Cognitive-behavior therapy to treat depression in a Latino with a diagnosis of HIV infection

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Cognitive-Behavior Therapy To Treat Depression In a Latino With a Diagnosis of HIV Infection

A Research Project
Presented to
The Faculty of the College of Social Work
San José State University

In Partial Fullfillment
of the Requirements for the Degree
Master of Social Work

by
Márcia de Oliveira-Howard
Spring, 1995
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Context of Services</td>
<td>2</td>
</tr>
<tr>
<td>Description of Subject Studied</td>
<td>6</td>
</tr>
<tr>
<td>Literature Review</td>
<td>10</td>
</tr>
<tr>
<td>Design of Evaluation Study</td>
<td>17</td>
</tr>
<tr>
<td>Results</td>
<td>26</td>
</tr>
<tr>
<td>Discussion</td>
<td>30</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>Appendix 1</td>
<td>38</td>
</tr>
</tbody>
</table>
Introduction

The purpose of this study was to demonstrate the effectiveness of the cognitive-behavioral therapy model in alleviating symptoms of depression and isolation of a client with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS). The client was a thirty-eight year old monolingual Spanish speaking male of low socio-economic background diagnosed with AIDS in 1991. The indicators examined in this study were (a) pre-intervention level of depression, isolation, and verbal communication with family (b) client daily self-monitoring of depression symptoms, (c) bi-weekly follow-up on assigned homework tasks, (d) post measurement level of depression and isolation from community and level of verbal communication with family.

The Agency

Natividad Medical Center is the county hospital for Monterey County. Natividad is a teaching hospital that offers a residency program in the family practice specialty to medical doctors and is affiliated with the University of California at San Francisco School of Medicine.

Natividad has 252 inpatient beds. The hospital also provides the following outpatient services:

Natividad Medical Center (NMC) is funded by the City of Monterey, the State of California, the federal government and by funds from the Natividad Medical Foundation, a private non-profit fundraising organization.

According to the 1990 census, Monterey County had a population of 394,000 people. The most significant change in this county’s demographics since 1980 has been the dramatic increase in the Latino population. During the ten year census period from 1980 to 1990, Monterey County’s Latino population increased by 59.1% (Monterey County Housing Authority, 1993). This change has resulted in an increased need for social services because of the low socio-economic background of this population, who migrate to the area to work seasonal jobs at the farms and ranches of the Salinas valley.

In short, NMC serves the biopsychosocial needs of those residing in Monterey County, of which sixty-five percent are of Latino origin (Armenta, 1995).
The Medical Social Work Department

NMC's four medical social work staff members provide a myriad of in and outpatient psychosocial services, including polysubstance abuse, mental illnesses, single parenting, advanced Alzheimer's disease, cancer, neonatal acute care, and HIV+/AIDS. Clients referred to the medical social work department are those "who have very limited support systems to help them deal with the consequences of their illness" (Ward, p. 2, 1993).

In fact, county hospitals are mandated by the California Senate Bill 2669 to provide medical social services "to all hospital patients, staff, and the surrounding community" (Ward, 1993, p. 2). Medical social services are also required by the Joint Commission on Accreditation of Health Services, Medicare, and the Omnibus Budget Reconciliation Act of 1987.

The NIDO Clinic

The outpatient AIDS clinic was founded in January of 1993 to provide comprehensive medical care and case management services for persons with HIV disease. Its name was carefully selected to provide maximum confidentiality to its clients. Natividad Immunology Division Outpatient (NIDO) Clinic provides medical
services to the local community by using a coalition of funding sources including Salinas Valley Memorial Hospital and Ryan White Consortium funds and is under contract with the Monterey County Health Department. NIDO Clinic relies on staff support from Natividad Medical Center.

Natividad provides four staff physicians, in-kind assistance (clerical support, office space, furniture, telephones, and supplies), and inpatient care for those in need of hospitalization. Monterey County Health Department provides funding for a Physician’s Assistant, a Medical Assistant, and a patient records/receptionist.

