



## Intervention Manual

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# The STAR Intervention Protocol

## Module 1



### I. Welcome and Introductions (20 minutes)

[Goal: Have participants feel welcomed to the sessions/project; participants should know some specific information (i.e., group meetings, logistics, schedules, etc.)]

*Welcome to Project STAR, which stands for “Staying healthy: Taking Antiretrovirals Regularly.” In this group, over the next few weeks, we will all be trying to make some positive changes in our lives. This group is one of many groups that are meeting to learn more about adherence to antiretrovirals, and to help each other start or maintain adherence.*

*Group members are here today because they care about their health. By coming here, you can become an adherence “expert” for your community. That is, you can be a person that has the healthy answers for people in your group of friends, your family, your neighborhood, or anywhere you personally talk to people. We’re glad you’ve joined us.*

*We’ll be meeting here together for about one and one-half hours a week for the next 5 weeks. If you miss a group, we’ll call you to make sure everything’s o.k., and to remind you of the next meeting.*

*The groups will be fun and lively with all sorts of information, snacks, and most importantly, you! Feel free to join in on the group discussions, but you shouldn’t feel pressure to talk.*

*We think it is important for people to attend these groups, so we are paying people for their time. You will be paid \$\_\_\_\_\_ at the end of each meeting for your attendance. Please be on time, because if you are more than 30 minutes late to the group, you will not be paid for that group meeting. Those who are here early or right on time will get an extra bonus of [\$1 or small gift].*

### Ground Rules

[Goal: To have participants generate, know, and understand the ground rules under which each group will be run.]

*Some of you may have participated in some type of group previously—a support group, an information group, or a therapy group. If so, you know there are certain ground rules that are important to make note of and understand before we get going here.*

*We need to think of ways to make talking in a group more comfortable. This is our group so we need to come up with some of our own group rules. Let’s spend a few minutes on this so that we’ve got this out of the way and set for today and the rest of our four sessions, and then we’ll be able to start getting to the real purpose of the group.*

Facilitators should have participants generate appropriate rules making note of each on the newsprint pad on the tripod. Note: this specific newsprint sheet should be saved and posted at every subsequent meeting of this group.

Brainstorm group rules. Write the Group Rules on newsprint. Assist the group in making rules by raising questions or giving examples. These rules will be posted during each group meeting.

Make sure that minimally the following rules are noted:

- Confidentiality (“privacy”) – *We will be talking about very private things and we need to trust each other that we will not talk about the private lives of other group members to our friends and families. When talking about other people outside the group, we should not use names and should not give a lot of detail.*
- Respect – *We need to listen to whoever is talking and to respect them even if some of us disagree. This means that there should be no interrupting, whispering, giving funny looks or making fun of other group members.*
- No put downs or judgments – *Everyone has their own opinions, feelings and values, and you should respect these, even if they are different from yours.*
- Openness – *It is important to be honest and open, without talking about extremely personal things about ourselves and others.*
- Right to choose to participate – *You should not feel pressured to participate in a certain activity or answer any questions that make you feel uncomfortable.*
- The right to ask questions – *Please ask questions whenever you feel that you don’t understand something or that you want more information.*

### **Introduction to project (5 minutes)**

[Goal: (1) Participants should have some understanding of the background and purpose of the project in which they are participating; (2) Replacing the concept of being overwhelmed by concerns, fears, and issues with the concept of overcoming them.]

*O.k., good. Now we have our ground rules. Let’s really get started now.*

*As HIV/AIDS became a global epidemic in the last decade, medical professionals have responded by trying to provide treatments that will allow infected individuals to live with hope while a cure is being found. These treatments are numerous and complicated; often side effects can be quite problematic. Most typical treatments these days involve usually 3 different medications and sometimes up to 36 pills per day. This certainly can be described as overwhelming, especially when one considers that we all live in the real world and have many other things, people and situations to handle daily. All these factors have led to increasing problems with medication adherence.*

*The issues involved are numerous with some very applicable to you. That’s why we’re here: to help you and to help others develop techniques and strategies that will increase adherence. With improved medication adherence, yours and others, we provide physicians and other researchers the time needed to produce better treatments. We will*

*focus throughout all of our five sessions on overcoming all the overwhelming concerns, fears, issues and barriers with which you have come into contact.*

## **Participant Introductions with Descriptions of Medication Regimens**

[Goal: Participants should get to know a little about each other and realize they all have something in common. This is an opportunity for facilitators to build group cohesion and motivate participants to examine the reasons why it is important to themselves to be adherent.]

*The goal of these sessions is to help improve adherence to medication for everyone here. To do this, we will need to know about you and the particular and specific issues and problems you deal with on a regular basis. To start with, we ask that everyone share a little information about their current medication schedules. That way, we can all get a sense of the things you have in common, as a group, in taking these medications.--*

*So, we would like for you now to share with the group a little information about yourself:*

- *your first name;*
- *about how long you've been taking antiretrovirals;*
- *how many different medications you have to take – we don't want your exact prescriptions and schedules right now – just an overall sense of how hard it is to follow your regimen.*

Facilitators should ask probing questions if participants skip some important information. They should also try to tie together group members by mentioning significant common factors among them, such as common medications and side effects, or other things if necessary (i.e., occupations). Special attention should be made to the four most frequent reasons for poor adherence: (1) side effects of medications; (2) poor result from prescribed medication regimen; (3) any subsequent and significant decline in positive initial effect; and (4) scheduling challenges. The goal of this exercise, however, is to establish a sense of shared experience, not to obtain details of everyone's medication schedule.

*O.k., now we've got a sense of what everyone is dealing with—some of you have similar challenges, and others of you have some unique challenges to deal with. You're all doing this for a reason, and you're all here to improve your adherence. So, you're all motivated--what are some of the personal reasons it is important to you to adhere to the medications to stay as healthy as you can be for as long as you can?*

[Goal: Motivational issues should be discussed, and positive outcomes of adherence. Facilitators should note some of these, as this discussion will be returned to again in Module 5 as having come full circle and to reiterate the importance of long-term maintenance.]

## **II. Simplified Medication Information: Rationale for Full Compliance (20 minutes)**

[Goal: To increase motivation for adherence and to provide participants with basic and general information about HIV, AIDS, current medications available and how they work.]

*Many of you know a lot about antiretrovirals; the rationale for adherence and how they work. Others of you may be fairly newer to this. So that we're sure everyone is "on the same page," so to speak, we'd like to briefly review why adherence is so important with these medications. Some of this information may seem a little simple to those of you who have been at this a long time, but like I said, we want to make sure everyone has the basics.*

Review simplified medication adherence rationale in Appendix A; present material on overhead slide projector and read through each section, allowing time for participants to look at the illustrations provided for some of the key concepts.

Allow brief discussion of rationale for adherence and clarification or review of any concepts participants are having difficulty understanding.

*O.k., now we all understand why it is important to adhere; we've just reviewed pretty much the rationale for adherence to antiretroviral therapy. Let's take a minute and talk a little bit about what adherence actually is. Most of you have probably thought about the fact that you are supposed to take a certain number of pills per day—we refer to this as your dosage. So, let's say you're supposed to take two pills, 3x per day, for a total of 6 pills. Each time you take two pills, you've met the goal of taking one of the 3 doses for that day that you're supposed to take. If you take two pills 3x during a day, you've met your dosage goal for that day.*

*But what about the schedule of when you take your doses? That's something people talk about a little less. A lot of people think as long as they get their doses in some time during the day, that's the main thing that counts. But there are reasons, in terms of how these medications work, that it becomes pretty important to try to stay on schedule as much as possible. Which of these is more of an issue for you, getting the number or dosage done per day, or doing it on schedule?*

Let participants discuss the issue of dose/schedule briefly, and state their particular difficulties. One of the facilitators may want to make brief notes for each of the participants, which can be used at the next session when individual adherence plans are first developed.

Provide the current medical thinking on the "window period" for medication schedule.

## **III. Introduction to Problem-Solving Approach (15 Minutes)**

[Goal: Provide participants with basic, initial information regarding the problem-solving approach. Participants should understand how this technique can be used to solve problems in general, and more specifically, the barriers to medication adherence.]

*In order to improve our daily adherence, we have to know exactly what adherence problems we have. That may sound easier than it actually is. Learning to solve a problem, any problem, is perhaps one of the most important life skills that one can learn. General problem-solving skills have been taught in a variety of ways to many groups of individuals—to help people quit smoking, to help them improve their diet, to help them lower their risky sexual behavior—for all sorts of problems. We will be using a problem-solving technique, not to solve one particular adherence problem, but instead, to solve a series of adherence problems as we encounter them. Problem-solving is an active, flexible, on-going process.*

All of the following information should be written on the newsprint pad. These pages should be saved and posted at future group meetings.

*Let's first break down the process into several stages:*

1. *Identifying the problem. It may seem obvious to you, but without recognizing that a problem even exists, one cannot attempt to solve it. For example, think about a time in your life when you lived with a really bad roommate, whom we refer to as "the roommate from hell" (RFH). Think about some of the most annoying inconsiderate habits s/he had. It would truly be impossible to solve these differences with the RFH unless you can communicate, describe and convince him/her that the problem exists.*
2. *Identifying the goal. Once recognition and identification of the problem has occurred, you have to decide exactly what the goal is. Using the same example from above, telling your roommate something vague about the way s/he treats the apartment and what you want to have happen won't usually cut it. Stating the problem using some behavioral or measurable terms is highly preferable. For example, "It really annoys me a lot that you consistently leave dirty dishes and glasses with leftover food in the living room and the den; these should be put in the kitchen when you've finished eating."*

*Does everyone see that being specific, that is, specifying in clear terms what it is that the RFH does, and needs to change is going to lead to a better outcome?*

3. *Think of strategies (brainstorming). This is the step in our techniques where most amateur problem solvers make the most mistakes. During this step, one should be creative and non-evaluative, that is, don't jump ahead and begin to evaluate ideas and eliminate possibilities. Just allow yourself to think of as many ideas and possibilities even if they may not finally be the chosen one. You never know how many good ideas come from the brainstorming experience!*

*What would be some solutions for the RFH situation?*

Get examples from group. Provide the following examples if group doesn't think of them:

- get RFH to pay you \$40 a month to clean up stuff left out
- get RFH to agree to put dishes in kitchen (preferably kitchen sink) or pay a fine each time you find dishes around the common areas more than 10 minutes after they've finished eating
- get RFH to pay for weekly maid service

- agree to cook or buy RFH dinner weekly if s/he changes habits

4. *Evaluating alternative strategies and choose the best solution.* Now comes the time when you should start evaluating the alternatives. Considering your options, keeping in mind time constraints, financial considerations, and other practical aspects of the proposed solution. What will work best? What alternatives can be combined to create yet a better alternative?

Briefly discuss how a strategy might be selected.

5. *Act on the best solution.*

Briefly discuss how they would do this (i.e., what might be a fair “trial period” before re-evaluation; how important it is to stop and review how things are going even if they seem to be working and to reward progress; how modifications may be needed over time—let’s say the roommate starts using paper plates, and argues that they are just going to be thrown away, so they can sit out longer, etc.).

*This is the final step. And there’s a tendency for some people to quit before there’s time for the development of a real outcome. So being determined to “hang in there” is incredibly important.*

#### **IV. Introduction to Adherence Strategies (10 minutes)**

[Goal: Participants should be exposed to a variety of basic adherence strategies that they may or may not have utilized in the past.]

Provide list of strategies.

*O.k., today we’ve talked about why it is important to adhere to the antiretroviral medication regimens. And we’ve talked about how we are going to figure out which adherence issues we each need to work on. But we haven’t talked yet about what exactly we will be doing to solve adherence problems.*

*Well, today we don’t have time to start an in-depth program for each person here, and it’s important that when we do start a program for each of you, which will begin at our next session, we’ve reviewed it carefully. So what we’re about to do is have a “preview of coming attractions”—think of this next exercise as a “trailer” for a soon-to-be coming movie. We’re going to review a list of some basic and general adherence strategies. We’ll work through the complicated strategies in a lot more detail at future meetings—right now we just want to give an overview of all of the techniques that might be helpful to you in an adherence plan.*

*We’ve divided them into seven not necessarily discrete categories. Over the next several weeks, you will be building some of these strategies into your own individual adherence plan, and as we move through each session, you will be utilizing some of these strategies as “building blocks,”—that is, you will be building on to your individual plan to make it as strong and comprehensive for your unique needs, problems, and lifestyle issues as possible.*

Facilitators review Module 1 Strategy List; post chart of strategies.

**Simple reminder strategies**

- Keeping your morning dosage at your bedside the night before.
- Leaving your pill box on the bathroom vanity next to your toothpaste.
- Having a friend or significant other remind you each morning to prepare your medication for the day.
- Leaving Post-It notes at your desk to remind you about your mid-day dosage.

**Preparation Strategies**

- Using special carriers for daily doses.
- Carrying food and water to fulfill special instructions.
- Preparing each day's dosage the night before to avoid "morning rush."
- Having a back-up dosage at work in case you forget to bring your regular dose one day.
- Planning for traveling with medications and time zone changes.
- Rotating "emergency" supply.

**Self-monitoring strategies**

- Checking off your dosages as you take them.
- Monitoring your dosages in your checkbook.
- Having a "secret" file on your computer where you monitor your dosages.
- Recording each night how you did for each dosage of the day.

**Reinforcement strategies**

- Material, social, & activity reinforcers with contingency management.
- Behavioral contracting.

**Information Strategies**

- Write down questions you have about your medication regimen to take to your next health care appointment.
- Carry a pad and pen to health care appointments to remind you to take notes.
- Take a friend/family member with you to health care appointments to help listen and remember important information.

**Cognitive strategies**

- Cognitive rehearsal/imaging of successful outcomes and the feelings associated with success to assist in dealing with barriers to adherence.
- Re-framing negative self-talk.
- Thought stopping and covert assertion.
- Refuting irrational beliefs.

**Cognitive-behavioral strategies**

- Cognitively rehearsal of dealing with specific adherence barriers.
- Behavioral rehearsal of strategies or negotiations utilizing shaping.
- Motivational narrative writing to emphasize commitment to the adherence goals.
- Changing environmental stimuli to facilitate adherence.

*You can see by this list that some are simple reminder strategies—the kind that might make you think, "Well, what am I doing here at this group, I can think of those myself!" If*



*adherence to these schedules were easy, none of us would be here. Even the simple strategies can be hard to use and make happen on a daily basis without some planning and support. Plus, we bet there were a few on the list you're not familiar with, that may be very helpful to you over time as you continue to meet adherence challenges.*

## **V. Overview of Sessions 2, 3, 4, & 5 (5 minutes)**

[Goal: Pique the participants interest in future sessions by providing brief information about what they will be learning and how it will positively impact their lives.]

*We will be meeting weekly for the next four weeks, building on the foundation we have started today. We wanted to introduce the problem-solving steps this week, so that next week we can jump right in and start using the technique to develop the basic individual adherence plan for each of you—the individual plan that each of you will be building on and making stronger at each of the following sessions.*

## **VI. Homework Assignment & Wrap-Up (15 minutes)**

[Goal: Provide participants with the opportunity to generate and set a specific positive health goal (not related to HIV/AIDS) and experience the potential difficulties/barriers that exist without a specific plan.]

