CASE REPORT

The HIV-Positive Intravenous Drug Abuser

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Key Words: acquired immunodeficiency syndrome • occupational therapy (treatment) • substance abuse • substance dependence

According to the Centers for Disease Control’s 1989 report, 20% of the adults and adolescents who tested positive for HIV and developed AIDS as of December 12, 1988, were intravenous substance abusers. Their ability to abstain from substance abuse and to develop a healthy, balanced lifestyle will affect the quality and length of their lives. The chronic, progressive nature of drug addiction coupled with HIV infection can make this task difficult, however. The first step in the treatment of persons with HIV infection who are substance abusers, therefore, is to help them discontinue their drug use and develop skills that will help them remain sober.

Drug addiction is a chronic, progressive disease characterized by physical, psychological, and social dysfunction that results from drug use. Psychological defense mechanisms, including denial, minimization, and projection, complicate the diagnosis and treatment of substance abuse. It is important that HIV-positive drug abusers seek treatment for their addiction, because the continued use of substances will increase their susceptibility to opportunistic infections and increase the risk of contagion through shared needles (Schindler, 1988). Drug and alcohol use decreases the immune system’s ability to combat disease and increases the risk that a person who is HIV-positive will develop AIDS-related complex (ARC) or AIDS (Trenk, 1989).

Sobriety entails a person’s working toward a productive life without depending on mood-altering drugs (Kinney & Leaton, 1987). Persons who abuse substances often lack the critical skills that support sobriety. Proficiency in interpersonal skills, time management skills, relapse prevention skills, stress management skills, and basic living skills is necessary to maintain sobriety. Such skills are often lacking in this population for one of two primary reasons: (a) the person did not acquire the skills because he or she was actively using substances during the developmental period when they are normally acquired, or (b) the person’s skills were underused. Helping a person learn or relearn sobriety skills is an essential component of treatment.

Persons who test positive for the HIV virus need to learn skills to cope with the short- and long-term effects of HIV infection. Declining physical, psychological, and social functioning requires adaptive responses to maximize independence. The similarity of and overlap between sobriety skills and adaptive responses are illustrated in the following case report.

Occupational therapists play a vital role in treating HIV-positive substance abusers. Training in psychosocial and physical dysfunction enables occupational therapists to understand the biopsychosocial implications of alcohol and drug addiction. Occupational therapy evaluation and treatment can help sub-
stance abusing patients identify their deficits and strengths in the skills needed to maintain sobriety. The occupational therapist also can help patients cope with the changing personal roles and functions associated with HIV infection. The following case describes the course of occupational therapy treatment for an intravenous drug abuser with HIV infection.

Case Example

Jim is a 31-year-old single white homosexual man with an 18-year history of substance abuse. He tested positive for HIV in 1986 and was diagnosed with ARC in 1987. His HIV-related symptoms included night sweats, weight loss, and fatigue. He had a preexisting seizure disorder of unknown etiology.

Jim was referred to an inpatient substance abuse facility by the neurology clinic at a large urban hospital where he was being medically monitored. The referral was precipitated by missed appointments, failure to follow the treatment plan, and abuse of prescription medications. Jim was admitted to the substance abuse facility for a 26-day detoxification and rehabilitation program. The treatment team consisted of occupational therapists, nurses, social workers, physicians, counselors, psychologists, and family therapists.

Substance Abuse History

Jim first used alcohol and marijuana at age 13 years. Prior to admission, he was using Percocet (60 mg/week), Xanax (6 mg/day), or Valium (30 mg/day), vodka (1 quart/day), and heroin when available. Jim reported two prior treatment attempts in 1980 and 1984.

Family and Vocational Histories

Jim's mother died from cirrhosis in 1970 and his father was an active alcoholic. Jim had been disowned by his father and three sisters because of his gay lifestyle. As a child, Jim had been physically, emotionally, and sexually abused. He never married, but he had a daughter who was given up for adoption at birth. Jim's last relationship ended when he was diagnosed as having ARC. His former lover has also developed ARC.

