Counseling the Person Living with HIV/AIDS*

Ricardo Sotelo Guanzon, MD, MAEd, EdD, FPAFP, RGC**
Arnel Gerard R. Gazmen, MD, MDM, FPSMS***

Persons with HIV infection ultimately develop life-threatening diseases due to immune-suppression which eventually leads to AIDS. Approximately 40,000 new HIV infections occur each year in the United States, 70 percent of them among men and 30 percent among women. It disproportionately affects the most socially and economically vulnerable.[1] The latter part of 2012 also see a rising incidence in the Philippines.

AIDS surveillance case definition is an important principle in the monitoring for the manifestations of HIV/AIDS and its changing epidemiology. These are monitored, to identify geographic distribution, cultural patterns and/or possible genetic differences for susceptibility patterns.[2] HIV contains an RNA -dependent DNA polymerase (reverse transcriptase) that directs the synthesis of a DNA form of the viral genome after infection of a host cell.

The latest statistics of the global HIV and AIDS epidemic were published by UNAIDS, WHO and UNICEF in November 2011, and refer to the end of 2010.[3] There are roughly 34 million people living with HIV/AIDS (PLWAHS) with3.4 million children worldwide, as of the end of 2010 (The prevalence rate). AIDS death was at 1.8 million. In 119 countries reported 95 million testing positive in 2010. Only about 6.65 million HIV-positive people had access to ART in low- and middle-income countries in 2010.[4]

Key Words: Medical Counseling, HIV/AIDS, ELIZA

* Based in part on a lecture delivered during the Iota Phi Annual Conference & Seminar-Workshop, May 4, 2012, Central Colleges of the Philippines, Manila

* Consultant, Department of Family Medicine –Region 1 Medical Center & Professor, The Graduate School, Pangasinan State U

* Med Specialist III & Consultant, Department of Internal Medicine & OIC – Chief of Clinics and OIC – Chief of Support Services, Region 1 Medical Center, Dagupan city

Local Epidemiology

The DOH through the National Epidemiology Center (NEC) reported that from 1984 to 2012, there were 8,850 HIV antibody sero-positive cases reported, of which 7,865 (89%) were asymptomatic and 985 (11%) were AIDS cases. Eighty-three percent (7,356) were males. Ages ranged from 1-73 years (median 29 years). The age groups with the most number of cases were: 20- 34 at 68 %.[5]

Sexual contact was the most common mode of HIV transmission, accounting for 93% (920) of all reported AIDS cases. Of these, more than half of the cases acquired infection by sexual transmission through heterosexual sex, followed by homosexual contact and bisexual contact. Other modes of transmission include: mother-to-child transmission, blood transfusion, injecting drug use, and needle prick injuries. [6] Table 1 shows the biomedical issues related to HIV infection that is worrisome.

Table 1. The Biomedical Issues of HIV

1. It is a dreaded disease
2. Primarily a sexually transmitted retroviral infection (though a lot are non-sexually contracted like placental transfer)
3. It has no known CURE but treatment is available (2012)
(Meds primarily to prolong life and improve quality of life)
4. It is a wasting disease

Table 2. Shows us very compelling reasons to be compassionate and understanding of the person living with HIV/AIDS.

Table 2. Facts About the Disease

Patients are unable to tolerate antiretroviral treatment
Some are unable to benefit from better therapies due to psychosocial factors such as poverty, limited access to care, unmet basic needs such as adequate food or housing, and concomitant psychiatric illness and/or substance abuse
Some patients die of end-stage liver or kidney disease, malignancy, or treatment-related complications
Palliative care is required throughout the disease Trajectory to 1) alleviate suffering, 2) relieve pain, 3) promote treatment adherence, 4) reduction of side effects and toxicity, 5)manage life-limiting co-morbidities, 6) provide quality end-of- life care

HIV Symptomatology

In 50 % of patients, progression to AIDS does not occur for 10 years. During the first infection, there is transient illness, fever, swollen lymph nodes, rash, inflammation of the meninges (occurs in 15 % if infected individuals). The rest are asymptomatic at the time of infection. As time passes, development of swollen lymph nodes – progressive generalized lymphadenopathy (PGL), may become symptomatic (ARC), AIDS - related Complex have fever, night sweats, weight loss, minor infections such as yeast (thrush) – do not revert to asymptomatic stage.

HIV INFECTION

Most prominent malignancies observed in AIDS patients include:

Kaposi's Sarcoma – tumour of the endothelial cells Burkitt's lymphoma involving B cells. Common opportunictic infections are those due to:

Pneumocystic carinii (PCP)

Candida albicans

Mycobacterium avium-intracellulare

Toxoplasma gondii

Crypstosporidium spp.

Genital and anal herpes simplex

HIV course

When absolute CD4 T cells count falls below 600/ul the patient begins to lose cell-mediated immunity and opportunistic infection occurs.

Laboratory tests will show: 1) CBC – an initial relative lymphopenia (CD4+ and CD8+) followed by lymphocytosis (atypical lymphocyte but CD4 never recovers), 2) ELISA (Enzyme-linked immunosorbent Assay) is the initial screening test, which detects antibodies to HV core proteins and surface glycoproteins and is useful 4 to 12 weeks of infection, and with 3) Western Blot – is a confirmatory test.