*Before we leave today, we would like to provide a little practice in setting goals and getting a feel for how difficult making changes can be, but also how that difficulty can be overcome. We don't want to start with the actual behavior change strategies from the chart. Because this session has been so full of information, we need more time for everyone to really work out a good individual plan. Next week we'll start identifying your own "triggers" or barriers to adherence, and utilize the problem-solving plan we did an overview of today, along with the strategies list we showed you, to help everyone begin to develop their own personal adherence plan. But we do want to get started today with something that will be useful for improving adherence.*

*One of the key challenges for each of you is to stay motivated over the long run. That can be hard to do. We all have tasks we really don't like, I don't like taking out my trash, attending most administrative meetings at work, or vacuuming. On the other hand, there are tasks I do like, such as scheduling and keeping an appointment to have my hair cut, 'cause it makes me feel good to have it freshly cut; I also like reading the latest articles on new antiretrovirals.*

Have participants briefly discuss some regular tasks they like or don't like to perform.

*O.k., you might all guess where we're going with this. Taking your meds can be a real challenge. When you look at your HIV medications, what goes through your mind?*

Allow participants to briefly state their cognitions regarding their medications.

*Taking your meds—if that is a task you don't really like—will always be more of a challenge for you unless you can turn this into a task you feel positive about. We would like for everyone to consider developing a strategy that lots of people have used and had*

*success with. Using simple and inexpensive colored dots like these, we can develop specific, individualized cognitions associated with each color.*

Hand out dot samples.

*For instance, one could place one of these dots on the bathroom mirror, on the car's rearview mirror, by the phone on your desk, on your computer monitor, on your medication bottles, or any place that you come into contact with. Each color could represent for you a specific thought—either a positive self-talk statement or a motivating statement—that you feel like you need to practice. Here are some ideas.*

Show Dot Example Chart.

- Red dot = “Stop thinking negatively! Taking my meds is a reminder of how much I have to look forward to in my life.”
- Green dot = “Go ahead, take charge, and stay healthy.”
- Yellow dot = “Wait, I need to stop and think about how good this is for me.”
- Blue dot = “Relax, it's going well; I am benefiting everyday from my medication schedule.”

*These are general ideas; you could develop a system that is personal and specific.*

*If you'll notice, this is an attempt through these reminder dots to actually begin to think of your medication adherence as a positive task in your life—something that you appreciate, and which has aspects you can actually enjoy—for some of you this is a huge challenge. But let's remember why it might be worth it to really work on turning our whole attitude around: it will be much easier to stay motivated and keep problem-solving and revising your own individual adherence plan over time if you look at your medication regimen as a buddy system or a partner in care—something that is helping you achieve all of the things you want in life.*

*We certainly aren't starting you out with something easy—trying to begin to change the meaning of the medications is a huge task (or to keep thinking positively about them for those of you who already feel positively most of the time).*

*O.k., now how do we choose an appropriate goal? Let's review the basics of goal-setting. We'll be using this every week, too, along with our problem-solving plan.*

Show Goal Setting Chart, and review briefly with participants.

- |             |   |
|-------------|---|
| Realistic:  | Is the goal not too easy/not too hard and can it be accomplished without depending on someone else's behavior change? |
| Clear:      | Is it obvious to anyone what the goal is?   |
| Timeframe:  | Do the steps to reach the goal seem like they can be accomplished within one week?                                    |
| Measurable: | Will it be clear when the goal is accomplished?   |

Each individual should set up a specific plan—in this case what a dot means to them, how many and where they will put them, their goal of how many times per day to say the connected attitude phrase. Facilitators should encourage appropriate goals for each participant for the one-week time period.

*O.k., everyone has a goal. Now we have just one more task for you to do before our next meeting and a kind of fun “tool” to help you do it. The first step in developing your adherence strategies is to be sure that we have an accurate record of the medication schedules you are all on, including doses and special instructions. We have these little reminder booklets for each of you, and sheets of stickers, pill stickers, activity stickers, and special instructions stickers. We would like you to take the schedule card home with you this week and complete it, taking the information from your prescription bottles. Here is one I have completed [Hold up completed daily plan]. You can see that this person is supposed to take Crixivan, every eight hours, on an empty stomach, and with lots of water. So I put a sticker showing Crixivan at 7, 3 and 11 pm. – every eight hours. The reminder activity for the morning dose is brushing the teeth, so then I put the sticker with the toothbrush on the reminder row. I also put the sticker showing “no food” and one for water, on the row for special instructions. The middle reminder activity for this person is watching the T.V. show, “Oprah,” so I used the TV control sticker, and the special instructions remained the same. The reminder for the last dose is setting their alarm clock at night, so I used a sticker with the alarm clock. The rest of this person’s medications are Zerit and Epivir, both taken at 9 am and 7 pm, with no special instructions. Does anyone have any questions? We think that these planners could be helpful to you and next week, when you bring them in with you we will also copy them. That way we will have a record of your medication regimen to guide us in helping you develop adherence plans.*

*Well thank you all, it’s been a really good first session. Good luck with your dot goals and don’t forget to fill out your schedule card. We’ll see you all at the next session.*

Review date, time, and place of next session; tell participants they may receive a reminder call. Emphasize that the only real way they can fail the assignment is by not attending next week’s group.

Complete Research Forms for the session.

# Module 2



## **I. Follow-up to Homework Assignment (15 minutes)**

[Goals: (1) to identify common barriers we all come into contact with when we try to change a health behavior; (2) to continue to build group cohesion and review the issues that exist as participants share their successes, failures and concerns; (3) to reinforce working toward the goals and successes.]

*Each week as we get together, we will start off with sharing about our goals from the last session. We will all learn from your shared victories and successes, as well as the times when only part of a goal was met or times you failed to meet a goal. Most importantly, we need to always be up-front and honest about what happened during the week, even when it didn't go so well, so that we can assist each other in figuring out what the next step should be to improve chances of success.*

*Let's talk about your experiences using the dots. What are some of the meanings you set for them? Did anyone have any problems using the dots?*

Facilitators should be prepared to:

- Praise any significant changes/progress achieved
- Reframe any attempts to make progress that was not fully achieved
- Identify barriers to the lack of progress achieved

Using the newsprint pad on a tripod, make note of the barriers stated by the participants; try to organize them into the 5 categories that you will introduce in the next section (i.e., times, situations, people, moods/feelings, substances).

## **II. Identification of Barriers to Compliance (15 minutes)**

[Goal: Participants should learn how to quickly identify the common barrier(s) that interfered with their adherence]

*Barriers or obstacles to adherence can fall under 5 main categories: people, places, situations, moods or feelings, and substance use. We'll give a couple of examples, and then we have an exercise that's kind of fun to give us all some practice identifying types of barriers.*

*People who influence a participant's behavior can be obstacles to antiretroviral adherence. For example, a close friend may have very strong beliefs about using only alternative therapies (i.e., acupuncture, massage, etc.), and may influence a friend on antiretrovirals to stop taking their meds.*

Ask the participants to reflect on who are some of the people that influence them (i.e., significant other, family member, best friend).

*People are some of the hardest obstacles to overcome because you might find it difficult to talk about adherence with people you care about. Some possible reasons that certain people might be obstacles to adherence might include:*

- *Not wanting to be on a different eating or sleeping schedule than your partners*
- *Not wanting co-workers to know about your HIV status*
- *Not wanting to take pills in front of one's kids because they don't know your HIV status*
- *Not wanting to look "different" in front of friends*

*Places may also influence adherence. You might not want to take antiretroviral medications when you're in public, like a restaurant or bar. What are some other places that could influence adherence?*

Participants may note some of the following:

- Work
- A party
- Their date's apartment
- Their parent's home

*Situations can influence adherence behavior, and not always be obvious. For example, you might go away for the weekend and decide to stay an extra day, but not have enough meds with you. What are some other situations that could influence adherence?*

Participants may note some of the following:

- Changing time zones on a trip, and missing scheduled doses
- Being out late and missing a scheduled dose of pills

*Moods/feelings may be powerful obstacles or barriers to adherence. For example, if you are feeling upset and lonely you may be more likely to miss doses. What are some thoughts or feelings that might influence adherence?*

Note to facilitators: these are important issues, so if participants do not generate each of the following, the facilitators should bring them up for brief confirmation that these may influence adherence):

- Feeling like they will get sick with AIDS no matter what they do (resignation or feeling overwhelmed and/or helpless)
- Irritation and/or worry about the toxicity of the medications
- Anxiety and wishing that you can eat and drink whatever you want, like "normal" people do
- Fear (of the future, of the toxicity of the medications)
- Happiness about something and forgetting about HIV for a while
- Believing you deserve a break from your adherence schedule
- Anger (that they have to take so many pills, that they are "different")

*Substances can be a barrier to adherence. For example, if you are drunk or high you may be less inclined to take your meds, or you might be more likely to forget.*

Encourage the participants to think about ways in which drugs and alcohol affect their adherence.

- When a person is drinking, he/she may forget to eat the right sorts of food with the antiretroviral doses.
- When a person is high, he/she feels like nothing can touch her/him, not even HIV.
- When people get drunk or high, they may not be able to take their meds, as some are not to be taken with alcohol.

*O.k., let's practice identifying barriers or obstacles to adherence.*

Facilitators will have three decks of cards. The blue cards have scenarios that can be considered fairly straightforward and simple. The orange deck contains stories that are slightly more complex and barriers may be multiple and/or are linked together. The yellow cards are blank and individuals will be writing their own scenarios on these cards.

*Identifying the barriers to medication adherence is the first important step in creating a new, powerful individualized adherence plan (IAP).*

*We've developed these scenarios based on real people that we've interviewed over the last few years. We've summarized their stories and printed them on these cards that I'm about to hand out. We've picked these stories because they illustrate real and specific issues) that are commonly encountered.*

Distribute one blue card to each participant.

*O.k., we're going to go one at a time, and have each of you read the scenario you've been given. After you read through one, you'll try to identify what you think is the primary barrier for the individual described in your scene; try to think of the 5 categories as you read your card. I'll start, to demonstrate what we're going to do.*

### **Blue Card Scenarios**

*Ever since Matt moved out, Bill isn't going to AA meetings and his drinking is getting problematic again. He knows that his medication interacts strangely with the alcohol so he's been skipping dosages at a higher rate lately.*

[Barrier category: substance.]

*Liz is supposed to be taking 24 pills each day, some with food, and some on an empty stomach. She finds this schedule almost impossible because she has two children who do not know her HIV status. If she takes her pills in front of them at meals, they are bound to ask questions.*

[Barrier category: people.]

*While Jake is glad he isn't with his ex-boyfriend, he still feels that when he sees him or thinks of him too much he gets angry and frustrated about his situation and usually "forgets" to take his medication.*

[Barrier category: moods/feelings.]

*Walt feels that his current medication schedule is too complex; he doesn't understand why he needs to follow it, but doesn't want to talk to the clinic nurse because she will probably think he's stupid.*

[Barrier category: moods/feelings.]

*When Jensen hits the usual dance clubs, even though he doesn't drink alcohol, he remembers the "good old days," when he was HIV-negative, and taking his medication is the last thing on his mind.*

[Barrier category: place.]

*Drew is supposed to take his medications on an empty stomach, but when he gets home from work he is so hungry he'll eat whatever's fast in the fridge, and then have to take his evening dose on a full stomach.*

[Barrier category: situation.]

*Great. Now that we've practiced identifying barriers, let's try some that are a little harder—when the problem is not so clear cut.*

*These cards are similar to the ones we just read. They are slightly different in that some of the issues or barriers may be more complex or combinations of two or more categories. Let's see if we can figure out what's going on in these situations.*

Hand out orange cards; repeat procedure.

### **Orange Card Scenarios**

*Neil is beginning to feel like his coworkers think that he's weird. They see him taking his "vitamins" all the time and he's afraid that someone will soon catch on.*

[Barrier category/categories: moods/feelings; situation.]

*Mark is really excited to be on the newest medication available. He still takes his other medications, but feels that some of them aren't necessary anymore and he's begun to skip some so that he feels better—he feels like he has fewer side effects when he deletes some doses.*

[Barrier category/categories: moods/feelings.]

*Pat's medicines have always made her feel a little bit sick. She tries to take them regularly, but on "special days" when she has movie tickets, or wants to feel good for a party, she'll skip that day's dosages.*

[Barrier category/categories: situation; moods/feelings.]

*Larry hates his doctor. The doctor never explains anything, treats him like he's a kid, and spends no more than 5 or 10 minutes with him at appointments. Larry doesn't feel like doing anything this doctor says, so he sometimes doesn't take his medication the way the doctor told him to.*

[Barrier category/categories: people; moods/feelings.]

*Simone isn't one to let anybody know her business. She cannot figure out how to conceal all of her medication, all day long, so she refuses to keep any in her car, briefcase, pocket, or purse. On days when she's out from 7 A.M. until 10 P.M., she usually misses her doses.*

[Barrier category/categories: situation; people.]

*O.k., good. Now we've had some experience with more complicated sets of barriers. You can see that in each of these cases the "solution" or the strategy that might work for a person really has a lot to do with what the actual problem or barrier is. In each of these cases that we "solved" in terms of identifying the barrier, we were using the first problem-solving step that we taught you at the end of the last meeting: identifying what exactly is the problem.*

*What we'd like to do now is shift to having you consider what are your biggest challenges, and identifying at least one or two of your current barriers or problems in adherence.*

*In order to accomplish this we'd like to divide the group into pairs.*

Split group into pairs that you feel would be most beneficial; if odd number exist, facilitator could join group member or you can have one trio.

*In this exercise, we want each of you, one at a time, to think back to the last 2 or 3 times you were non-adherent with your medications. One of you can be the "interviewer" and ask the other the following questions, and then you can switch roles. The questions that may help you identify and define your problem areas are:*

- *The last time you didn't take your medication(s), what were you doing?*
- *Who were you with?*
- *Where were you?*
- *What time of day was it?*
- *What were you doing?*
- *When did you realize that it happened?*

*Then repeat the questions for the time before that when you didn't take your medication(s). It's important to go back over the last few times, because like the card examples we just went through, you might have different barriers that effect you at different times. For example, you may never sleep through a dose during the week, but maybe you do on the weekends.*

*Briefly write down your scenarios. Use the yellow cards that we're passing out*



### **III. Developing Strategies Using the Problem-Solving Approach (25 minutes)**

[Goal: Participants need to learn how to take their own issues/barriers, apply the problem solving technique and develop an adherence strategy based on the best alternative]

Have pairs join back together again to form one group.

*It's interesting to us to hear how similar your issues might be to the examples we've just learned about. What we will need to do is apply our problem-solving approach to the problems encountered by members of our group.*

*Before we apply our problem-solving technique to your issues let's first review the adherence strategies that we mentioned last time.*

Facilitators should review behavioral strategies briefly; mention the cognitive-behavioral strategies only generally as a group, as the focus for the initial IAP goal for each participant later in this session should be a fairly simple behavioral strategy to start with; next week's module will focus on cognitive-behavioral strategies to build on to the IAP.

#### **Adherence Strategies [Post Chart from Module 1]**

*What we will learn to do now is how to apply the problem-solving technique to our barriers in developing a new, individualized adherence plan.*

Facilitators can go in one of two directions:

1. Preferably, they can choose a group member to volunteer their issue and problem solve it in front of the group. Choosing the "right" person/issue is key. Facilitators have just circulated and watched the participants identify their barriers in the previous exercise; they should encourage someone with a good example to volunteer for problem-solving.
2. If the facilitators are unsure, they may choose to problem-solve the following "canned" example.

#### **Recognizing Barriers Example**

*Raoul has a good understanding of his medication schedule. He is adherent most of the time but realizes that on days when he "celebrates" with a little weed, sometimes at home alone, but sometimes hanging out with pals, he's likely to forget his dose.*

1. *Recognition--Raoul is beginning to recognize that his adherence is becoming a problem and will affect his viral load.*
2. *Definition--the barrier here seems to be substance use.*
3. *Brainstorm--what are all the possible alternatives Raoul has for solving this problem?*
4. *Evaluation--which ones are most appropriate and can be initiated?*
5. *Selection--which one will Raoul start now?*
6. *Initiation--try it out*

Go through group and apply problem-solving to their barriers/problems identified in the last paired exercise.