HIV Epidemiology in Monterey County

The NIDO Clinic was implemented as a response to the high number of diagnosed cases in Salinas that weren’t receiving appropriate medical care elsewhere. In 1993, NIDO served 73 clients. As of July of 1994, it had served 100.

HIV disease has been a rapidly growing epidemic throughout Monterey County. According to the Monterey County AIDS Statistics, in 1984 there were 4 diagnosed cases in the County. In 1993 there were 99. The total number of diagnosed cases as of September 30, 1994 was 459. Ninety-four were Latinos. Forty-eight are women.
One hundred and eighteen of the total number of diagnosed cases live in Salinas (Monterey County Health Department).

Since the beginning of the AIDS epidemic Latinos have been disproportionately affected. Data from the Centers for Disease Control (1989) show that 15.3% of HIV infected persons are Latinos while Latinos comprise 8% of the U.S. population. "Sadly...AIDS cases [among Latinos] almost certainly represent an undercount, since Chu et al. (1989) found that over 20% of Hispanic AIDS cases in California have been classified as non-Hispanic white." (Marín and Marín, 1990, p. 107).

People with AIDS face a complex set of byopsychosocial concerns and issues. Macks (1989) identified some of the major distresses and needs for people infected with the HIV virus such as: (1) the need for information, and services; (2) substance abuse issues; (3) neuropsychiatric complications; (4) dealing with difficult feelings; and finally (5) coping with medical treatment (p. 2).

Before clients are referred to the medical social work department by the NIDO Clinic, they generally have been counseled by the Monterey County AIDS Project on financial issues such as State Disability Insurance,
Social Security Disability, housing, etc.; and the NIDO medical staff has gone over their medical condition and treatment options. Therefore, the tasks of the social workers are to assess and intervene with the clients’ distressing feelings; clients whose lives may now be in crises.

Psychosocial History of Client

The subject studied was referred to me by the NIDO Clinic’s Physician’s Assistant (P.A.). He has been followed by the NIDO Clinic’s medical staff since 1991. The P.A.’s primary concern at the time of referral was the client’s depression and poor living conditions.

During the initial session my goal was to create an atmosphere of nonjudgemental acceptance to discuss with the client reasons for seeking therapy (Ramirez, 1991, p. 58). The client was clear about seeking therapy for symptoms of depression, anxiety, miscommunication among extended family members/housemates, and lack of contact with other Latinos infected with the HIV virus.

Luiz is a 38 year old monolingual Spanish speaking male who was diagnosed with the HIV infection in the fall of 1991. It is the client’s self-report that he contracted the HIV virus through intra-muscular injections in México. Shortly after his HIV positive
Pertinent Family History

Luiz has been married for 12 years and the couple has three children: a 10 year old girl and two boys, a seven year old and a five year old. Shortly after their wedding in México he and his wife, who is a Mejicana, moved to the United States.

My client explained that he was raised by a surrogate mother because his biological mother could not afford the ten children she reared; some of them going to live with a more economically stable family in a nearby pueblo in México. Luiz reports to have a closer relationship with his surrogate siblings—a total of seven—than with his biological siblings.

State Supplemental Insurance (SSI) has helped to support Luiz since the beginning of 1992, when he became unable to perform his work duties. His wife works at a packing company to supplement the household income. Despite his wife’s income the family is unable to rent their own dwelling; having to share a three bedroom apartment with Luiz’s biological brother, wife, and their three children.

Luiz was the first child in both the biological and the surrogate family to immigrate to the United States. He worked in the fields of Salinas Valley and lived a
better lifestyle than his relatives in México; thus setting an example for all of his siblings, nephews and nieces. He was able to help many of them to settle in the United States.

Reason for Referral

During the intake session Luiz described that his depression was rooted in his poor living situation and his sense of isolation. He explained that in the three years that he had lived with his brother and family he had kept his HIV status a secret to everyone but his wife (the family was told he had "an eye problem that needed a lot of medical attention").

