparing for End of Life Issues

Traditional models of grief have divided the bereavement process into stages or tasks which must be accomplished if the bereaved person is to heal. In Leick and Davidsen-Nielsen's (1991) model of grief work these tasks include: accepting that the loss is a reality; entering into the emotions of grief; acquiring new skills; and, reinvesting energy in new ways. These authors maintain that if these tasks are not accomplished or are inhibited, the grief cannot be resolved and so develops pathologically. Moreover, the authors divide pathological grief into three categories: delayed grief, avoided grief, and chronic grief. However, the limitations of this and related models as applied to those grieving the loss of a friend or loved one to AIDS-related complications is clear. What was once viewed as pathological grief is often seen as the most adaptive response possible. Similarly, delayed grief, avoided grief, and chronic grief have become common-place occurrences to counseling. Thus, models of facilitating AIDS-related bereavement have had to be established (Yedidia & MacGregor, 2001). People who grieve the death of someone from HIV-related complications often also face a unique set of issues that challenges historical models of bereavement (Kain, 1997). Rather than approach bereavement from a perspective with strict developmental/linear stages or tasks, current models of bereavement have begun to take into account the experience of people who have lost a loved one to AIDS-related complications and allow for the flexibility of each individual's experience (Rosengard & Folkman, 1997). With regard to euthanasia, the U.S. Supreme Court ruled that terminally ill people do not have a constitutional right to doctor-assisted suicide (Evans, Ferrando, Fishman, Goggin, Rabkin & Sewel, 2000). In 1997, the Court gave the states the option of enacting their own assistance-in-dying statutes. Still evolving, however, is the role of the mental health professional in working with terminally ill people. There is still much controversy and difference of opinion about the end-of-life process and, therefore, end-of-life care. Although many people consider depression "normal" in a seriously ill person, depression is a diagnosable illness and is highly treatable. Colon and Lyke (2003) found that the first task of a counselor when dealing with a terminally ill person is to separate the patient's prospective grief, fear of dying, fear of the unknown, and fear of pain from a clinical depression. It is often assumed, incorrectly, that the most pain-ridden, physically distressed terminally ill patients are more likely to become depressed or suicidal when compared to other less afflicted patients. In reality, a person's lifelong values, temperament, and behavior are often better indicators of suicide risk-thoughts when ill. There is no simple formula for what motivates an ill person to want to end his or her life. Most research points to multiple causes including anxiety, fear, desire for control and dignity, a lack of information or an inability to get questions answered, depression, and cognitive losses. Although pain management is at times a problem for terminally ill patients, pain, in and of itself, is not the single most important factor in suicide ideation. Appropriate roles for the counselor in helping terminally ill clients making end-of-life decisions include:

protecting clients' rights; supporting family; not allowing physicians to affix an inappropriate mental illness diagnosis; and, evaluating whether the client has the capacity to make rational decisions. Supportive relationships with consistent contact is important. Family, friends, partners, and providers offer different types of support. Lacking a close friend or confidant, as well as feeling lonely and isolated, are strong predictors of suicide potential among people with HIV infection (Fernandez, Perrino, Bowen, Royal & Varga, 2003). Social support, therefore, plays a particularly important role in protecting HIV positive persons with an inclination to end their lives. Because having AIDS is still very highly stigmatized, counselors can help clients realize the many harmful beliefs they may have internalized. Because of stigma, fear, and anger, HIV-positive clients often find themselves rejected by family and friends.

Education: Intervention & Prevention

HIV infection often brings a sense of meaning to people. It is common for people to gain a new appreciation for small pleasures in life (Vidrine, Amick, Gritz & Arduino, 2003). A sense of meaning among people with HIV is often achieved through efforts to live each day to its fullest (Fernandez, Perrino, Bowen, Royal & Varga, 2003). Education, intervention & prevention strategies that have been found effective include 1) small group counseling and skills training; 2) peer outreach; 3) counseling and testing; 4) hotlines; 5) media programs; and, 6) community interventions. Studies have suggested that 1) starting HIV prevention when rates of HIV are still low; 2) providing sterile injecting equipment through needle exchange programs and over-the-counter pharmacy sales; 3) conducting community outreach; and 4) providing drug treatment on demand works in reducing HIV transmission in these populations (Britton, Rak, Cimini, & Shepard, 1999; Des Jarlais, 1995). One effective program in several medium-sized cities trained [the most popular] people in social settings to deliver AIDS risk-reduction messages to friends and acquaintances in venue setting. As a result, fewer gay men practiced unprotected sex (Kelly, 1992).