For each participant, give them the IAP Form so that they can write out their adherence plan.

Use newsprint pad to write out the entire problem-solving thought process. This will form the basis of participants learning this technique on their own. Repeat problem-solving strategy for as many of the individuals in the group as time allows.

#### **IV. Develop and State First Individualized Adherence Plan (IAP) for Next Session (25 Minutes)**

[Goal: Participants develop and record their first IAP.]

*Let's break into pairs again. Now that we've practiced as a group, let's see if we can help each other in developing our first individualized adherence plan—we going to refer to that as an "IAP," so that everyone has a plan for the coming week. On the goal sheet I'm handing out now we will help each other draft this new strategy. As you proceed, we will both be circulating among you to help with the procedure. Remember the guidelines for choosing an appropriate goal.*

Facilitators post Goal Setting Chart.

*You'll want to start by looking at what barriers you have. Then you'll apply the problem-solving technique—and remember to use the Adherence Strategies Chart when you brainstorm solutions—we're going to brainstorm within the context of that chart, o.k.? When you've developed your plan, write it out on the IAP Form.*

Facilitators should make sure that participants are generating solutions from the Adherence Strategies Chart for the most part.

Facilitators should pay special attention to each IAP making sure that the goal is appropriate, that is, not too easy or hard, can be done during the week, doesn't depend too much on other people, and is measurable (i.e., the participant will know when they are successful).

It is likely that facilitators will want participants to focus this week on behavioral strategies for this week's IAP—saving the more cognitive-behavioral strategies needed by a participant for next week.

Reinforcement should be incorporated into all IAPs. Examples may include:

- Watching favorite t.v. shows only if adherent that day
- Playing a computer game after adherence to a dose/schedule
- Contracting with a friend to get together for a movie with you (or dinner, to play basketball, or whatever is reinforcing to the participant) if adherent during the week
- Making your favorite dinner for yourself on the weekend if you've adhered

Remember, all a reinforcer must be rewarding to that participant; so this is always individualized.

Make sure that in addition to the participants recording their IAP for the week to take with them that each IAP is recorded on the Facilitator Record of IAPs for use in the next session.

**V. Brief Group Review of IAPs for Next Session (10 Minutes)**

*Let's all join together again before we leave and have some of you share your IAPs, so we can get a sense of what different things people will be trying during this next week.*

Have participants who wish to share their plan briefly describe what they are going to do. After each person shares, asks them how sure they are on a 1 – 100 scale (100 “totally sure”) that they can stick with this plan. All participants should be very sure they can implement the plan.

*O.k., good luck with your plans; we'll be thinking about each other this week and I know hoping everyone will be able to meet their goals.*

Review date, time, and place of next session; tell participants they may receive a reminder call. Emphasize that the only real way they can fail the assignment is by not attending next week's group.

Complete Research Forms for the session.

# Module 3



## **I. Follow-up to Homework Assignment (30 minutes)**

[Goal: To review all IAPs from last session; to provide feedback in the form of positive reinforcement for success, reframing and problem-solving for shortfalls. Each participant should have an understanding of building upon this initial IAP utilizing information provided in this current session.]

*Welcome back everybody from what I hope was a productive week. I am very interested in hearing how you all did with your first IAP. So, let's start off by going around the room. I wrote down each of your personal goals at the end of last session. I'll state the goal, and we'll all find out how everybody did. Keep in mind, we know that everyone was probably not 100% successful—but maybe they were partially successful, or maybe we can learn from one another's mistakes. So please be honest—if you weren't completely successful with your IAP, we're here to problem-solve and hopefully create with your help a new, more successful IAP.*

Facilitators should be prepared to:

- Praise any significant changes/progress achieved.
- Reframe any attempts to make progress that was not fully achieved.
- Identify barriers to the lack of progress achieved.
- Help problem-solve how the goal can be achieved in the future.
- Encourage participants to reward themselves for hard work/effort.

Facilitators should involve other group members in the review in order to create a discussion. Facilitators should include similarities among the group members to create group cohesion.

## **II. Introduction to Behavior Chains and Complex Barriers (20 minutes)**

[Goal: Participants should understand that often some of their barriers are linked and therefore are complex; they should be able to closely analyze a complex situation and focus upon the initial barrier in a behavior chain.]

*I think we have all observed that our simple strategies for adherence can work for simple, common barriers. Unfortunately, we've learned over the past few years that most people have busy, complex lives with complex and sometimes unanticipated barriers.*

*Often in our lives, one initial problem will lead to another issue and sometimes that will lead to another, and so on, until we've got an enormous chain of problems. Let me give you an example:*

*We worked with this guy named Steve from one of our past groups. On the surface, it seemed to everyone, including Steve, that his barrier to adherence was a substance, alcohol; or maybe, hanging out in dance clubs and bars, which he did often in the evenings, to pass the time. Initially, his IAP surrounded getting him to change his hangouts to other places, away from alcohol, so he wouldn't drink and forget his medication doses. It didn't work. Anybody have an idea why? Let me show you what we discovered!*

*When we looked more closely at Steve's life, we realized what we had overlooked—the initial or primary barrier—the problem that initiated the chain.*

Write on easel or show graphic:

Boredom → Hanging Out → Alcohol → Forgetting Meds

*We call this a “behavior chain” because one behavior becomes “linked” to another and so forth. Some people's behavior chains can be even more complicated than this one. What's most important though, is to understand what's at the beginning of the chain; the single barrier or issue that gets it all going. If we can intervene and change the beginning barrier, we have much better shot of improving adherence.*

*So you see, because we were attempting to change a behavior here at the end [point to “alcohol”], we might have changed his alcohol intake, but not until our IAP for Steve addressed his boredom and loneliness [point to beginning of chain], did we really come up with a plan that should more permanently improve his adherence to his medication.*

*Steve's next IAP was designed to focus upon the barrier that was initializing his problems: boredom. In session, we had the group brainstorm alternatives for Steve; we then had Steve evaluate the alternative and choose the one he thought would be most beneficial and realistic.*

*His new IAP involved directly impacting his boredom and loneliness. He experimented with several free seminars his company offers after work. He also started attending an AA meeting several times a week. Finally, he made sure that on weekends, he always had plans to be with people at least part of the time. We even had a back-up plan in case his social plans fell through at the last minute.*

*In Steve's case, he was much more successful with his adherence when we had him busy and active. By not being lonely and bored, Steve avoided his related barriers of hanging out and drinking alcohol. He took his medications on schedule, felt better about himself, and positively affected his viral load.*

*Here's a simple behavior chain I bet everyone can relate to that I want to show you to illustrate a different point. If you don't like cookies, then just insert in your mind one of*

*your favorite foods that you don't like to eat too much of.*

Facilitator writes out this chain as they go through the following paragraph:

Hungry when grocery shopping → Buy cookies → Put on kitchen counter → Take bag to t.v. room → Eat while watching t.v.

*You're hungry when you go shopping, so cookies look really good, so you buy a bag → You put them on kitchen counter when unpacking and putting the rest of the groceries in the cabinets and refrigerator → You take bag of cookies in to t.v. room and eat while watching t.v., and since you kind of "mindlessly munch" when you watch t.v., you eat about half the bag*

*O.k. In this behavior chain, if you didn't take the bag of cookies into the t.v. room, but only took a couple, you may have only eaten a few.*

*Before that, if you had put the cookies away along with all of the other groceries, you might not have had any, or at least you would have had time to consider what you were doing before you started eating them.*

*But even before that, if you hadn't purchased them at the store, you wouldn't have had them to eat later at home.*

*And even before that, if you hadn't gone shopping when you were hungry, you would have been less likely to be tempted to purchase them.*

*The point of this example is that while you can often break into a behavior chain anywhere along the line to make things better, it's usually best to break into the chain as early as possible—that way you have a better chance at succeeding in changing the behavior, and you have fewer problems to deal with—you make it easier on yourself, so to speak.*

*By going back and re-examining an IAP that has not been successful, we can often discover that the barrier that we initially focus on was not primary and that we need to see if there are other issues linked to that barrier.*

If any of the participant examples from the previous week's goal review fits these examples, use them here and make the connections to the examples.

### **III. Introduction to Cognitive-Behavioral Techniques (25 minutes)**

[Goal: Participants should understand that how and what they think has a powerful effect on their long-term adherence; they should also understand that using cognitive strategies, they can change the way they think and therefore improve their adherence.]

*Because so many of our complex barriers involve mood and feelings, especially how we feel about ourselves, it is extremely important that we start to include cognitive techniques, or ways to change one's thinking, to all of our IAPs. These techniques can be*

*very useful and powerful.*

*Right now, we're going to role play exactly what I mean.*

One facilitator takes one copy of the following script, and gives the second copy of the script to a participant who volunteers to play “Tess.” The facilitator and the participant role play the following scenario. The facilitator should set up the scene with the following description:

*In this scene, two friends from the clinic having coffee at a nearby Starbucks after their medical appointments.*

Tess: He said I was doing better; that the numbers are lookin' better.  
Michelle: Yeah, been there, done that, got the T shirt.  
Tess: Whatya mean?  
Michelle: Seems like whenever I've been on my medication for a while the numbers always go up eventually.  
Tess: So?  
Michelle: Well, if they go up it's all been a waste of time. All those pills, all those side effects—all a big waste of time.  
Tess: First of all, I'm not sure that any of that is true. Maybe with your current meds, things will be different. Maybe next time the numbers will stay down.  
Michelle: Don't tell me you haven't seen some of our friends from the clinic get worse.  
Tess: Sure I have. But that doesn't mean it has to happen to me. Look, I made up my mind when this all came crashing down on me last year—I could get worked up, pissed off, wound up—or I could keep a positive attitude . . . concentrate on something positive . . . and try not to think of myself as just a sick person. It works most of the time.  
Michelle: Yeah, just most of the time.  
Tess: Whoa, you got the negative vibe bad. Maybe we need to hang out more; I think I need to help you with a better attitude.

*Can everyone see and understand what's going on here?*

Get responses from group. Ask them which person they identify with and why? Which person is likely to have a better chance at adherence to their medication? What processes does Tess use to help herself?

*Let's do another one.*

Ask if two participants want to do another one. Give each of them a copy of the script and assign the parts. Having participants participate might make them more comfortable later in the intervention to role-play non-scripted exercises.

*Two guys waiting outside the clinic. They've run into each other before and share “war stories.”*

Terry: Man, forget this. I show up on time and they say it's gonna be at least 30 minutes. I'm already late for another appointment.

Brad: You should see what it's like at the other clinic. They've got more staff—even better meds, I hear.

Terry: Hey, don't mention meds. I been takin' this stuff for 6 months, right on schedule, and I ain't feeling any better.

Brad: What's the doc saying?

Terry: You know what they say.

Brad: What?

Terry: Keep up the good work—take your medication regularly and it'll work.

Brad: So?

Terry: Man, I don't feel so great a lot of the time and he says the same thing every time I see him.

Brad: Maybe you shouldn't think so much about how you feel—I mean I know it's hard, but I've learned to concentrate on other things. Even on days when I'm feeling a little sick right after breakfast, I think about what bands are coming to the club, or that one of my friends has got an in with this guy who's got an in with someone who knows Elton John, and next time he comes to town I might get to meet him.

Terry: Think you can get me a ticket too?

Brad: Now there you go—thinking better already! I know it really doesn't necessarily change the big picture. But thinking about something else, something positive does help.

Discuss scene, ask again who participants identify with and how the different styles Terry and Brad have may affect their medication adherence.

*Let's review some of the cognitive strategies that you can use in your IAP.*

### *Imagery*

*Perhaps the most universal cognitive strategy is to create your own personal, private mental image of you regaining or maintaining your physical health. The more specific and "fleshed out" this image is, the more meaningful it will be to you, and so the more powerful it will be.*

*A good example would be of a past participant, Felicia. She had been non-adherent in ways similar to some of you. She developed an image of herself successfully regaining her health, and for her this included living in a small house in a nearby coastal community with just her daughter; having a three-quarter time position working, and keeping in contact with family—her mother and sister. This was her long-term, overall goal, and she was part-way to it. By focusing on it and remembering that to get it fully realized she needed to keep well, she was able to improve her adherence dramatically.*

*Felicia also started carrying a small photograph of her daughter, which helps her concentrate when things get hard. For instance, when she is nauseous, she often looks at*



*the picture and imagines what her daughter will look like when she's older, what sports she'll play, what she will wear when she starts dating, etc. This frequently helps Felicia pass the time until she feels better.*

### *Reframing & Re-labeling*

[Goal: To increase the participants' skills and confidence in adhering to antiretroviral medications by turning their negative attitudes into a positive reason for sticking with their regimens. Reframing involves turning a negative attitude into a positive reason for adhering to the antiretroviral regimen. Reframing involves: (1) identifying a positive motivator underlying the negative attitude; and (2) using that positive motivator to underscore what the participant wants—that is, adherence.]

*Reframing is a cognitive technique in which you turn a negative thought around, by examining what positive or successful progress you've been making—even if the progress was minimal—and concentrating on that, rather than focusing on only the negative or unsuccessful part of the plan.*

*Chris' primary goal was to increase his adherence by abstaining from alcohol and thereby not forgetting his medications. After his first IAP, Chris was disappointed because he stayed sober all week, but did drink wine a couple of times that week; he felt that he had failed his goal. He also worried that just because he hadn't gotten drunk, that if he'd had a couple more on those nights he would have blown it. We worked with Chris on reframing his thoughts: "Within one week, while I had some alcohol, I was able to completely refrain from getting drunk. I did a good job;" "It's good that my total alcohol consumption dropped so much this first week—this means I can do this IAP!"*

*He was very successful in limiting his alcohol consumption, as compared to before, and needed to continue to persevere, instead of concentrating on the negative aspects. By reframing, we take the negative thoughts or feelings and turn them around to something positive, which will lead to a better outcome the next week.*

*Let's try a few. What might be a "comeback" to each of the following negative self-statements or thoughts?*

The interventionist reads the negative "frame," and lets the participants generate the reframing statement(s). If participants cannot generate their own solutions the interventionist should give some examples.

Negative statement: I feel so down, often I forget to take my pills.

Comeback: When I forget to take my pills, I feel even more depressed than usual.  
Taking all of my doses makes me feel better about myself.

Negative statement: I am so overwhelmed about having to deal with this whole thing.

Comeback: Taking my medicines as prescribed makes me feel like I am in control of my health. Adhering makes me feel less overwhelmed and more in charge of my destiny.

Negative statement: No one knows if these medicines are going to work forever anyway.

Comeback: No one can predict the future; taking the antiretroviral medicines is the best way that doctors and scientists know of right now to keep people healthy.

Negative statement: I hate taking these medications—I have to live with remembering them all the time, and I have side effects from them.

Comeback: The side effects show me that the medication has entered my body and are working—doing their job to stop the virus from reproducing.

*Good. You can see that negative statements like these can become our “excuses” for not adhering. You can also see that when you re-frame, you take away that excuse and force yourself to focus on the reasons you want to stay adherent—and we all have different reasons that we talked about at the first session. Focusing on our motivators for adherence can really help us stick with our programs.*

*Another type of “re-framing” has to do with “re-labeling.” Have you ever noticed how important a label can be? If a product is labeled as “new and improved,” people will generally pay more for that item. Or if a restaurant is “marginal” in a review, are you really going to want to celebrate your birthday there? Well, we often label our own behaviors and ourselves.*

*What labels might you have acquired as a child that were hard to change as you grew up? (Examples: Clinton and Monica Lewinsky both felt like they were teased because they were “chubby” when they were young; if you are the minister’s kid that can cause you to be labeled; the youngest in a large family may always be referred to as the baby.) How do these labels affect your life?*

*Have you developed any labels for yourself since you’ve been taking medication?*

Facilitators should lead discussion and get participants to identify their negative self-thoughts, and assist them in selecting a cognitive strategy that may be useful.