He conveyed that he felt constantly bored and anxious since he stopped working. Luiz communicated his desire to meet other Latinos with the same diagnosis, which he hoped would both decrease his feeling of isolation and provide emotional support.

Luiz explained he had in fact known three Latino men with the HIV infection; two of whom died last year and the third actively dying at the time of this study. He had met these men through the Monterey County AIDS Project's staff members. It became clear after a few sessions with my client that his expectation of this
intern was to provide him with new contacts--Latino men infected with the HIV.

Client’s Religious Beliefs

My client explained that he is a devout Catholic who also believes in curanderos and spiritualism. He used to attend weekly Mass but had not done so lately. When questioned about this change of spiritual practice he avoided answering the question and later stated that he feared that people would question him about his medical condition.

Literature Review

Introduction

The focus of this study is on the delivery of psychotherapeutic services to a male, heterosexual Mejicano who has AIDS.

Mejicanos, as defined by Vega and Romero (1987), are individuals of Latin origin whose degree of assimilation into the Anglo culture is at its lowest level. (p. 17)

Review of literature shows that the Latino community living in the U.S. tends to underutilize health and social services. Jones and Korchin (1982), Levine and Padilla (1980), concluded that such underutilization can be explained through many arguments:
1. Latinos have less need for services than other ethnic groups due to natural support systems intrinsic to their culture.

2. Lack of access to the services, i.e., (for migrant farmworkers) differences in eligibility requirements from one place to another and discontinuity of services.

3. Alternative resources exist within the Mexican American barrio which are factored in certain circumstances over the formal public resources.

4. Psychological barriers: fear of appearing inept or divulging personal problems to strangers and possible social stigma attached to utilization of services.

5. Resources: lack of availability of resources at the time of need, present relative inflexibility and shrinkage of service budgets, inflexible interaction of supply and demand.


7. Social distance between majority staff and minority, poor, deviant clients.

Miranda (1976) analysis of both "theoretical and empirical data lead to conclude that impaired communication between client and therapist and inappropriate handling of clients' expectancies seriously contribute to the lack of success in

Cultural Sensitivity in Treating the Spanish Speaking Client

The model followed in this study is based on the "psychology of differentness". This school of thought was pioneered by the works of Karen Horney, George Sanchez and Franz Fanon.

Horney, a German born medical doctor, immigrated to the U.S. in the 1940s, where, after working with many female patients around issues of oppression in a sexist society, concluded that Freud's psychoanalytic theory "ignored important cultural realities: the powerless position of most women in society, and the central role of culture in personality dynamics." (Ramirez, 1991, p. 23). It was Horney who wrote, in 1937:

One can diagnose a broken leg without knowing the cultural background of the patient, but one would run a great risk in calling an Indian psychotic because he told us that he had visions in which he believed. In the particular culture of these Indians the experience of visions and hallucinations is regarded as a special gift, a blessing from the spirits (cited in Ramirez, M., pp. 10-11).

George Sanchez, a Mexican-American psychologist, moved forward in 1932 to challenge the Anglo psychologists and educators' efforts to prove that Hispanic and African-American children were intellectually inferior to Anglo children. As Ramirez points out "Sanchez made it clear
that racial and ethnic superiority could not be claimed because... literature on intellectual testing indicated that environmental and linguistic factors were significantly related to performance on intelligence tests" (1991, p. 11).

It was not until the 1960s and 1970s that Horney’s and Sanchez’s theory found fertile grounds to sprout in the form of “Community Psychology” or also called the “true psychology of the Americas” (Ramirez, 1983), i.e., the psychology that reflected the concepts of the ‘melting pot’ in the U.S., and of the Mestizo (cultural and genetic mixture of Native-Americans and Europeans) in Mexico and other Latin American countries.

The paradigm shift from the Eurocentric superiority to what Julian Rappaport (1977) called multicultural person-environment fit world view has brought about changes in the application of psychotherapy models to minorities: models that lend to the empowerment of people, in which individual and cultural differences are respected (Ramirez, 1991, p. 24).