Jim is a high school graduate and has a degree in culinary arts. He worked as a caterer for 13 years. His most recent employment was as a nurse's aide in a residential program for AIDS patients. He lost this position in 1986 because of his substance abuse. He began receiving social security disability benefits in 1987, when he learned he had ARC.

Jim was referred to occupational therapy on Day 6 of his 26-day treatment program. The initial effects of the narcotic and alcohol withdrawal had subsided. Occupational therapy was ordered to assess his functional skills and to develop a treatment plan to increase his proficiency in sobriety skills.

Assessment

The patient was assessed with a structured interview that included specific questions that indicated the patient's level of sobriety skills. Those skills that would help maintain sobriety and ease the transition to outpatient treatment and aftercare were emphasized. The specific areas addressed were interpersonal skills, time management skills, relapse prevention skills, stress reduction skills, and basic living skills.

Information on Jim's interpersonal skills was gathered through interviews, observation, and role-playing. Jim described what it was like to lead an isolated lifestyle and to have no active support systems in the community. He correctly formulated assertive responses to sample situations (e.g., drug refusal) that he would experience in early recovery. Jim was active in unit activities. He initially struggled with disclosing his HIV-positive status to peers, but eventually did so. Jim assumed the role of caretaker on the unit. He had difficulty saying no to personal requests from peers and was unable to ask for help. Jim was familiar with Alcoholics Anonymous, Narcotics Anonymous, and local AIDS support groups. He had not been actively involved in these organizations due to the progression of his drug addiction.

Prior to admission, Jim spent his time obtaining and using both licit and illicit drugs. He did not report any current leisure interests. Past interests included drawing, walking, and crafts. His proficiency in crafts was evidenced by a sweater he had knitted, which he often wore on the unit. He had not engaged in leisure activities for approximately 2 years.

Jim was able to abstain from using substances from 1984 to 1986. He correctly described relapse as a process of returning to drugs after a period of sobriety. Jim attributed his relapse to his positive HIV test results. After this diagnosis, he attempted suicide and consequently was hospitalized. Jim continued to contemplate suicide during the first 15 days of hospitalization. He identified the substitution of prescription drugs and depression as personal warning signs of relapse.

Jim defined stress as his body's and mind's reaction to pressure. He identified his HIV-positive status and the distance between his house and his primary medical care center as his major stressors. His stress symptoms included increased anxiety, decreased concentration, and medication-seeking behaviors. Leisure interests had helped him manage stress in the
past, but he was not currently engaging in them at the time of his treatment.

Jim was independent in basic living skills. He did need additional time to complete tasks because of the fatigue and peripheral neuropathies, which were clinical manifestations of his HIV-positive status. He lived alone, 90 minutes from his primary medical care center. He felt the distance contributed to his fatigue and failure to comply with treatment. He was interested in moving to an urban area. Initial neuropsychiatric deficits (e.g., decreased concentration) diminished after detoxification and were attributed to alcohol withdrawal. The consulting psychologist ruled out cognitive dysfunction secondary to HIV.

Treatment

Jim and I, as his occupational therapist, with the assistance of additional staff members, established treatment goals using the information presented during the assessment. Emphasis was placed on developing goals that could be achieved during the time-limited hospitalization. Goals agreed upon were as follows:

- Apply assertive skills to interpersonal communication.
- Identify low-, moderate-, and high-energy leisure interests.
- Develop a balanced schedule of substance-free activities to follow after discharge.
- Develop a list of relapse symptoms and strategies for coping with them.
- Learn three relaxation exercises.
- Identify energy-conservation techniques.

Jim's treatment program consisted of activities involving interpersonal skills, time management skills, relapse prevention skills, stress management skills, and basic living skills.

Interpersonal skills. Because Jim's basic communication skills were good, treatment focused on supporting healthy coping mechanisms while helping him express feelings related to his HIV infection and drug addiction. Jim was assigned to an assertiveness training class to help him learn how to express these feelings and related needs. He participated in role-playing to practice saying no to personal requests by other people. In this group, he also rehearsed calling the local AIDS support group for help in finding new housing. Jim was responsive to feedback about his verbal and nonverbal behaviors in these exercises. Simultaneously, he was able to improve his problem-solving skills through the exercises used in this group.