*O.k., let’s go over a few more cognitive strategies—bet you didn’t know there were so many!*

*Positive Self-talk*

*Here is a cognitive technique that I bet some of you use without even knowing it. Do you ever find yourself talking yourself through a difficult, unique, unusual or complex situation? For example, when we first learn to drive, or learn a new sport, or some complicated behavior, we often encourage ourselves mentally—it helps us “settle down”*

*anxiety, concentrate on what we're doing, and perform the behavior with greater ease.*

*Mitch often felt that no matter what he did, he could not carry out his IAP from week to week. We sat down with him one-on-one and realized that he had almost no confidence in himself regarding turning around his adherence problems. We helped Mitch develop some self-talk statements that were personalized for him. For example, "I will not let a tiny virus that got in my body destroy my health without fighting!" "I can take this medication—it's a matter of preparing my medications each night for the following day. I'm organized; I can do that." He really began to believe these self-statements and his ability to stay adherent to his medication schedule was improved.*

*We've just discussed three cognitive strategies. Did anyone recognize themselves in the imagine, re-framing, or self-talk descriptions? Which of these strategies, if any, might be helpful for you?*

#### **IV. Building on Your IAP: Incorporating New Techniques (15 minutes)**

[Goal: Participants should generate an improved IAP utilizing information provided in this module, primarily focusing on complex barriers that include cognitive components.]

*Keeping in mind the cognitive strategies we discussed today and how you each did with your goal from last week, let's talk about a new IAP for next week.*

*Let's break up into small groups (or pairs) and build on the IAPs from last week. If you think it would be a good idea, focus on a cognitive strategy that would work for some of your barriers.*

Put up graphic about how to set a goal.

Facilitators should be prepared to help participants refine and improve their IAPs.

*O.k., we're almost out of time. Who wants to share their new goals they are adding to their IAP?*

Facilitators should encourage participants to share the new behavioral goals they've added to their IAP. Facilitators should record each participant's revised IAP on the Facilitator Record of IAPs (Appendix D).

Provide an appropriate pep talk for all individuals as they exit. Emphasize that the only real way they can fail the assignment is by not attending next week's group.

Review date, time, and place of next session; tell participants they may receive a reminder call.

Complete Research Forms for the session.

# Module 4



## **I. Follow-up to Homework Assignment (30 minutes)**

[Goal: To review all IAPs from last session; to provide feedback in the forms of positive reinforcement for success, reframing and problem-solving for shortfalls. Each participant should have an understanding of building upon this IAP utilizing information provided in this current session.]

*Welcome back everybody from what I hope was a productive week. I am very interested in hearing how you all did with your IAPs. So let's start off by going around the room. I wrote down each of your personal goals at the end of last session. I'll state the goal, and we'll all find out how everybody did. If any of you had difficulty, we're here to problem-solve and modify your program, to keep working out the "kinks" until you have something that works well for you.*

Facilitators should be prepared to:

- Praise any significant changes/progress achieved
- Reframe any attempts to make progress that were not fully achieved
- Identify barriers to the lack of progress achieved
- Help problem-solve how the goal can be achieved in the future
- Encourage participants to reward themselves for hard work/effort

Facilitators should involve other group members in the review in order to create a discussion. Facilitators should include similarities among the group members to create group cohesion.

## **II. Increasing Control Regarding Medical Care Through Information Gathering (15 minutes)**

[Goal: Participants will understand that the more they are involved in understanding their medications and obtaining appropriate input regarding their medications, the less difficulty they will have with their adherence levels.]

*O.k., we've been focusing on strategies and planning that you do yourself, pretty much, to help you adhere to your medication schedule. But when people are instructed what to do, how to do it, and when to do it, without the whys, often they feel apart or separate from the goal or end-product. This is how it may be for you regarding your medication. We've found that often, a busy health care professional may not have explained to you an appropriate or full rationale for your medication regimen. If this is the case, it would be understandable why you may not feel fully invested in it.*

*One of the reasons we went through our simplified rationale for adherence to treatment at the very first session is that we felt everyone needed to be "on the same page"*

*regarding the “whys” of adherence. But other issues are going to come up possibly as you change your medication regimen, or experience side effects, or whatever. So, there are going to be times when it is important to go to the clinic or your doctor’s office or call in there and discuss issues.*

*Think about all the interactions you’ve had with health care professionals during the time since your first diagnosis. Have you had any difficult or awkward experiences?*

Let participants discuss some of their interactions; try to focus the discussion on times when they didn’t feel they got the information they wanted, or they didn’t understand something.

*I’d like everyone to take at least one of these index cards. As we go through the group exercises and we discuss issues today, we’d like you to be prepared to write down any questions or issues you wish to discuss with a health care provider. For instance, would it benefit your health if you were to have a discussion with your pharmacist? With your physician assistant? With the clinic nurse? What is it you want to know or understand?*

*So hold on to those cards for a few minutes, because we’re going to use them in a little bit.*

*Some of you may have or have had certain issues you’d like to discuss with a health care provider, but the big issue was when should I do this? For example, some of you may wonder if you miss a dose of medication, should you “double up” the next time? And then you start to wonder if it is worth calling to find out, or should you just decide yourself and then ask the next time you have an appointment—if by then you even remember to ask. See, these note cards can come in handy so that you jot things down as you think of them, and then you take it with you to your next appointment.*

*What are some other things that are difficult to decide when you should ask your health care provider?*

Provide the following examples if the participants don’t:

what if I can’t do the special instructions that I’m supposed to do with certain doses?

how severe may the side effects be before I call in to suggest that this regimen isn’t working for me?

Have discussion of these and participant issues; the nurse can answer questions that are general, but specific questions should be noted on their notecards for their next appointment, or if the nurse thinks it should be asked immediately, for them to plan to call their health care provider as soon as possible following the group session.

### **III. Increasing Control Regarding Medical Care Through Role-Plays (20 minutes)**

[Goal: Participants will learn to assertively ask for information regarding their medications from various health care professionals.]

*For many people, including those whom we've met, talking or asserting oneself in the right way with a medical professional can sometimes be an intimidating or difficult situation.*

*Communication involves more than just the words we use or say. We communicate a lot with our bodies--our tone of voice, our eye-contact, our posture, and our hands. In short, there is body talk as well as word talk. There also are three different ways of communication: Passive, Aggressive, and Assertive. One of these three ways is a very effective way to talk; the other two are not.*

*There's a really easy way to remember this communication stuff that I like a lot.: There are three ways to say things:*

- Passively "with too little attitude"*
- Aggressively "with too much attitude"*
- Assertively "with the right attitude"*

*Passive talk or talk with "TOO LITTLE ATTITUDE" means you fail to state your goal, need, or view, ignoring your own needs and wishes. Passive talk doesn't respect your own feelings and ideas. It is:*

*Being unable to tell someone how you really feel about a situation or what you want or need.*

*Saying yes when you really want to say no.*

*And the nonverbal ways in which you communicate passively involves:*

*Speech: saying nothing at all; saying "um" a lot; skipping around the subject*

*Voice: soft, or complaining/whining*

*Eyes: not looking at the person, looking down or away*

*Posture: shoulders drooping, head down, nervous fidgeting*

*Hands: shaking*

*Aggressive talk, or communicating with "TOO MUCH ATTITUDE" means communicating in such a way that doesn't show respect for another person.*

*You may get your way when you use aggressive talk, but you may not have a relationship with the other person once you're through. It means:*

*Expressing yourself, standing up for yourself in a way that is punishing, demanding or threatening to someone else.*

*Trying to get your way by putting someone else down.*

*The nonverbal ways in which you communicate aggressively involve:*

*Speech: cursing, name calling, put downs, hostile remarks*

*Voice: loud, tense, shouting*

*Eyes: cold, staring, angry, calculating, glaring*

*Posture: stiff, rigid, hands on hips, turning your back to/head away from someone while engaging in conversation*

*Hands: pointing finger, waving fist, throwing hands up in a manner that dismisses that person (“talk to the hand syndrome”)*

*Assertive talk or communicating with the “RIGHT ATTITUDE” means saying what you want, in a way that is respectful of the other person’s feeling. It means:  
Communicating your feelings and opinions in a direct and honest manner instead of hoping the other person will figure out what is on your mind.  
Saying “No” to things you don’t want or that you can’t do.  
Using I statements to let the other person know how you feel helps keep you in control and responsible for the situation. It is very difficult to argue with an I statement.  
Statements that begin with the word “You” can sound very blaming.*

*The nonverbal ways in which you communicate assertively involve:*

*Speech: honest, direct words*

*Voice: clear, firm, confident, loud enough to be heard but not too loud*

*Eyes: direct eye contact but not glaring*

*Posture: head and shoulders raised*

*Hands: relaxed*

*Let’s look at a few examples of some interactions. Let’s see if we can identify each of the following examples.*

Have two participants role-play each of the following three scripts. Have the watching participants at the end of each identify if the patient in the example had “too much attitude,” “too little attitude,” or the “right attitude.”

Scripted Role-Play #1: Assertive:

Doctor: Hello. Have you had any trouble with the medications since I saw you last?

Patient: Well, I have missed doses a couple of times.

Doctor: What was going on when you missed the doses?

Patient: Well, I really have a problem with the taste of the medications. Sometimes just thinking about taking them makes me feel sick to my stomach.

Doctor: Okay. Other people have had some luck taking their pills with a beverage such as Ensure which helps to mask the unpleasant taste. Why don’t you try that and see how it works?

Patient: All right, I’ll give it a try.

*Was that assertive, aggressive, or passive – “too much attitude,” “too little attitude,” or the “right attitude”?*

Scripted Role-Play #2: Aggressive:

Doctor: Hello. Have you had any trouble with the medications since I saw you last?  
Patient: Of course I have. I don't understand why you gave me such a hard schedule in the first place. You must be nuts to think that anyone can take all of these pills everyday.  
Doctor: When exactly are you having problems?  
Patient: All of the time.

*Was that assertive, aggressive, or passive-- "too much attitude," "too little attitude," or the "right attitude"?*

Scripted Role-Play #3: Passive:

Doctor: Hello. Have you had any trouble with the medications since I saw you last?  
Patient: Not really. It's been . . . well, hard, but o.k., I guess.  
Doctor: Great, let's take a look at your lab results.

*Was that assertive, aggressive, or passive-- "too much attitude," "too little attitude," or the "right attitude"?*

*Now let's look at a final interaction which will illustrate the best way to interact. Pay particular attention this time to Rudy. I'm going to play one part, who wants to role-play the other part?*

In this case, one of the facilitators should take the part of Rudy, modeling direct eye contact and mild/appropriate tone of voice. One of the participants can take the role of the physician.

Scripted Role-Play #4: Assertive

Dr. Carter: I'm going to put you on Viracept. You should take it three times a day, with food. The directions will be on the bottle.  
Rudy: Does Viracept cause any side effects?  
Dr. Carter: Nothing serious, sometimes a little digestive trouble. It won't last too long. You'll be fine.  
Rudy: I think that I will be able to manage things better if I know just what might happen. Could you tell me more about what kinds of problems I might have and what I can do about them without messing up my HIV medicines?  
Dr. Carter: Well, the most frequent side effect is diarrhea. If this does occur, you can take a non-prescription remedy, such as Imodium.  
Rudy: Is there anything else I should know about Viracept?  
Dr. Carter: Well, if you are taking Viracept, you shouldn't take some kinds of antihistamines. Now, I reviewed your chart before prescribing the Viracept and right now you are fine. Are you taking any medications that you haven't told me about?  
Rudy: I sometimes take my sister's hay fever medication. I don't remember the name.



Dr. Carter: Don't take it any more. Don't take any other medications that you haven't checked with me about first.

*So what do you think about Rudy's behavior? Did he get his point across, while at the same time, not alienating the doctor? Do you know people who are good at this? What are the components of their behavior that are especially helpful?*

*Notice that when Dr. Carter initially failed to give Rudy the exact information he needed, Rudy was able to ask again in a way that gave Dr. Carter an opportunity to be helpful without reproaching him or making him feel defensive. People often want to be helpful and will respond to a direct request for help, while they will react to criticism by defending themselves. What other things did the character Rudy do that were helpful in achieving his goal?*

Assist participants in listing the following:

mild tone of voice

good eye contact

non-accusatory statements

"I" statements

*What we'd like to do now is get some real life examples from the group. Have any of you got a question or concern written on your card that you can share that we can use to role-play?*

Facilitators will act as coaches for the two volunteers. That is, if either volunteer gets stuck or off-track, the facilitator whispers correcting information in the ear of the volunteer. If no one wants to volunteer, facilitators can do the first a role-play for the group.

*Remember, it may help if a simple assertive statement about your goal is added into the description of the problems you are having, such as: "I would like to do a better job taking my pills. Do you have any suggestions that may help me?"*

Do as many of the participant examples as time for this exercise allows (i.e., have participants look at their cards where they wrote questions they want answered or interactions they want to have with their health care provider).

If no one volunteers their situation, the following examples are provided, with one participant role-playing the health care provider who asks about adherence, and one role-playing the patient.

*Helen needs to tell her physician that she's been lying about taking all her medication; she's been skipping the midday dose on a regular basis because of the side effects.*

*Al hasn't been straight with the clinic nurse; lately, he's been drinking regularly, and skipping some medications so that he can drink, but not reporting it because he knows that the nurse will fuss at him.*

*Wendi has been seeing someone new and when her friend comes through town, she skips her medications because she doesn't like to have it remind him and her of her HIV status. Lately,*

he's been staying over a lot and she's noticed that she forgets to take her medication when he stays over.

*O.k., these have been some difficult situations. I hope that you can see that with practice we all can become better communicators and assert our needs in the medical forum. Remember that the more comfortable you feel with this skill, the more you will use it. And the more you use it, the more you will feel that "sense of control." This control will help you stay adherent to your medication schedule.*

*Now let's see if we can utilize some of the information we've learned today to build a better, more advanced IAP.*

#### **IV. Develop New IAP Building on Initial Plan and Incorporating New Techniques (25 minutes)**

[Goal: Participants should generate an improved IAP and back-up plan utilizing information provided in this module, primarily focusing on complex barriers that include cognitive components.]

*Before we build on the IAPs for next week, let's incorporate an important concept.*

*With all the experiences we've had as a group over the past month, it seems like a good idea to always have a back-up plan as part of your overall IAP. We cannot control everything, so why not plan ahead and be prepared? For instance, what if your strategy has been to prepare your medication doses for a day the night before, but one night you come home pretty tired and plan to do it in the morning, and in the morning you take your morning dose, but wind up at work without your meds? Having a back-up "stash" at work could really help that day.*

*So far, we've primarily worked on day-to-day planning, which is the base for regular adherence. Now might be a good time to start thinking about the things that can go wrong, and incorporating "back-up plans" into the IAPs.*

*O.k., now keeping in mind all the strategies we discussed today and how you each did with your goal from last week, let's talk about your IAPs for next week. You might want to build on your IAP with either of the two major things we talked about today: (1) planning a discussion with a health care provider, if that's something that would be helpful, for example, reviewing and continuing to add to your index card list that most of you began today; or (2) starting to incorporate more "back-up planning" into your IAP to ensure success even in unexpected situations.*

*Let's break up into small groups (or pairs).*

Put up graphic about how to set a goal.

Facilitators should be prepared to help participants refine and improve their IAPs. Facilitators should record each participant's IAP on grid sheet.