According to Organista (1993), culturally responsive psychotherapy should deliver services based on guidelines of linguistic matching, ethnically similar therapists matching, and according to Torres-Matrullo,
1982, "short-term, directive, problem-solving oriented therapies that are more consistent with the unstable realities of poverty backgrounds than in psycho dynamic, insight-oriented psychotherapies" (Organista, 1993, p. 230).

According to Miranda (1976), expectations of traditional Latino patients include immediate symptom relief, guidance and advice, a problem-centered approach and cultural sensitivity (Organista, 1993, p. 229).

**Depression in Medical Patients**

Kamerow's (1989) research conclusion shows that depression is one the most common problems seen in general medicine, making up to 30% of patients seen by primary care physicians. Katon (1982, 1987) found that depression may be the most common medical or psychiatric disorder seen in medical care clinics (Organista, 1994, p. 242). Katon (1987) also concluded that "depression in medical patients often goes undetected because patients selectively focus on the somatic components of their depressive disorder and because the comorbidity of depression and medical disorders amplifies somatic complaints" (Organista, 1994, p. 242-243).

Wells et al. (1989) concluded that:

"the combined effects of depressive symptoms and medical conditions on functioning were
addictive...i.e., the combination of heart disease and depression was associated with twice the reduction in social functioning associated with either condition alone. Thus, the argument for detecting and treating depression in medical patients is a compelling one" (Organista, 1994, p. 243).

Cognitive and Behavior Therapy with Latinos

"Cognitive therapy is an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders, from anxiety and phobias to depression and pain control. The theoretical rationale behind this approach relies on the concept that individual’s affect and behavior are largely determined by the way in which he structures the world. His cognition (verbal or pictorial “events” in his stream of consciousness) are based on attitudes or assumptions (schema), developed from previous experiences“ (Beck et al., 1979, pp. 3-4)

The therapeutic techniques are based on identification, reality-test, and adjustment of distorted thoughts and dysfunctional beliefs (schemas) underlying these cognitions (Beck, 1979).

Empirical investigation concerning effectiveness of cognitive and behavior therapy techniques conducted by Comas-Díaz (1981) among 26 Spanish-speaking Puerto Rican single mothers showed a significant reduction in depression for both cognitive and behavioral treatments (Organista, 1993, p. 229).
According to Organista, who conducted a study applying cognitive-behavioral therapy to a low-income minority sample of 175 subjects at the San Francisco General Hospital from 1986 to 1989, barriers to service utilization were eliminated by making services free, accessible, and by providing the subjects with linguistically and ethnically-matched therapists. Results showed that 55% of the referrals having utilized mental health services on a short (one session assessment, n = 14) or long-term basis (n = 74), which is noteworthy, given the low utilization rates of low-income and ethnic minority patients (Organista et al, p. 256).

The most frequent themes brought into therapy by Latinos are interpersonal conflicts in marriage and family, interpersonal relationships, symptoms of mental illness, culture shock, acculturation stress, somatization of emotional problems (Humm-Delgado, 1984, Comas-Diaz, 1985) and adaptation to chronic medical conditions, e.g., diabetes, heart condition, chronic pain, etc. (Organista, 1993, p. 231).

Ethnic Variations in Death and Dying

According to Rosenblatt "new anthropological studies of dying, death, and grief suggest that there is no one
grief theory nor one psychology of ego defenses that applies to everyone" (1993, p. 13). In the Latino culture and specifically in the Mexican culture death is believed to be the nature's way of 'clearing' itself in order to replenish the earth with new life (Younoszai, 1993, p. 69). In México, the dying person may concurrently visit a doctor and a curandero or just a curandero if they are living in a distant pueblo.

Latinos also tend to simultaneously believe the Catholic principles and santería, which makes death a more acceptable passage (Younoszai, 1993, p. 71). Cremation is discouraged by the Catholic church.