Previous as well as recent studies of HIV prevention, found that using fear resulted in only short-term gains. Therefore, it appears that interventions must be based on moderate fear messages with attention to other components of the model. For example, the *model of reasoned action* stresses that intentions are a combination of personal attitudes toward the behavior as well as the norms of peers, both of which are heavily influenced by the social milieu. The *AIDS risk reduction model* suggests that in order to change behavior, one must first label the behavior as risky, then make a commitment to reduce the behavior and, finally, take action to perform a desired life-style change. Factors influencing movement between these stages include fear and anxiety and social norms. According to the *social cognitive model*, learning as a social process is influenced by cognition and interactions with others. The environment is therefore influential in reinforcing and shaping the beliefs that determine behavior. A change in any of these components - behavior, physical, or social - influences the others. Skill training and the development of self-efficacy, the belief that one is capable of performing a new behavior in the proposed situation, are essential features of this particular model.

Ultimately, people need to decide where HIV fits in with other life concerns. Goal-setting is important because living with HIV is characterized by pervasive uncertainty about the future, and clients will need help in reframing their planning processes. They need to feel entitled to set goals and focus on quality rather than quantity of life. Spirituality and religion are important in helping many people cope, especially in ore traditional ethnic communities (Fernandez, Perrino, Bowen, Royal & Varga, 2003). A fine line often exists between denial and hope. Even plans that appear illogical or irrational for the future keep people alive. Clients cross the line between healthy and unhealthy denial when their wellness and health maintenance is compromised. Coping resources such as self-esteem, deriving meaning from illness, and maintaining a sense of control over one's destiny offer means of adjustment (Toro-Alfonos, Varas-Diaz & Andujar-Bello,

2002). Planning for the future should also include a will; a living will; and, when applicable, provisions for their children's welfare. It should also include planning for possible retirement from work and permanent disability status. Attention to disability insurance and the potential of receiving funds from life insurance policies are important.

Many of the coping responses that are observed in other life threatening illnesses are also observed among people coping and adjusting to HIV infection. Clients living with HIV/AIDS may use a full range of coping strategies that include emotion-focused coping strategies that improve how a person feels without addressing the problem and problem-focused coping strategies that target the source of stress (Van Servellen, Carpio, Lopez, Garcia-Teague, Herrera, Monterrosa, Gomez & Lombardi, 2003). Coping responses that offer immediate and tangible outcomes have significant benefits to clients who view their time as limited. Examples of problem-focused coping strategies include action-oriented responses such as seeking medical care, enrolling in clinical treatment trials, seeking social support, making healthy changes in one's lifestyle, becoming socially and politically active and seeking information. Emotion focused coping strategies consist of cognitive and behavioral actions that do not directly intervene with the problem but do enhance personal adjustment. Examples of emotion focused coping include denial of the condition, avoidance and escape from stressors, distractions away from the problem, and reappraising a situation as a positive outcome.

METHODS

Using a mixed methods approach with an emphasis on both program evaluation and action research, participants in this pilot study were recruited from a local multi-service mental health agency serving Latinos. While this agency has traditionally provided outreach, education and referrals for substance abuse treatment, it's immediate and long-ranges goal is to respond to the increased needs of the community by providing more HIV/AIDS related services.

Participants

Data was collected in the fall of 2004 from 42 adults attending one of three court mandated counseling groups at a local Hispanic-based multi-service mental health agency. A total of 20 subjects completed the survey using the English version, and 22 subjects completed the Spanish language version. All subjects participating in this pilot study were identified as "high risk" – that is experiencing problems in one or more of the following areas: (1) MSM, (2) engaging in unprotected sex, (3) arrested for DUI, (4) drug possession/convictions, (5) alcohol/substance abuse or dependence, and/or (6) domestic violence.