Provide an appropriate pep talk for all individuals. Emphasize that the only real way they can fail the assignment is by not attending next week's group.

Review date, time, and place of next session; tell participants they may receive a reminder call. Emphasize that the only real way they can fail the assignment is by not attending next week's group.

Complete Research Forms for the session.

# Module 5



## **I. Welcome and Check-In (5 minutes)**

*Today is our last weekly session. We will be meeting as a group in approximately one month to have our first of several booster sessions, but this is the last time for our weekly get togethers. So today, our focus will be on long-term issues. As each of you leaves today, we want to make sure that you are confident that you have the skills needed to maintain your medication adherence. Remember: medication adherence is a skill that you can learn; and with anything that is learned, it can be honed and improved.*

*We usually begin by reviewing our goals from last session. Since this is our last intervention session, we will be changing things a little bit. Today we will start off by presenting some new material/skills and then we'll end the group with reviewing our IAPs and setting new ones for the next months.*

## **II. Review of Benefits of Adherence (10 minutes)**

[Goal: To increase the participants' positive attitudes toward antiretroviral adherence, and to motivate the participants to make a commitment to adhere to their antiretroviral regimens by helping them to understand the benefits of adherence.]

*In addition to our own personal motivators to stay adherent, that we discussed at the very first session, and have used in examples throughout these past weeks that we've been meeting, there are a number of practical issues as to why you should be adherent. Let's review these; some of these are things you might want to incorporate into the "dot" strategy or a similar plan for moving your attitude towards seeing your medication regimen as a buddy system that assists you in life goals.*

Put up the Benefits of Adherence Chart.

### Benefits of Adherence

1. The more adherent you are, the less likely you are to have viral resistance
2. When you adhere, the antiretroviral medications are working at their full strength to fight HIV
3. Adherence can make you feel healthier, and less worried
4. Adherence can make you feel good about yourself because you are taking charge and taking care of yourself

## **III. Long-term Adherence Issues/Relapse Prevention (30 minutes)**

[Goal: Participants will understand all concepts regarding long-term adherence issues and be able to problem-solve what they consider to be their own barriers to long-term adherence.]

*Let's make a list of the things that we think may interfere with our ability to maintain our long-term level of adherence. Let's think about the timeframe between today and our*

*booster session (1 month) and beyond. What are the mostly likely issues (not everyday stuff but, special or infrequent events/situations) that will create a problem for you?*

Facilitators should note all ideas generated by the participants on the newsprint. If they have difficulty starting, provide some examples from your experience with the group. Examples: change in medications, Christmas holidays, change in routine, change in health status, major trip to Europe, impending holidays, visits from family, etc.

*This is a great list. Does it make anyone here feel scared or worried about the future? While we know that not all of these are likely to happen in the next few months, we are sure that something will happen to many of you. That's why we are talking about it now. There's an old saying that goes, "Forewarned is forearmed." Does anybody know what I mean by that? Well, it means that if you are prepared for something that you know will happen, and then it happens, you will be ready to handle it, and the likelihood is that you won't freak out.*

*So let's examine some of the things that you can do if one of these things happens to you.*

*Remember our example from last week regarding Olympic ice skater Michelle Kwan? We used her as an example of how you can break things down to smaller, more manageable pieces, and how that can increase your ability to pull it off. Well, if you've ever seen any ice skating on TV you've definitely seen mistakes. In fact, it's rare to see a skater pull off a perfect routine. They slip and they fall on their butts all the time! (Get participants to agree or even tell their own stories about mistakes they've seen in other sporting events.)*

*What is most interesting about all these examples is what the athlete typically does when the mistake is made. Does Michelle Kwan skate off the ice dejected and depressed? Typically, professional athletes train themselves to expect a slip and therefore are prepared to deal with it. In all ice skaters' training, they are prepared to "get off their butt" and get on with it (remember their music is still playing and they need to catch up). Well, isn't it the same for us? We need to learn to expect a slip, "get up," and get with the music? Any questions?*

Generate discussion following this introduction. How do these examples directly apply to medication adherence? How is the experience of being a good medication "adherer" just like training yourself as an athlete?

*There's another very important psychological phenomenon that we also want to talk about now. I'm sure you're all familiar with it, but the fancy term (jargon) is the "goal violation effect." Let's look at the following scenario and see if you recognize what's going on:*

*Dorothee has been on her Weight Watchers diet for the past 3 weeks. All in all, things have gone rather smoothly; she's exercising moderately, eating according to her food plan, and has lost 4 1/2 pounds. Next Monday night, all the employees at Haberstam & Co. are going to a goodbye dinner for one of the secretaries at the local Italian restaurant. Dorothee already anticipates a problem but has consulted with her weight loss group leader who has recommended that she have a side salad with low-fat dressing*

*on the side and a single slice of pizza with vegetable toppings of her choice. Dorothee agrees to this plan.*

*The goodbye dinner is great fun and Dorothee sticks to her plan. Unfortunately, the people in charge of ordering ahead of time have greatly “over-ordered” and there’s plenty of extra pizza. Dorothee has a hard time not having another slice of pizza, especially because it’s the “supreme” kind with all of her favorite toppings including, pepperoni, sausage, and two kind of olives. Dorothee bargains with herself and decides that “one piece can’t hurt.” She figures that she can simply be more careful tomorrow. After eating the slice, the birthday cake is brought out, something that Dorothee forgot to anticipate. It’s a chocolate mousse cake with her favorite type of icing. Dorothee panics; she figures that an ultra small piece would be the best she could manage, but when the plates are delivered to her end of the table, a corner piece is hers, and she quickly eats half of it. Feeling extremely guilty and “out-of-control,” Dorothee decides to finish the entire piece, and then finishes the piece that her friend left over when she departed several minutes earlier. At this point Dorothee figures that the entire day/week are ruined due to her overeating and buys some Haagen-Dazs ice cream on the way home to “finish off” a terrible night.*

*The next day Dorothee still feels like a complete failure. She struggles to stay on any kind of a reasonable food plan for the next week. However, when she weighs herself that morning, she hasn’t gained anything. She tells herself she still has to go back to her diet, and struggles to do so, but all week she also thinks about how she “got away” with that break in her diet, and this comes into her mind, and she finds it easier and easier to justify slips and harder to stay on her diet.*

*Can anyone identify with Dorothee? Even if it doesn’t have to do with food or eating, has anyone ever had this experience with other behaviors?*

Have brief discussion with participants.

*Obviously, this can happen with medication adherence. When the goal is violated, there’s the tendency to “throw in the towel” and “crash and burn” rather than “get off your butt” and get back on the ice!*

*Who in the group sees the direct relation between what Dorothee experienced, Michelle Kwan experiences when she falls, and the slips you might have during the long-term?*

Discuss times when the participants slipped and might not have done the correct thing.

*Can anyone here today directly apply Dorothee’s experience with eating to adherence to HIV medication adherence? What would it look like if we “rewrote” this scenario of Dorothee, but instead her goal was to take your medications on schedule?*

After participants have discussed this a little, if this point has not been mentioned, the facilitator should bring it up:

*Sometimes people modify their medication instructions or skip some doses and feel fine. Maybe their viral load doesn’t rise at their next clinic visit. So they think they can “get away” with these slips or changes. What they don’t see is that the negative effects of*

*nonadherence may take time to show up and these effects, such as increase in viral load and possible resistance to medications are much more serious than falling off a diet.*

*Now, when it comes to medication adherence, what do we mean by get back on the ice? Simply put, there's a two-step procedure that we recommend.*

*Step 1. Decide immediately to get back on your program; to re-instate your IAP.*

*Step 2. Problem-solve to figure out what went wrong; do you need to modify or add to your IAP?*

*We've already talked a good bit about Step 1. As soon as possible, one needs to recognize the slip, and immediately return to the medication schedule.*

*Step 2, however, is where your STAR training comes in. Often people don't sit down and consider what went wrong. Maybe they're afraid if they dwell on the slip, they will become more discouraged. However, the opposite is true—by not taking charge and evaluating the situation, it may be likely to happen again. For example, if you have a medication adherence slip, you need to consider what went wrong. For example, you need to stop and think whether this was an unusual occurrence that probably will not happen again. You would need to think about whether you might need to tell your health care provider. If a back-up plan is needed because you think this is likely to happen again, you need to problem-solve. Won't you have a better outcome from a future slip if you learn to do the same thing now?*

*And that's exactly why we're talking about it today. By using your basic problem-solving technique, everybody in this room should be able to figure out what went wrong, restart your medication regimen, and develop a back-up plan for next time.*

*Let's look at the example of Mark, a past participant.*

*By the time Mark finished the first five sessions of STAR, he certainly had improved his adherence. He had developed a useful IAP and improved upon it weekly by adding powerful cognitive components that were personalized to his own situation in life. He was feeling better about himself and his future.*

*Just as we will be doing today, in Session 5 he anticipated what his major issues might be regarding slips. He recognized that in the past it was easy for him to become discouraged when he became disappointed for any reason. In the past, he had become disappointed in the slow progress of reducing with his viral load and would start blaming his health care provider for the lack of immediate success. He also would become disappointed with the fact that his family hadn't helped him very much with adherence, and would find himself thinking it was their fault if he screwed up. The anger sometimes took the form of "Well, I'll show them, and then they'll work harder with me."*

*Can anyone recognize what Mark's problem-solving chart looked like when we sat down with him?*

Start discussion; move into having participants start to talk about their own medication slip concerns.

*Now, let's finish Mark's story.*

*What Mark did in Session 5 was to problem-solve his barrier: the feelings of disappointment, which turned to anger and blaming, which turned into "slips." (Everybody notice that here is our old friend "the behavior chain.") As we've learned, Mark needed to get in there and cut this behavior chain off at the very beginning. He used reframing as a major cognitive strategy to combat the feelings that would lead to his non-adherence slip. Specifically, he was able to reconsider his disappointment in slipping by realizing that he had not considered all the positive successes he had made and that while reducing his viral load had taken time, he was successful in maintaining it at a low level, and that was cause for major celebration! If Mark found himself at the second stage of the chain, blaming others, he used a couple of strategies. He continued reframing, reminding himself that he was the one in control, but he also negotiated with his brother to check in with him and to reward him when he was being successful. This turned out to be good for both of them, as the brother usually buys Mark dinner every other week now as a reward, and they get to spend time together, which they both enjoy. His brother has learned a lot about how difficult this is for Mark—now he's educating the other family members. They may or may not join in and be supportive, but Mark feels better for someone else having taken on the burden of educating them—he felt whenever he did something he sounded defensive.*

*Have you included in your IAP a role for cognitive strategies should you have a slip?*

*I want to be clear that we have been talking about "slips" or occasional nonadherence, not "drug holidays" or sustained periods of time when you go off one or all of your medications. If you are thinking about taking a "drug holiday" or if you think that there is some reason why you will have to stop taking all or some of your medications for several days, you should talk to your health care provider first and see what s/he says about this.*

#### **IV. Review Progress of IAPs/Advanced Role-Plays (35 minutes)**

[Goal: Have participants review their progress during the intervention and provide them with individual time with the facilitators; practice advanced role-plays.]

*During this next portion of the session, we're going to do two things at once. We are going to have some individual time with each of you in which we will be able to discuss with you in some detail your IAP—the purpose of this is to make sure everyone feels good about what their plan is for the next couple of months; we want everyone to have the best shot at 100% adherence. Meanwhile, the rest of the group will be working on what they think their slip or lapse scenario might be that possibly awaits them—and what they plan to do about those.*

One facilitator should help the individuals with their long-term IAPs. The other facilitator should help the group with the role-plays.



## **Individual Activity**

*This is the only opportunity we will have to discuss IAP issues and problems one-on-one.*

Facilitators should have the IAP grid that will now have a record of the participants' progress and/or problems on a weekly basis. This information can be used if the participant isn't motivated to start this individual activity. Participants need to finish this activity by developing an IAP that will be relevant for the next months as well as a back-up plan for anticipated problems or changes in routines. One can problem-solve barriers, incorporate new strategies, provide verbal praise for good progress, or discuss any particular fear that the participant may not have shared in the group setting.

## **Group Activity**

[Goal: The first step in preventing a slip is to recognize situations which might lead to relapse. The second step is to develop a strategy to avoid these situations or to have a strategy to prevent the slip. The next exercise is designed to help the participant to identify the situations which might lead to slips and to develop an approach for preventing the slips.]

*Many times people learn a new skill — losing weight, stopping smoking, exercising — but they don't keep it up. Let's talk about how you can continue being adherent to your antiretroviral medications even after you finish this program. Let's assume that you have been doing a great job taking your pills as prescribed. But then something happens that could put you in danger of falling backwards. This might be:*

- *When you start a new job and have to take pills at work during the day.*
- *When you are depressed because a love relationship has ended.*
- *When you are on vacation.*
- *When your friends quit their antiretroviral medications and they seem to be staying healthy, so you start wondering why you should keep this up even though your health care provider says you need to.*

*We know ourselves pretty well—let's go around and have everyone share what they think their own personal “triggers” are for a slip or lapse. Right now, let's just figure out what they are—not how we'll solve them; we'll get back to that. So what might cause you to relapse after you've been doing so well throughout the group and you've been working so hard at this—what is your own personal slip/lapse scenario?*

Have each of the group members project what they think their most common trigger might be for a slip or lapse; some members may note multiple situations.

[Goal: To increase the participants' skills and confidence for adhering under difficult situations. It is possible that some participants may have real concerns about taking their antiretroviral medications at work or other places where people may not know about their HIV status. For example, participants may be concerned that if they openly take their medicines at work, their boss or co-workers will find out about their HIV status and they will be discriminated against or possibly even fired. This tool is designed to help participants to find a solution to protect their adherence under these sort of difficult situations. Creative negotiation

is a tool that should be used in special circumstances, and when all other techniques have failed.]

*O.k. Most of you have some ideas about what are likely to be your triggers. Now we get to the harder part—how do we either prevent these triggers from making us slip, or lapse, or at the very least, how do we react when we do slip or lapse in response to these situations? Let’s go back around and see if people have ideas, and everyone feel free to join in if you have suggestions for how to avoid or deal with these.*

If participants are not generating their own examples the facilitators can use the following examples for discussion.

Example #1:

*Gil had used as a main motivator to adhere to medication the fact that he wanted to live a long time with his partner. He even carried a picture of his partner, and when things got rough—he felt overwhelmed by his medication schedule, or he had side effects—he’d pull out the picture and focus on why he was doing this every day. He was sticking with his IAP, which consisted of preparing his meds every evening for the next day, a back-up plan of a stash at work, the “dot” reminder plan for positive self-talk (which he really relied on a lot), tying his medication schedule to his daily routines, and his partner rewarded him with adherence for the week with one of his two favorite dinners. Gil is in a panic right now—his partner is leaving him, and he realizes his plan—while having some components that don’t rely on this partner—rests fairly heavily on this person who will now be gone.*

Discussion: What if this happened to you? What could you do to make sure this doesn’t turn into a severe slip that turns into continued nonadherence?

Example #2:

*Let’s think about this scenario:*

*Leo works at a large insurance firm. Although he has been HIV-positive for over 5 years, he has never disclosed his status to anyone at work. He worries that his co-workers might discriminate against him or be uncomfortable working with him if they knew the truth. Sometimes, he hears them make jokes about AIDS and about people who are gay. His antiretroviral medications must be taken on a strict time schedule, so he must take some of his doses at work. His co-workers sometimes see him taking so many pills and ask, “Leo, are you sick? Why are you taking all of those pills?”*

Let participants generate examples of how Leo might respond. Here are some examples that can be used by the facilitators:

- No, I’m not sick, but I have started a really great vitamin and mineral regimen. I take these vitamins to boost my health.
- You know, I have really bad allergies, so I have to take a bunch of allergy medicines during the day.