Time management skills. Jim identified high-risk times during the week that were more stressful and in which the urge to use alcohol or drugs increased. He selected a variety of activities that he could engage in, depending on his level of fatigue. He listed low-, moderate-, and high-energy substance-free interests and identified additional leisure interests to structure high-risk times (e.g., weekends, the day he received a check). Jim engaged in recreational activities on the unit to help him renew interest in his previous hobbies. Finally, he completed a daily schedule to follow after discharge that included a balance of basic living skills, leisure interests, and self-help and support groups.

Relapse prevention skills. Relapse is preventable if appropriate interventions are used. Jim was able to identify some of his relapse warning signs, for example, failure to attend Alcoholics Anonymous meetings and preoccupation with somatic complaints and HIV infection. Peers suggested that he mark on a calendar those meetings he attended so he could monitor them. For his preoccupations, it was suggested that he record his thoughts in a journal and communicate them to his counselors and physician. With the support of the treatment team, Jim identified fatigue, depression, and obsession with drugs as additional warning symptoms. The staff encouraged Jim to use his problem-solving skills to develop strategies to diminish these symptoms as well as other symptoms that could appear in the future.

Stress management skills. Jim learned three relaxation exercises—progressive relaxation exercises, guided imagery, and deep breathing—through participation in a stress management group. He also attended a mild exercise group three times a week, which assisted him in developing a new leisure interest (exercise) while countering his depression and helping him maintain his current physical condition.

Basic living skills. Although Jim admitted that he felt increased fatigue when he performed daily tasks, he minimized overexertion's potential contribution to relapse (e.g., being too tired to attend meetings). No adaptive equipment was indicated at the time, but Jim was taught energy-conservation techniques such as planning and pacing.

Discharge Summary

On the 27th day of treatment, Jim was discharged to his home with the assistance of the local AIDS support group. He had a completed schedule for the first week after discharge and had a list of Narcotics Anonymous and Alcoholics Anonymous meetings in his area. He also had information on outpatient counseling resources for substance abuse. He was referred back to the neurology clinic for medical follow-up. Outpatient occupational therapy was not indicated because he did not need to develop any major skills. Social isolation, increased stress, and changing...
roles and functions (e.g., unemployment, physical disability) are among the difficulties that challenge people who test positive for HIV. The ability to communicate effectively, use time appropriately, and decrease stress are skills they will need to master. Jim learned these skills in a short-term substance abuse setting and was taught how they can assist him in coping with his HIV-positive status.

Relapse is an aspect of the disease of addiction. Successful treatment is determined not only by abstinence but also by the length of time between relapse episodes and the severity of the illness during relapse. Substance abuse treatment, however, has a cumulative effect (Gorski, 1987), that is, previous knowledge is expanded upon. Due to the acute nature of the substance abuse program (patients often cannot be located after discharge), follow-up is difficult to maintain. It is hoped that Jim was able to maintain his sobriety and use community resources to cope with his addiction and HIV positive status. As of 6 months after discharge, Jim had not required readmission.

Conclusion

Intravenous substance abusers with HIV infection present complex treatment challenges. They need assistance in discontinuing their addictive behaviors and maintaining sobriety as well as support in adjusting to their positive HIV test results. These are both long-term tasks. The patient's hospitalization is just the first step in the treatment process.

HIV-positive patients who enter treatment for substance abuse do not always choose to disclose their HIV-positive status to other patients. To respect their confidentiality, occupational therapists can treat these patients' AIDS-related functional problems in individual sessions.

In occupational therapy, it is important to establish short-term achievable goals and to provide a treatment environment that is safe and supportive. These conditions provide a positive treatment experience for the patient, which can strengthen the patient's desire to use community resources and to seek the long-term care that is necessary to his or her health.

References


Editor's Note. To continue the Case Report department, we need and welcome reports that document the practice of occupational therapy for specific clinical situations. Guidelines for writing case reports are available from the Editor.