Instrument

The survey was initially created by the primary author following a series of consultation meetings with the agency's administrators beginning in July 2004. As part of a service-learning experience supported in part by the CSUS Office of Community Collaboration, graduate students who were enrolled in two sections of *EDC250: Research in Counselor Education* assisted with revisions of the survey process. Meeting the needs of the identified population, literacy comprehension was established for an 8th grade reading level. The survey was then translated into a Spanish language version by 5 bilingual graduate students also in the Department of Counselor Education at CSUS. Once completed, the original survey was 4 pages in length with 3 major sections: Section 1 included 13 closed-ended items that were demographic in nature. Section 2 contained 10 closed-ended items that asked for personal information, specific to HIV/AIDS. Both of these sections provided a fixed set of response alternatives (multiple choice) from which to choose. Finally, Section 3 contained open-ended questions and covered 4 areas: 1) service satisfaction; 2) barriers; 3) client involvement; 4) open-ended reflection. The purpose of the open-ended reflections/questions was to provide freedom of expression. The survey provided clear directions and guidance, and was organized so that early questions maximized the response rate but did not affect responses to later questions. Survey completion time was between 20-30 minutes.

Limitations

As is often the case when conducting a pilot study, an unanticipated complication occurred on the day data collection was to commence (delaying data collection by two days). Once informed of the problem, the primary author worked to facilitate a compromise between agency coordinators and permission was granted to proceed with changes being made to page 2 of the survey. This had the effect of changing the HIV/AIDS specific questions to more general health related questions. While this would change the dynamics of the intent of the original pilot study, the author gained permission to include a questionnaire that asked indirect questions related one's awareness, and knowledge about HIV/AIDS. Another limitation had to do with the comprehension level of the survey. Future adaptations of the survey will need to be made with regard to the reading comprehension level (possibly 6th grade), and to revise the Spanish language version to reflect more formalized and regional linguistic considerations.

Setting & Procedures

In preparation for data collection, all clients were to have been informed of the needs assessment by their [group] counselors at the agency one week prior to data collection. All data collection schedules were conducted on site by trained, bilingual group facilitators/interviewers. Although the research subjects were court mandated to attend counseling, their participation in this pilot study was entirely voluntary. Adhering to Standard G.2. of the American Counseling Association's Ethical Standards of Practice (2001), the subjects were informed they could decline to participate or discontinue their participation at any time during the interview without risk. As a result, three potential subjects declined to participate from the start (42/45). Finally, because of the subjects' court-mandated status, a decision was made by program administrators that no research incentive would be offered during this piloting of the data collection.

Because of issues related to literacy and reading comprehension among the population overall, there were two methods used to collect data: (1) surveys were completed directly by the subjects who possessed functional literacy ($n_1=36$); and (2) face-to-face interviews were conducted for those subjects ($n_2=6$) who requested or were offered assistance (non-functional literacy) by trained bilingual facilitators/interviewers. With this second method, questions were read and responses recorded by the trained facilitators/interviewers. After the *Consent to Participate* form was signed by the subject, the trained facilitator/interviewer commenced with the interview.

Facilitators/Interview Process

Ten bilingual facilitators/interviewers were recruited from among graduate students enrolled in *EDC250: Research in Counselor Education* at California State University Sacramento. They received reading materials and informal guidance to build upon their academic counseling training in the area of group facilitation skills, interviewing techniques, and recording procedures. In addition, they attended a mandatory orientation led by the agency's program coordinator, who was also present and available to supervise them during the data collection process. In recognition of initial subject apprehension, the interview process was designed to begin with fairly simple, non-threatening questions (demographics) as a means of reducing tension and encouraging active participation.

Method of Analysis

Data analysis began once the data collection process was concluded. As part of the semester long service-learning experience, graduate students enrolled in the research course (*EDC250: Research in Counselor Education*) were assigned the task of tabulating, then calculating the raw data of sections 1 and 2, using descriptive statistics. Content analysis of Section 3 was initially conducted by the trained facilitators/interviewers who assisted in the translation and data collection process. Following this, all students participated in the qualitative analysis, including an unfocused overview of the text, making interpretations through successive readings, and finally, finding language that accurately conveyed research themes.