- I recently started taking a bunch of different herbs to make me feel healthier. My acupuncturist says I need to take them every 4 hours to get the maximum benefit.

Choose two participants to be Leo and a co-worker; the facilitator can be a coach and another participant can help coach the other volunteer. Provide discussion following role-play. What was good about the experience? What could have been better?

Example #3:

*Reardon's local pharmacist has recently changed; the previous one was extremely discrete about Reardon's medications, but this new guy seems not to care about discussing details in a loud voice in front of other customers. Reardon tells his friend Chris that he's developing avoidance about refilling his prescriptions.*

As with above, choose volunteers to participate in role-play.

Example #4:

*Janet had been doing a great job at adhering to her antiretroviral regimens when she got a new job as a receptionist at a busy dentist's office. During the first week on the job, she missed several doses of her medication, because she got busy answering the phone at work and interacting with the patients who came to the clinic. Moreover, she did not feel comfortable taking her medication in front of the patients and other staff members and never seemed to have the water and food handy to take her pills. She now feels upset about spoiling her adherence record.*

Facilitate discussion of what could be done in this situation. If participants don't generate some of the following solutions, mention them for discussion.

- Always carry water and food to work.
- Take short breaks during the day to take her pills in a "safe" place, such as in the ladies' room or else outside the office.
- Practice taking pills unobtrusively at home, to feel more able to do this without drawing unwanted attention to herself while at work.
- Tell herself that she had been doing a good job and one slip isn't a reason to stop adhering (in fact it's an excellent reason to keep adhering!).

*A big problem in maintaining adherence comes in dealing with slips. A slip is any episode of nonadherence to the antiretroviral regimens, after having made a commitment to adhere. However, one slip doesn't mean total failure. Slips are to be used as opportunities for learning how to keep adhering to the medications.*

*If you say to yourself, "Well that shows I can't adhere, so I might as well forget about it," you will have trouble continuing to adhere. Or if you say something like, "Oh, I feel terrible. How could I do that after all this hard work? I guess I'm just not worth the effort," you will have trouble continuing.*

*People are only human and mistakes can happen with regimens as complicated as the antiretroviral medications.*

## **V. Planning for the Future/Maintaining Motivation/Closing (10 minutes)**

[Goal: Have a brief discussion to increase motivation for the next few months; have participants increase their confidence about their adherence between now and booster sessions.]

*O.k., has everyone been pulled aside for individual time to review their IAP plan?*

*Good. Before we break-up for today, we would like to give everyone here an opportunity to share a little bit about his or her feelings about the next few weeks. What are your major concerns and how can the group help to provide confidence or support?*

*Perhaps you'd like to share what was the one major concept that you learned here that will be helpful to you for as long as you need to take medication, or, if you've been encouraged by something done or said by another participant in the group that will impact your behavior in a positive way, you might want to share that.*

### **Closing**

*In the very first group we had, only a few weeks ago, we asked each of you, "what is the primary thing that keeps you going, what's really important to you?" We've heard all kinds of examples; the most frequent are \_\_\_\_\_, \_\_\_\_\_. These are the very things that will keep you motivated through the hard times. Please, as you leave today, try to incorporate these powerful images and thoughts into your daily thinking. In fact, some of the most successful people carry reminders with them. A snapshot of your significant other, your child or a relative's child who you are close to, a picture of a place you want to visit someday, a copy of a love letter or poem that is important to you, anything that reminds you of your main reasons for wanting to adhere.*

*Remember that the only way that you can truly fail is to fail to return to the booster session. We can all look forward to sharing our victories and experiences.*

*We've truly enjoyed working with all of you. Any last minute suggestions or final thoughts before we end for the day?*

Thank participants for attending.

Complete Research Forms for the session.

# Appendix A: Simplified Rationale for Treatment

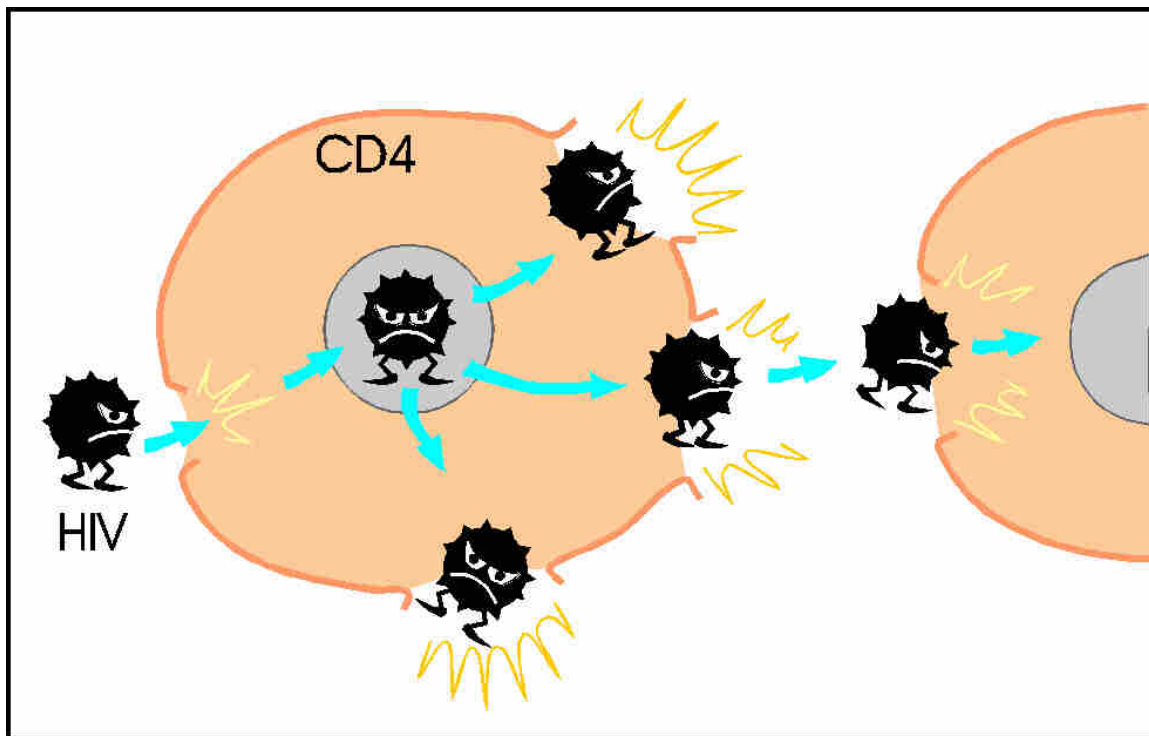
## 1. Overheads

# **HIV AND ANTIRETROVIRAL THERAPY**

**HIV is the virus that leads to AIDS.**

**Once HIV gets in someone's body, it goes into healthy cells. There it makes new copies of itself.**

**These copies go into other cells. There they make even more copies of HIV.**



**Doctors can measure “viral load.” This is the amount of HIV in your blood. The lower the number on this test, the better the result.**

**Lower numbers mean less HIV in your body.**



**One of HIV's favorite targets is a white blood cell. This is also called a CD4 (t-helper) cell.**

**CD4 cells are important. They tell other cells when to start fighting infection.**

**People lose CD4 cells when they have HIV. Then they can get sick from germs that do not usually hurt healthy people.**

**Doctors measure the level of CD4 cells in the body. They call this a “CD4 count.” The CD4 count helps them keep track of how strong the immune system is and how far HIV has progressed. The higher the CD4 count, the healthier your body is.**

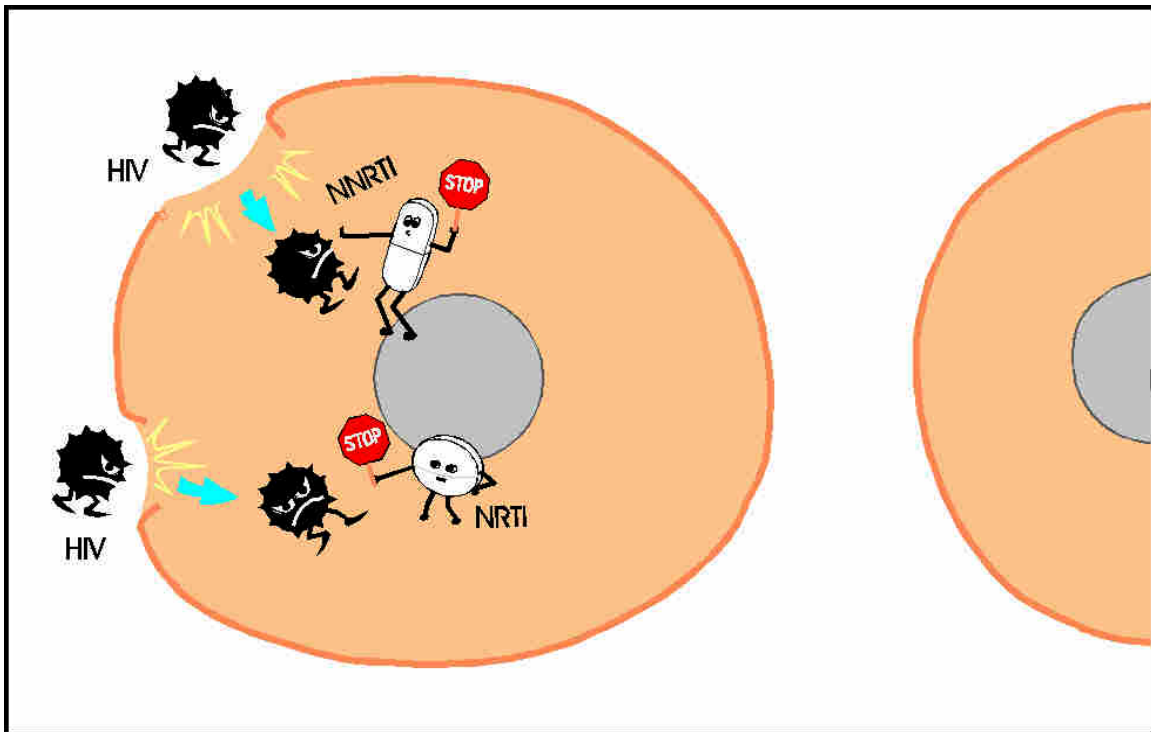
**When someone’s CD4 count is below 200, or when they become sick enough, they are said to have AIDS.**

**You can take medicines to fight HIV.**

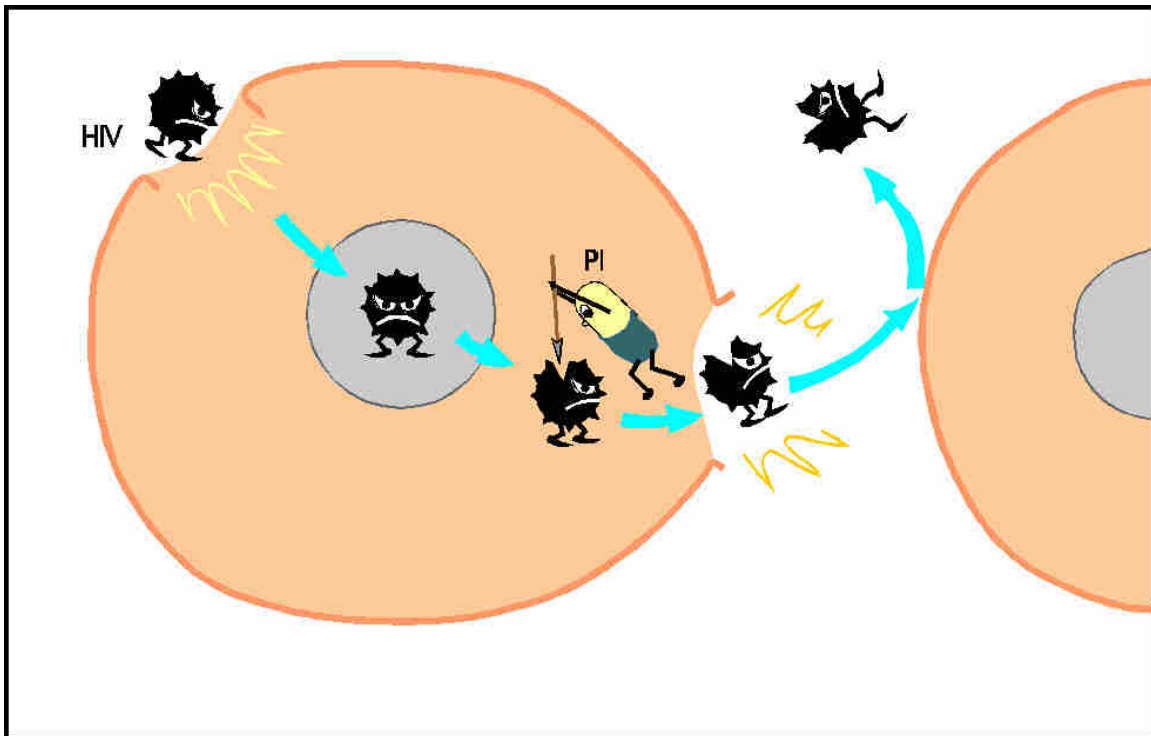
**These help keep HIV from making successful  
copies of itself.**

**Different medicines fight HIV in different  
ways.**

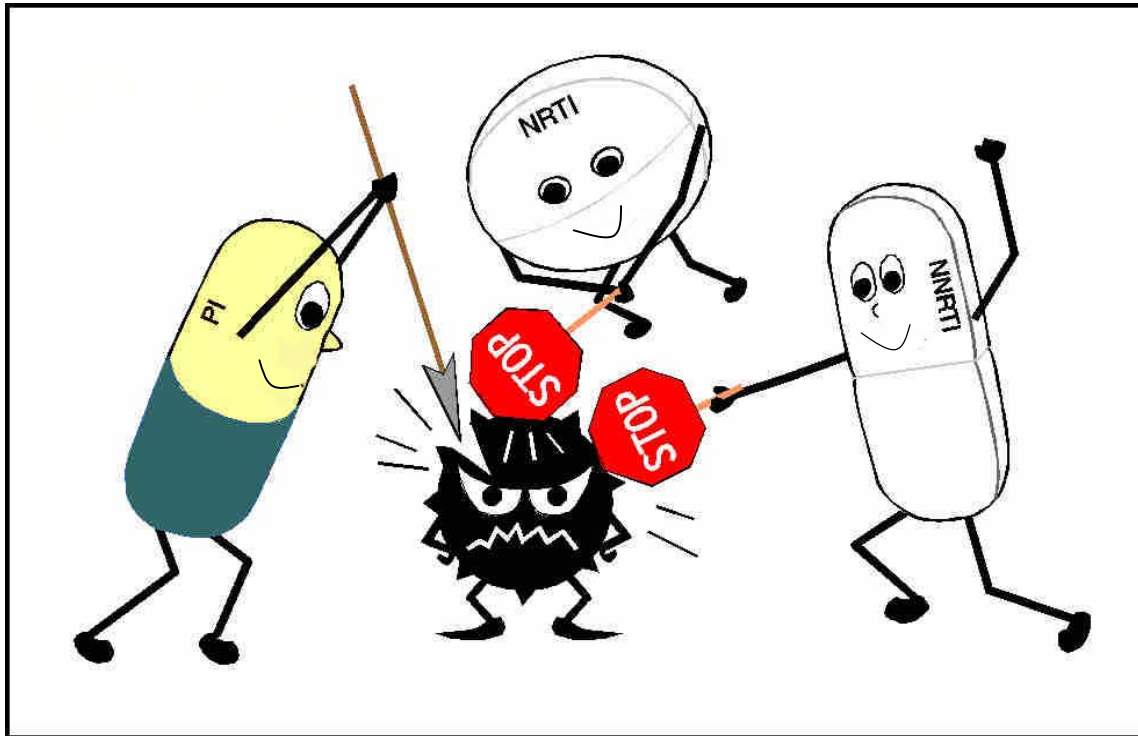
**Two classes of HIV medicines fight HIV the same way. They are the NRTIs and the NNRTIs. They both keep HIV from getting to the center of a healthy cell to make copies of itself.**