"Treatment" of HIV

Interferon alpha and Zidovudine in combination may be used or Azidothymidine which inhibit the reverse transcriptase of HIV plus Lamivudine can be used.

Prior to HIV testing, counseling must also be considered to prepare any client with a high index of suspicion. The confirmed case is also given a more thorough counseling strategy or protocol. Some of the issues in counseling the patient include the following:

1) Acceptance

2) Understanding the condition and possible outcome

3) Analyzing emotional concerns

4) Familial concerns

5) Moving on

The physician must be adept to handle patients having this medical condition. The success of pharmacologic treatment hinges also on the physician's understanding of the sources of distress of the patient living with AIDS or HIV (PLWAH) which need to be addressed as enumerated by Medina

1. Physical – pain, fatigue, somatization

- Psychosocial – anxiety, depression, coping and adjustment
- Family Problem – dysfunction, instability, conflict
- Burden of medical intervention – financial, physical, social, psychological, spiritual
- Existential and spiritual problems
- Empathic suffering with family

The Psychosocial Approach to the Management of HIV Infection/AIDS

The physician must always consider the high anxiety, sense of direction, the concerns for the future of the PLWAH upon diagnosis and in the course of the disease trajectory:

Medina further stresses the need for dignity conserving perspectives. These are questions phrased to elicit and induce the following dignity conserving or enhancing strategies to better arm the patient with this dreaded condition and live a more meaningful life even after acquiring the HIV infection. These are:

Continuity of Self - Are there things about your life that are not affected by your physical limitation? What is it about your life that you value most?

Role Perseveration – What are the things that you did that are important to you? To refocus on self- respect, promote self-esteem, independence.

Maintenance of Pride – What aspects of your life, about your life are you proud of? Realize respect, promote self-esteem

Hopefulness –What are the things that you still can do? To Encourage and enable meaningful activitiesAutonomy and Control – How in control do you feel? To promote autonomy, involvement in care and decisions

Generativity and Legacy – How do you want to be remembered? When acceptance has been defined (Life album, journal)

Acceptance – How at peace are you with what is happening now? To gauge baseline or further psychosocial support

Resilience and Strong Fighting Spirit?- What part of you is strong? To enhance sense of well-being.

Medical Counseling

Counseling of HIV- seropositive persons should be highly individualized. This includes interpretation of the test result, and a discussion of the biomedical and psychosocial implications. The persons with positive HIV test should be instructed to notify their sex partners or those who share needles with them and suggestion of counseling is given. The physician may, alternatively inform the partner/s of the person with HIV of their partner's condition and suggest HIV testing as well for them. This, in the event the person with HIV is reluctant to tell the partner.

Counseling strategies may include what we may call *semiotic counseling*. The physician draws the client's (patient) perspective on HIV infection along his/her cognitive ability, assess the intellectual and emotional dimension, and the social-anthropological sphere. Initially just let the client express his feelings and concerns about having the HIV infection. After the physician has drawn the client's "meaning" along the different planes (the emic perspective), it is now the turn of the physician to validate these (the etic perspective).

It is thus, a client's view about the infection which is ranged against what is the current empirical data or scientific view. Along this is the physician's identification of incongruent beliefs, maladjustive responses, inadequate coping style, and irrational concerns. These concerns may also be drawn from the socio-anthropological sphere including personal reaction to the family and society. Health beliefs about the infection may also be drawn primarily to serve as an anchor for emotional support and research to address misperceptions about the mode of transmission and other related issues. At the end of the counseling, it is expected that the client's cognitive, emotional, intellectual, and social -anthropological dimensions (which may be after several sessions) have been addressed. This is to include end-of-life issues for the person living with AIDS. Other counseling approaches may also be used.

The most important issues to address are the client's hope, and maintenance of a sense of direction, the total well-being, and the removal of the sense of shame, stigma or discrimination. Finally, family function must be optimal with the patient able to address and face his family without guilt, blame or shame.

Corresponding author:

Dr Ricardo S. Guanzon, Department of Internal Medicine & Family Medicine, R1MC,

Email: guanzon.ricardo@yahoo.com

CP +639175084511

References:

1.Piot P & Merson, MH. Global perspectives on Human Immunodeficiency Virus infection and Acquired Immunodeficiency Syndrome. In: Mandell GL, Bennet, JE, Dolin R, editors. Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases. 5th Ed.Philadelphia, Pennsylvania: Churchill Livingstone, 1332-1340. 2000.

2.Del Rio C, Curran JW. Epidemiology and prevention of acquired immunodeficiency syndrome and human immunodeficiency virus infection. In: Mandell GL, Bennett JE, Dolin R, editors. Principles and Practice of Infectious Diseases. 7th ed. Philadelphia, Pa: Elsevier Churchill Livingstone; 2009:chap 118.

3.http://www.avert.org/worldstats.html accessed July 2, 2012

4.http://www.who.int/gho/hiv/epidemic_response/en/index.html accessed July 2, 2012

5.http://www.doh.gov.ph/sites/default/files/NEC_HIV_June-AIDS Reg2011.pdf

6.http://www.doh.gov.ph/content/233-new-hiv-aids-cases-recorded-aprildohaccessed July 2, 2012.

7.Medina, M Jr. F. Manual of Palliative Medicine, 2nd Ed.2007