QUANTITATIVE RESULTS

Among the participants for this pilot study, 78.6% were male, 19% were female and 1% self-identified as transgendered. All subjects fell into the category of low socio-economic-status. With regards to ethnicity, 61.9% identified as Latino (19% of these self-identified as *Mexican*), 21.4% identified as Caucasian, and 16.7% identified as African American. Ages ranged from 18-50 years, with a mean age of 30 years. Fifty percent reported Spanish as their preferred language, 45% reported speaking English as their primary language, and 4.7% of the sample reported being bilingual.

The majority of participants were married (42.8%), followed by 40% who identified as single/never married. Seven percent of the subject's cohabitated with others, and 4.7% reported being married but separated. Another 2.3% reported being in a partnership, but declined to describe the orientation of the relationship. Regardless of relational status, 35.71% reported having children.

When asked to identify their level of education, 4.7% reported earning an associate degree, while 16.6% graduated from high school and 4.7% had earned a GED. The largest number of subjects (40%) reported attending but not graduating from high school, and 31% of the subjects had less than an eighth grade education. A significant number of the sample was employed full-time (69.4%) while 9.5% were employed part-time. A total of 14.28% were unemployed, and 2.4% were involved in some form of volunteer work.

When asked about their living arrangements, only 14.3% reported owning their own home, while over half of the sample (57%) reported renting. Thirty-eight percent reported living with friends temporarily, while 26% stated they resided with extended family. Table 1 illustrates place of residence by County and zip code. This information was requested by the agency in order to provide access and needed services to the region. The largest percentage of the sample (85.71%) lived in Sacramento County, with 14.29% residing in the 95820 zip code.

TABLE 1
Place of Residence by County and Zip Code (N=42)

| <u>County</u> | <u>Percentage</u> |
|--------------------|-------------------|
| Sacramento County | 85.71% |
| Placer County | 7.14% |
| Yolo County | 2.38% |
| <u>By Zip Code</u> | <u>Percentage</u> |
| 95610 | 2.38% |
| 95612 | 2.38% |
| 95621 | 2.38% |
| 95630 | 2.38% |
| 95661 | 2.38% |
| 95670 | 4.76% |
| 95758 | 2.38% |
| 95820 | 14.29% |
| 95821 | 4.76% |
| 95822 | 9.52% |
| 95823 | 2.38% |
| 95824 | 9.52% |
| 95827 | 2.38% |
| 95828 | 7.14% |
| 95829 | 4.76% |
| 95831 | 2.38% |
| 95832 | 4.76% |
| 95834 | 2.38% |
| 95838 | 2.38% |
| 95864 | 4.76% |

Only 38% of the sample reported having health insurance. Among these, 19% were members of an HMO, and 2% had some other form of private insurance. An alarming 62% of the participants had no health insurance, while 9.52% reported receiving government assistance in the form of Medicare. With regards to both medical and mental health problems, 73.8% of the participants reported that they had no known health problems at the time of completing the survey, while only 33.3% of the sample rated their health as very good. This is of particular interest with regard to personal perception when one considers that all participants were recruited from court-mandated programs and had been identified as “high risk” – that is experiencing problems in one or more of the following areas: (1) MSM, (2) engaging in unprotected sex, (3) arrested for DUI, (4) drug possession/convictions, (5) alcohol/substance abuse or dependence, and/or (6) domestic violence. Among those who identified a health problem, 16.67% reported such diagnosable mental disorders as bi-polar disorder, depression, and/or schizophrenia. Comparatively, 14.39% rated their overall health as fair, while 26% cited health problems such as bronchitis and asthma. Twenty percent of the participants also reported that an immediate member of their household had a current medical or health-related problem, as follows: wife (12.5%), partner (12.5%), relative (15.5%), and roommate/friend (12.5%).