**Another class of HIV medicines is the Protease Inhibitors, or PIs. They cause HIV to make bad copies of itself. These copies cannot go on to infect other cells.**



**No one way of attacking HIV is enough to keep the virus down by itself.**



**Doctors often have you take several medicines to fight HIV. These medicines fight HIV in different ways.**

**Taking these together means that they can  
fight HIV at their full strength. You have to  
take them the way the doctor says to take  
them.**

**You need to take them when the  
prescription says you should.**

**The medicines only work for a certain time  
after you take them.**

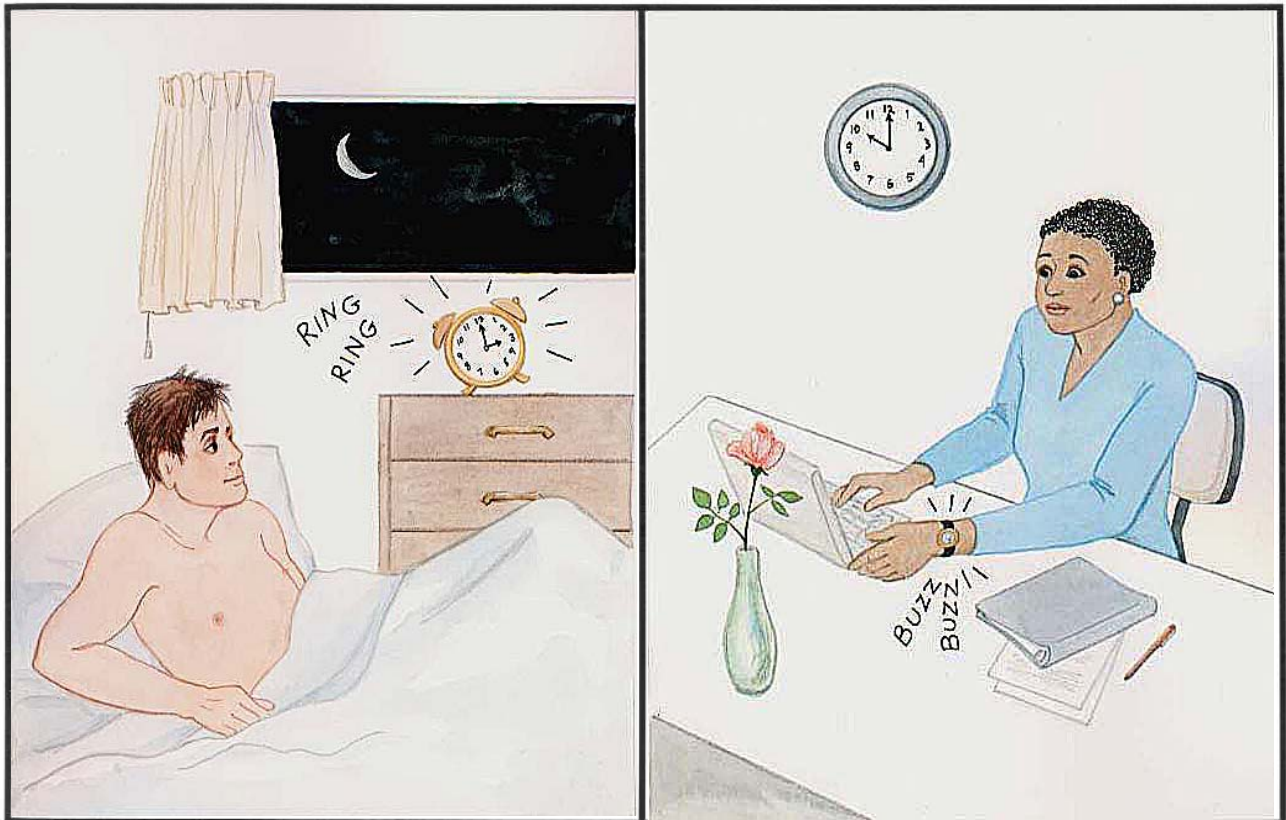
**You want the medicines to be working at all  
times. That way they will keep the virus from  
making copies of itself.**

**That's why you need to take the medicines  
just the way the doctor says to take them.**



**Sometimes you will have to set your alarm to  
take some pills at night.**

**You may have to stop  
during the day to take your medicines.**



**You have to take them exactly the way  
the prescription says you should.**

**If your prescription says to take them  
with food, then you should take them with  
food. Your doctor may say to take  
them on an empty stomach.**

**Then you shouldn't eat  
before taking them. It can make the  
difference between the medicines  
working or not working.**

**Your doctor may say not to take other medicines with your HIV medicines. These might be medicines for headaches or stomach aches.**

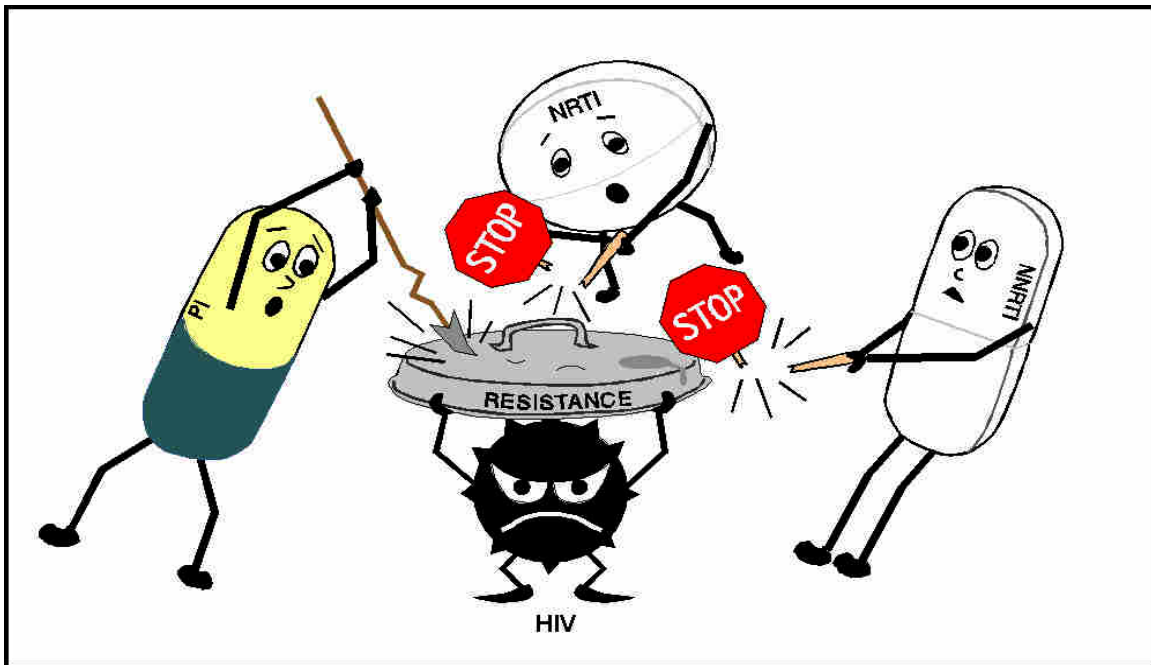
**Do not take them.**

**It can make the difference between your HIV medicines working at full strength or not.**

**Be sure that the doctor who gives you your  
HIV medicines knows about all  
of the other medicines you take!**

**“Close” is not good enough in fighting HIV. The instructions with your medicines help you make sure that each medicine you take gets into your body to fight HIV at its full strength.**

**When your medicines are not fighting at full strength, the HIV in your body can learn to protect itself from them. This is called “resistance.”**



**If your HIV learns to protect itself from one medicine, it may learn to protect itself from other HIV medicines you have never taken.**

**This is called “cross-resistance.”**

**If the HIV in your body  
becomes resistant to one type of  
medicine, and to other medicines like  
that one, then you have lost several  
weapons to use in the fight against HIV.**

**Resistance can develop when people miss a  
few days of their medicines. It can even  
develop when people miss several doses of  
their medicines.**



**Taking your medicines as prescribed means  
you are doing everything you can to prevent  
resistance.**

**There are no medicines right now that can kill all of the HIV in your body. The medicines you take can keep the amount of HIV in your body so low that you don't get sick. You can keep the amount of HIV so low that doctors call it "undetectable."**

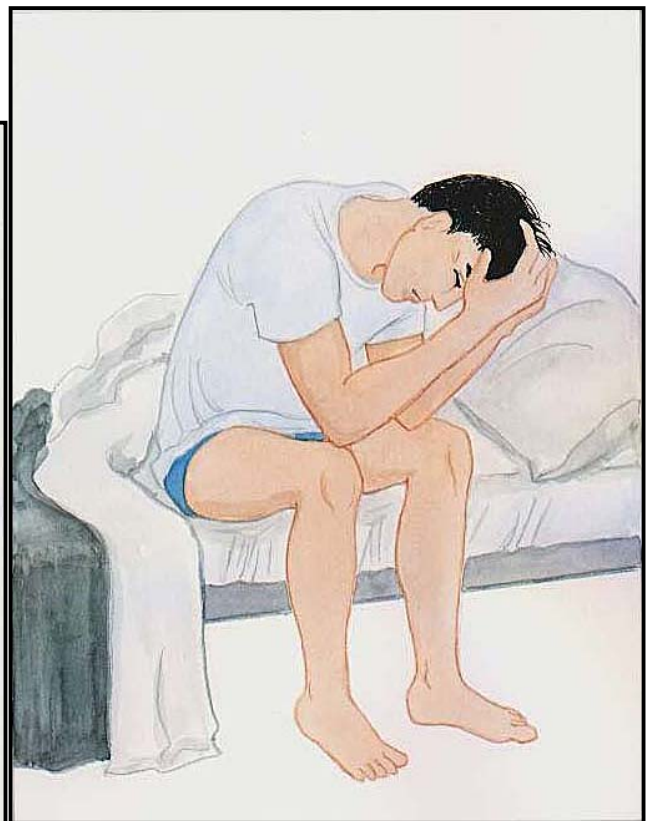
**But even if HIV is “undetectable,”  
it is still in your system.**

**It can come back to high levels if you stop  
taking your medicines.**

**That’s why you  
need to keep on taking the medicines.**

**What if I feel fine? Then do I have to  
take anything?**

**The reason you take the HIV medicines is to  
keep from getting new infections. You need  
the protection they give you, whether you feel  
fine or not.**



**What if the HIV  
medicines make me feel bad?**

**Sometimes, when you start HIV medicines,  
you will feel bad for a while. Some people  
have rashes. Some have stomach aches or  
headaches.**

**These things usually don't last long.**

**You should tell your doctor about any bad things that happen.**

**That way you can work with her or him to make a new plan that is more comfortable to you.**

**Your doctor may have you take different medicines.**

**Talk to your doctor first. Don't stop taking your medicines or change the way you take them before you talk to your doctor.**



## **Taking HIV medicines**

**can be very hard. Is it worth it?**

**Studies show that combinations of HIV medicines can reduce both the death rate and illnesses associated with HIV/AIDS. One study showed that the death rate was reduced by 2/3 between 1995-1997. During the same time, illnesses associated with HIV/AIDS were reduced by almost 3/4.**



**Get your doctor to talk to you about any problems you think you will have taking your medicines. Your doctor can help you plan how to handle them.**

**It isn't easy to take HIV medicines as  
carefully as you must, but**

**YOU ARE WORTH IT!**

# **Appendix B: Module 1 Charts, Handouts & Forms**

1. Problem Solving Approach Wall Chart
2. Adherence Strategies Wall Chart
3. Dot Example Chart Wall Chart
4. Goal Setting Chart Wall Chart
5. Facilitator Record of IAPs
6. STAR Intervention Attendance Sheet

# Problem Solving Approach

1. Identifying the problem
2. Identifying the goal
3. Think of strategies (brainstorming)
4. Evaluating alternative strategies  
and choose the best solution
5. Act on the best solution

# Adherence Strategies

## Simple reminder strategies

1. Keeping your morning dosage at your bedside.
2. Leaving your pill box in the bathroom next to your toothpaste.
3. Having a friend or significant other remind you each morning to prepare your medications for the day.
4. Leaving post-it notes at your desk to remind you to take your medications.

## Preparation Strategies

5. Using special carriers for daily doses.
6. Carrying food and water to fulfill special instructions.
7. Preparing each day's doses the night before to avoid "morning rush."
8. Having back-up doses at work in case you forget to bring in your medications.
9. Planning for being away from home or traveling and time zone changes.
10. Rotating your back-up "emergency" supply.

## Self-monitoring strategies

11. Checking off your doses on a checklist as you take them.
12. Monitoring your doses in your checkbook.
13. Having a "secret" file on your computer where you monitor your doses.
14. Recording each night how you did for each dose of the day in a journal or diary.

## Reinforcement strategies

15. Rewarding yourself for sticking to your medication schedule.
16. Behavioral contracting: making an agreement to reward yourself if you meet a certain adherence criteria.

## Information Strategies

17. Writing down questions you have about your medications to take to your next health care appointment.
18. Carrying a pad and pen to health care appointments to remind you to take notes.
19. Taking a friend/family member with you to health care appointments to help listen and remember important information.

## Cognitive strategies

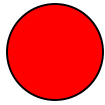
20. Imagining successful outcomes to difficult barriers that interfere with adherence.
21. Re-framing negative self-talk.
22. Thought stopping.
23. Challenging irrational beliefs.

## Cognitive-behavioral strategies

7. Mentally rehearsing what steps you can take to deal with specific barriers to adherence.
8. Breaking your adherence goals into small steps, and practicing taking each step one at a time.
9. Writing in a journal to help you focus on your commitment to adherence.
10. Changing things in your environment to help you with adherence.

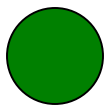
## Dot Example Chart

**Red Dot**



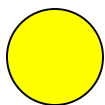
= “Stop thinking negatively!  
Taking my meds is a  
reminder of how much I  
have to look forward to in  
my life.”

**Green Dot**



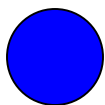
= “Go ahead, take charge,  
and stay healthy.”

**Yellow Dot**



= “Wait, I need to stop and  
think about how good this  
is for me.”

**Blue Dot**



= “Relax, it’s going well; I am  
benefiting every day from  
my medication schedule.

# Goal Setting Chart

**Realistic:** Is the goal not too easy/not too hard and can it be accomplished without depending on someone else's behavior change?

**Clear:** Is it obvious to anyone what the goal is?

**Timeframe:** Do the steps to reach the goal seem like they can be accomplished within one week?

**Measurable:** Will it be clear when the goal is accomplished?

# Facilitator Record of IAPs

Participant's First Name: \_\_\_\_\_

	Session				
Goals:	1	2	3	4	5
1:					
2:					
3:					



# STAR Intervention Attendance Sheet

Session 1

Wave # \_\_\_\_\_

Session Date: \_\_\_\_\_

Name of participant 1 <sup>st</sup> name and last initial only	Present*	Absent*
1.		
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\*If participant leaves session early or arrives late, indicate which elements for which s/he was present or absent.

Elements	Completed/Omitted
1. Introduction	
2. Shared regimens and personal reasons for adherence	
3. Introduction to problem-solving approach	
4. Introduction to adherence strategies	
5. Dots – homework goal	

# Appendix C: Module 2 Charts, Handouts & Forms

1. Barriers to Compliance Handout
2. Blue Card adherence barrier scenarios
3. Orange Card adherence barrier scenarios
4. Adherence Barrier Descriptions Handout
5. Problem Solving Handout
6. STAR Intervention Attendance Sheet

# Barriers to Compliance

People	Places	Situations	Moods/Feelings	Substance Use

Ever since Matt moved out, Bill isn't going to AA meetings and his drinking is getting problematic again. He knows that his medication interacts strangely with the alcohol so he's been skipping dosages at a higher rate lately.

Liz is supposed to be taking 24 pills each day, some with food, and some on an empty stomach. She finds this schedule almost impossible because she has two children who do not know her HIV status. If she takes her pills in front of them at meals, they are bound to ask questions.

While Jake is glad he isn't with his ex-boyfriend, he still feels that when he sees him or thinks of him too much he gets angry and frustrated about his situation and usually "forgets" to take his medication.

Walt feels that his current medication schedule is too complex; he doesn't understand why he needs to follow it, but doesn't want to talk to the clinic nurse because she will probably think he's stupid.

When Jensen hits the usual dance clubs, even though he doesn't drink alcohol, he remembers the "good old days," when he was HIV-negative, and taking his medication is the last thing on his mind.

Drew is supposed to take his medications on an empty stomach, but when he gets home from work he is so hungry he'll eat whatever's fast in the fridge, and then have to take his evening dose on a full stomach.

Neil is beginning to feel like his coworkers think that he's weird. They see him taking his "vitamins" all the time and he's afraid that someone will soon catch on.

Mark is really excited to be on the newest medication available. He still takes his other medications, but feels that some of them aren't necessary anymore and he's begun to skip some so that he feels better—he feels like he has fewer side effects when he deletes some doses.

Pat's medicines have always made her feel a little bit sick. She tries to take them regularly, but on "special days" when she has movie tickets, or wants to feel good for a party, she'll skip that day's dosages.

Simone isn't one to let anybody know her business. She cannot figure out how to conceal all of her medication, all day long, so she refuses to keep any in her car, briefcase, pocket, or purse. On days when she's out from 7 A.M. until 10 P.M., she usually misses her doses.



Larry hates his doctor. The doctor never explains anything, treats him like he's a kid, and spends no more than 5 or 10 minutes with him at appointments. Larry doesn't feel like doing anything this doctor says, so he sometimes doesn't take his medication the way the doctor told him to.

# Adherence Barrier Descriptions

## **Last Time You Were Nonadherent**

1. What were you doing?
2. Who were you with?
3. Where were you?
4. What time of day was it?
5. What were you thinking or feeling?
6. When did you realize that it happened?

## **The Time Before Last**

1. What were you doing?
2. Who were you with?
3. Where were you?
4. What time of day was it?
5. What were you thinking or feeling?
6. When did you realize that it happened?

## **The Time Before That**

1. What were you doing?
2. Who were you with?
3. Where were you?
4. What time of day was it?
5. What were you thinking or feeling?
6. When did you realize that it happened?

# Problem Solving

1. Identifying the Problem

2. Identifying the Goal

3. Thinking of Strategies (Brainstorming)

# STAR Intervention Attendance Sheet

Session 2

Wave # \_\_\_\_\_

Session Date: \_\_\_\_\_

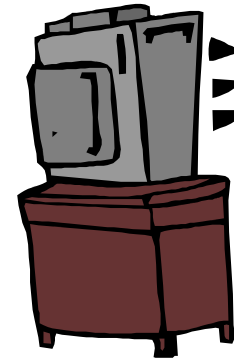
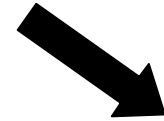
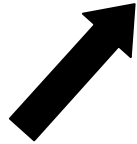
Name of participant 1 <sup>st</sup> name and last initial only	Present*	Absent*
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9.		
10.		
11.		

\*If participant leaves session early or arrives late, indicate which elements for which s/he was present or absent.

Elements	Completed/Omitted
1. Follow-up on homework assignment	
2. Barriers to compliance	
3. Develop strategies using problem-solving approach	
4. First Individual Adherence Plan (IAP)	

## **Appendix D: Module 3 Chart, Handouts & Forms**

1. Behavior Chain Chart
2. Role-play scenario 1 script: “Tess and Michelle”
3. Role-play scenario 2 script: “Terry and Brad”
4. Cognitive Strategies Chart
5. Sample Negative Statements
6. STAR Intervention Attendance Sheet



# Role-play Scenario 1

## “Tess and Michelle”

**Tess:** He said I was doing better; that the numbers are lookin’ better.

**Michelle:** Yeah, been there, done that, got the T shirt.

**Tess:** Whatya mean?

**Michelle:** Seems like whenever I’ve been on my medication for a while the numbers always go up eventually.

**Tess:** So?

**Michelle:** Well, if they go up it’s all been a waste of time. All those pills, all those side effects—all a big waste of time.

**Tess:** First of all, I’m not sure that any of that is true. Maybe with your current meds, things will be different. Maybe next time the numbers will stay down.

**Michelle:** Don’t tell me you haven’t seen some of our friends from the clinic get worse.

**Tess:** Sure I have. But that doesn’t mean it has to happen to me. Look, I made up my mind when this all came crashing down on me last year—I could get worked up, pissed off, wound up—or I could keep a positive attitude . . . concentrate on something positive . . . and try not to think of myself as just a sick person. It works most of the time.

**Michelle:** Yeah, just most of the time.

**Tess:** Whoa, you got the negative vibe bad. Maybe we need to hang out more; I think I need to help you with a better attitude.

## Role-play Scenario 2

### “Terry and Brad”

- Terry:** Man, forget this. I show up on time and they say it’s gonna be at least 30 minutes. I’m already late for another appointment.
- Brad:** You should see what it’s like at the other clinic. They’ve got more staff—even better meds, I hear.
- Terry:** Hey, don’t mention meds. I been takin’ this stuff for 6 months, right on schedule, and I ain’t feeling any better.
- Brad:** What’s the doc saying?
- Terry:** You know what they say.
- Brad:** What?
- Terry:** Keep up the good work—take your medication regularly and it’ll work.
- Brad:** So?
- Terry:** Man, I don’t feel so great a lot of the time and he says the same thing every time I see him.
- Brad:** Maybe you shouldn’t think so much about how you feel—I mean I know it’s hard, but I’ve learned to concentrate on other things. Even on days when I’m feeling a little sick right after breakfast, I think about what bands are coming to the club. Or I think about my friend who knows Elton John and that when Elton comes to town I might get to meet him or get tickets to his concert.
- Terry:** Think you can get me a ticket too?
- Brad:** Now there you go—thinking better already! I know it really doesn’t necessarily change the big picture. But thinking about something else, something positive does help.



# Cognitive Strategies

- Imagery
- Reframing and Re-labeling
- Positive Self-talk
- Compartmentalizing

## Sample Negative Statements

1. I feel so down, often I forget to take my pills.
2. I am so overwhelmed about having to deal with this whole thing.
3. No one knows if these medicines are going to work forever anyway.
4. I hate taking these medications—I have to live with remembering them all the time, and I have side effects from them.

## Sample Negative Statements

1. I feel so down, often I forget to take my pills.
5. I am so overwhelmed about having to deal with this whole thing.
6. No one knows if these medicines are going to work forever anyway.
7. I hate taking these medications—I have to live with remembering them all the time, and I have side effects from them.

# STAR Intervention Attendance Sheet

Session 3

Wave # \_\_\_\_\_

Session Date: \_\_\_\_\_

Name of participant 1 <sup>st</sup> name and last initial only	Present*	Absent*
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\*If participant leaves session early or arrives late, indicate which elements for which s/he was present or absent.

Elements	Completed/Omitted
1. Follow-up on homework assignment	
2. Complex barriers to compliance	
3. Introduction to cognitive-behavioral techniques	
4. Second Individual Adherence Plan (IAP)	

## Appendix E: Module 4 Handouts & Forms

1. Scripted role-play #1: Assertive
2. Scripted role-play #2: Aggressive
3. Scripted role-play #3: Passive
4. Scripted role-play #4: “Dr. Carter and Rudy”
5. STAR Intervention Attendance Sheet

# Scripted role-play #1

## Assertive

**Doctor:** Hello. Have you had any trouble with the medications since I saw you last?

**Patient:** Well, I have missed doses a couple of times.

**Doctor:** What was going on when you missed the doses?

**Patient:** Well, I really have a problem with the taste of the medications. Sometimes just thinking about taking them makes me feel sick to my stomach.

**Doctor:** Okay. Other people have had some luck taking their pills with a beverage such as Ensure, which helps to mask the unpleasant taste. Why don't you try that and see how it works?

**Patient:** All right, I'll give it a try.

## Scripted role-play #2

### Aggressive

**Doctor:** Hello. Have you had any trouble with the medications since I saw you last?

**Patient:** Of course I have. I don't understand why you gave me such a hard schedule in the first place. You must be nuts to think that anyone can take all of these pills everyday.

**Doctor:** When exactly are you having problems?

**Patient:** All of the time.

## Scripted role-play #3

### Passive

**Doctor:** Hello. Have you had any trouble with the medications since I saw you last?

**Patient:** Not really. It's been ... well, hard, but o.k., I guess.

**Doctor:** Great, let's take a look at your lab results.

## Scripted role-play “Dr. Carter and Rudy”

**Dr. Carter:** I’m going to put you on Viracept. You should take it three times a day, with food.

The directions will be on the bottle.

**Rudy:** Does Viracept cause any side effects?

**Dr. Carter:** Nothing serious, sometimes a little digestive trouble. It won’t last too long.

You’ll be fine.

**Rudy:** I think that I will be able to manage things better if I know just what might happen. Could you tell me more about what kinds of problems I might have and what I can do about them without messing up my HIV medicines?

**Dr. Carter:** Well, the most frequent side effect is diarrhea. If this does occur, you can take a non-prescription remedy, such as Imodium.

**Rudy:** Is there anything else I should know about Viracept?

**Dr. Carter:** Well, if you are taking Viracept, you shouldn’t take some kinds of antihistamines. Now, I reviewed your chart before prescribing the Viracept and right now you are fine. Are you taking any medications that you haven’t told me about?

**Rudy:** I sometimes take my sister’s hay fever medication. I don’t remember the name.

**Dr. Carter:** Don’t take it any more. Don’t take any other medications that you haven’t checked with me about first.



# STAR Intervention Attendance Sheet

Session 4

Wave # \_\_\_\_\_

Session Date: \_\_\_\_\_

Name of participant 1 <sup>st</sup> name and last initial only	Present*	Absent*
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\*If participant leaves session early or arrives late, indicate which elements for which s/he was present or absent.

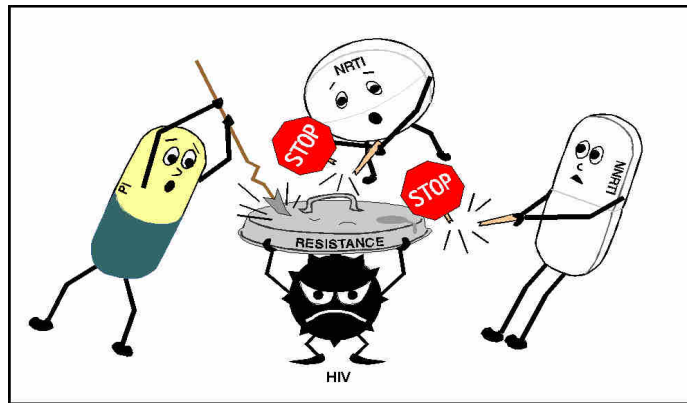
Elements	Completed/Omitted
1. Follow-up on homework assignment	
2. Increasing control through information-gathering (index cards for questions)	
3. Role plays with medical provider	
4. Third Individual Adherence Plan (IAP)	

# Appendix F: Module 5 Charts & Forms

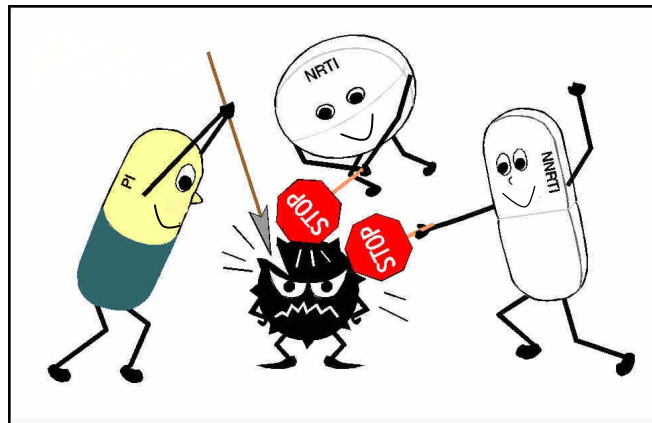
1. Benefits of Adherence Chart
2. Dorothee Scenario laminated handouts
3. STAR Intervention Attendance Sheet

# Benefits of Adherence

1. The more adherent you are, the less likely you are to have viral resistance.



2. When you adhere, the antiretroviral medications are working at their full strength to fight HIV.



3. Adherence can you make you feel healthier, and less worried.
4. Adherence can make you feel good about yourself because you are taking charge and taking care of yourself.

# Dorothee Scenario

Dorothee has been on her Weight Watchers diet for the past 3 weeks. All in all, things have gone rather smoothly; she's exercising moderately, eating according to her food plan, and has lost 4 1/2 pounds. Next Monday night, all the employees at Haberstam & Co. are going to a goodbye dinner for one of the secretaries at the local Italian restaurant. Dorothee already anticipates a problem but has consulted with her weight loss group leader who has recommended that she have a side salad with low-fat dressing on the side and a single slice of pizza with vegetable toppings of her choice. Dorothee agrees to this plan.

The goodbye dinner is great fun and Dorothee sticks to her plan. Unfortunately, the people in charge of ordering ahead of time have greatly "over-ordered" and there's plenty of extra pizza. Dorothee has a hard time not having another slice of pizza, especially because it's the "supreme" kind with all of her favorite toppings including, pepperoni, sausage, and two kind of olives. Dorothee bargains with herself and decides that "one piece can't hurt." She figures that she can simply be more careful tomorrow. After eating the slice, the birthday cake is brought out, something that Dorothee forgot to anticipate. It's a chocolate mousse cake with her favorite type of icing. Dorothee panics; she figures that an ultra small piece would be the best she could manage, but when the plates are delivered to her end of the table, a corner piece is hers, and she quickly eats half of it. Feeling extremely guilty and "out-of-control," Dorothee decides to finish the entire piece, and then finishes the piece that her friend left over when she departed several minutes earlier. At this point Dorothee figures that the entire day/week are ruined due to her overeating and buys some Haagen-Dazs ice cream on the way home to "finish off" a terrible night.

The next day Dorothee still feels like a complete failure. She struggles to stay on any kind of a reasonable food plan for the next week. However, when she weighs herself that morning, she hasn't gained anything. She tells herself she still has to go back to her diet, and struggles to do so, but all week she also thinks about how she "got away" with that break in her diet, and this comes into her mind, and she finds it easier and easier to justify slips and harder to stay on her diet.

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# STAR Intervention Attendance Sheet

Session 5

Wave # \_\_\_\_\_

Session Date: \_\_\_\_\_

Name of participant 1 <sup>st</sup> name and last initial only	Present	Absent
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

\*If participant leaves session early or arrives late, indicate which elements for which s/he was present or absent.

Elements	Completed/Omitted
1. Follow-up on homework assignment	
2. Review benefits of adherence	
3. Long-term adherence issues/relapse prevention	
4. Review progress of IAPs/Advanced role plays	
5. Planning for the future/maintaining motivation	