With regards to medication, only 10% reported taking prescribed medicine for their health problems at the time of completing the survey. The medications most cited were Lithium and Wellbutrin, both psychotropic drugs frequently prescribed for bi-polar disorder, depression and schizophrenia. Interestingly, when participants were asked about taking prescribed medications for any health problems, an overwhelming 90.47% reported that they were taking no medications at present. However, when asked how they paid for their medications when needed, 53% reported paying for them out-of-pocket, while only 11.9% reported their private insurance/HMO covered the cost, and 11.9% reported that their prescription costs were covered Medicaid, Medicare and/or MediCal. Two percent of the sample reported receiving Worker’s Compensation at the time of completing the survey, and 4.76% reported receiving Social Security Disability. Finally, 35% of the sample reported receiving “other” benefits, but did not elaborate.

Table 2 illustrates SERVICE NEEDS. Specifically, subjects were asked to check off any relevant services they presently used, as well as to indicate whether or not they would use a particular service if it were made available to them. The service needs items most frequently cited were consistent with earlier data results from this pilot study. These included 26% of the subjects who reported needing assistance in paying health insurance premiums, 29% who reported needing help in finding or getting meals and medication, 33% who said they needed help in meeting their rent on a monthly basis, 29% who stated that emergency financial assistance would be used if made available, 33% who were in need of dental care, and 29% who reported needing employment assistance as well as vocational counseling and training. Finally, 29% of the respondents indicated they needed assistance with child care services, while 21% reported needing assistance as it related to foster-care services.

| TABLE 2 Service Needs | I’m Using This Service | I’d Use This Service If Available |
|--|---------------------------|--------------------------------------|
| Mental health counseling in individual or group sessions | 12.% | 17.% |
| Assistance paying health insurance premiums | 18.% | 26.% |
| Substance abuse treatment or counseling sessions | 31.% | 10.% |
| Substance abuse treatment in 24-hour residential setting | 7.% | 21.% |
| Assistance in finding or getting meals/medication management and/or personal care provided | 5.% | 29.% |
| Rent assistance | 18.% | 33.% |
| Emergency financial assistance | 7.% | 29.% |
| Dental care | 19.% | 33.% |
| Legal services | 5.% | -0- |
| Employment assistance/ vocational counseling and training | 18.% | 29.% |
| Baby-sitting or child care services | 2.% | 29.% |
| Adoption/foster-care assistance | 7.% | 21.% |
| Rehabilitative services | -0- | -0- |
| Other (specify) <i>“longer and more frequent classes.”</i> | 17.% | 18.% |

Table 3 illustrates subjects' awareness, and knowledge about HIV/AIDS. Not surprisingly, awareness and knowledge seemed to be connected with levels of literacy, and language exposure. Low educational attainment and limited language-and-reading fluency appeared to be associated with lower AIDS awareness and knowledge. Methods of infection were misunderstood as well as general facts about AIDS and the likely means of HIV transmission.

| TABLE 3 HIV/AIDS Awareness | True | False |
|--|-------------|--------------|
| AIDS is caused by a virus called HIV | 10% | 82% |
| Blood, semen, vaginal fluids and mother's milk for babies can transmit HIV | 80% | 17% |
| You can get AIDS & Hepatitis C if you share needles | 70% | 25% |
| The following may be warning signs of infection with HIV: rapid weight loss, dry cough, unexplained fatigue, and fever or profuse night sweat. | 55% | 35% |
| HIV is not spread by casual contact: sitting next to someone, eating in a restaurant, or using a restroom, | 47% | 45% |
| AIDS affects only homosexuals and drug addicts. | 67.5% | 27% |
| Alcohol and drugs do affect my decision to practice safe sex. | 62% | 38% |
| Saliva, urine, and sweat are some of the body fluids that transmit HIV | 32% | 60% |
| I'd be able to use a condom for vaginal or anal sex even if my partner didn't want to. | 75% | 17.5% |
| HIV/AIDS Question | Yes | No |
| Is there something in your life that you want to change to reduce the HIV risk, but are having trouble doing it? | 37.5% | 37.5% |

QUALITATIVE RESULTS

The following themes emerged through the process of the qualitative analysis:

Theme 1: Satisfaction with Agency Services

The majority of participants reported that they were satisfied with the services at the agency. Moreover, they felt that the agency provided a supportive, caring and protective environment and structure in which they felt welcomed. Many of the respondents also felt that the various mandated group counseling offerings worked with regard to scheduling and available group offerings as it allowed them to maintain employment. The following participant comments illustrate this theme:

"The location and times of groups are helpful because it goes with my job hours."

"I've always felt highly supported here."

"The hours of operation let me keep my job too."

"The people here have treated me good."

"They are flexible and that helps me to keep my life at work and do better with my family."

"They are helping me good with my problems at the support groups."

"The class times are really good & the group leaders are really good."

"The organization is good. I would recommend it to others."

"The first or second group I had here I was the only man but everyone made me feel welcome by including me in, even if I was new."

"This program has so far helped me understand that I have a problem & now to overcome some points of my addiction has been helpful. By asking and gaining information I receive the help and support necessary."

Theme 2: Client Concerns and Interests

There were a number of frequently cited comments made by respondents. These comments had to do with job security and/or job searches, housing, learning more about their own recovery/health, and better English language fluency. Similarly, because the agency provided bilingual services, the subjects felt supported and welcomed. This was not the case when they ventured outside the confines of the agency. In this case, respondents reported feeling a sense of alienation and discrimination when out in other institutional and commercial settings. The following statements illustrate this theme:

"Maybe MAAP can prepare us to find jobs."

"They can have workshops for obtaining a better job."

"I would like more work assistance (find a job) and workshops about how to get a job."

"They need to reduce the payments of what they charge here. I can't afford it all the time, so sometimes I can't do other things I need to."

"Look for preparation (for a better job) and learn English."

"I have no complaints here, but in other agencies I feel uncomfortable for not speaking English."

"Because I don't speak English, the interpreter at Court was not very friendly. I'd like for MAAP to send an interpreter to help me there."

"Tell all the counselors to give out the same helpful information-- some people get more help than others – make the counselors help everybody equally."

"I want to make sure the information of my case is correct in their computers to avoid any problems in court. I want to stay out of jail."

"We are trying to get housing since we started CPS. We need help but don't seem to be able to find it."

Theme 3: Hope for a Better Future

In this theme, subjects shared a common dream – to be better parents, find a job with security and buy a home. Respondents made frequent comments about their motivation and enthusiasm to be involved in their own health and wellness. The following quotes highlight this theme:

"Well, I would think I would like to give better examples to my children."

"My participation here has helped me to better my life and show me how to stay drug free one day at a time."

"I'd like some more information booklets about my disease and illness."

"I want to start over and move on with my life – do things better."

"I want to learn more about drugs and their harms and how I can change my life."

"One of the things I've learned here is more tolerance – that helps me be a better mom."

"I want to stop drinking for my life and to buy home for my family."

"Be happy with myself and secondly with my family and positively guide my children."

"Maybe MAAP can prepare us to find jobs."

"They can have workshops for obtaining a better job."

"Look for preparation (for a better job) and learn English."

"To maintain myself free from addictions."

"I would like to get my kids back and keep them safe."

"I look at my 5 month old daughter How pretty she is I don't want to put her in a [sic] purdicament like that anymore."

"Go to meetings/stay busy with work and be better to my son and realize how [sic] harmfull the drug is."

"My biggest challenge in the future is to be together with my family again."

"I like that I don't cause problems to my family any more."

DISCUSSION

The impact of HIV/AIDS-related knowledge and awareness, reading comprehension, literacy, and language exposure, stable employment and medical/prescription drug coverage have significant and far reaching effects on the health and well being of this vulnerable population. The following recommendations are made:

Increase

- Accurate HIV/AIDS Knowledge & Awareness
- Understanding of Family As Social Unit/Source of Support
- Understanding of Interpretations of Cultural Values/Gender Roles

Assist

- Medical/Prescription Drug Coverage
- Social/Institutional Advocacy
- Career/Vocational Counseling

Improve

- Levels of Literacy/Reading Comprehension
- Language Exposure/Fluency
- Educational Attainment

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