Mexicans and Mexican Americans greatly emphasize the family and family life. When death occurs in a family immediate and extended relatives that may not have been united for years before the death gather to mourn the deceased. Emotional response to death is more open and demonstrative, i.e., people accompany the casket to the cemetery and may stay around longer, visiting other gravesites, remembering who died when and from what cause.
Design of The Evaluation Study

The therapeutic intervention I chose to use for the subject studied was adapted from Beck's "Cognitive Therapy of Depression" and Organista's "Cognitive Behavioral Therapy (CBT) with Latino Outpatients".

Operational Definition of Intervention Method

This study was conducted in 10 sessions. The client was seen on an average of twice a week for a length of 50 minutes each session.

The model followed for each session was adapted from the model created by Beck, Shaw, Rush, and Emery from their study of "Cognitive Therapy of Depression." (1979).

A. Preliminary Evaluation:

- complete psychosocial evaluation: mental status, history of present physical illness, past history, family history
- clinical scales (pre-test): Beck Depression Inventory (BDI)
- frequency and duration of interviews and duration of treatment: 10 visits over a period of 5 weeks, 50 minutes per session.

First Interview:

- inquiry regarding expectations of therapy
• elicitation of negative attitudes regarding self, therapy, or therapist
• pinpointing most urgent and accessible problem
• explanation of cognitive-behavioral strategies with emphasis on the rationale for behavioral assignments and homework
• assign first homework

Second Interview
• discussion of problems and accomplishments since first interview
• review of homework assignments
• discussion of automatic negative thoughts
• preparation of homework assignments

Third/Fourth Interviews:
• follow same general format as in the second session
• further instructions in identifying negative automatic thoughts (role-playing if necessary)
• explanation of how these automatic thoughts represent distortions of reality and are related to other symptoms of depression
• relationship to homework assignments

Fifth/Sixth Interviews:
• demonstrate to the client ways of evaluating and correcting cognitive distortions (automatic thoughts)
• check progress in accomplishing homework tasks

Seventh/Eighth Interviews:
• continue to remove psychological blocks
• continue to identify negative automatic thoughts

Ninth/Tenth Interviews:
• administer a BDI as post-test on the ninth session
• increase responsibility for homework to the client
• preparation of the client for termination of therapy
• emphasis on continuation of homework assignments and practicing other techniques such as relaxation, breathing, and sharing with friends in order to maintain low levels of depressive symptoms accomplished during intervention

Bi-weekly homework assignments consisted of culturally appropriate activities, such as churchgoing and prayer, pleasant activities such as Sunday lunches with family and walking in the park with his children; and client self-monitoring of his mood, vegetative symptoms of
depression, and level of interaction with family and community.

Desired Outcomes

The primary goals in this study were (a) to ameliorate client's symptoms of depression, (b) to decrease isolation; and (c) to increase level of disclosure with his children and extended family regarding his AIDS diagnosis. The desired outcomes are operationally defined as follows:

a. Depression:

This goal was set up because of client's chief complaint of feeling sad, frequent crying spells, low level of energy, and lack of motivation to pursue meaningful activities.

The objective within this goal was to decrease client's level of depression. The stages of intervention for this goal were measured by:

- pre and post test to measure depression using the Beck depression inventory (BDI)
- client daily log given to client to monitor his vegetative signs of depression:
  a. quality of sleep (Likert scale: 1 [terrible], 5 [excellent])
b. appetite (Likert scale: 1 [very poor], 5 [excellent])
- mood (Likert scale: 1 [very happy] to 10 [suicidal])

b. Decrease client isolation:

This goal was set up because client felt alone, having nobody with whom to confide the psychological burden of his illness. As Macks identified, “people with AIDS are better able to live with their disease when they maintain or develop ties with supportive family, friends, and community members as well as with others who are living with the disease.” (1989, p. 15). Luiz’s family was not aware of his diagnosis. His wife worked full-time outside of their home; and two of his friends having died within the past year. In order to decrease my client’s level of isolation and improve community network for emotional support homework some assignments were given:
- attend weekly church mass and prayer groups
- attend volunteer training to become a “First Hand Speaker”
- help HIV/AIDS agencies to organize a “Latino HIV+ telephone tree”
- a verbal contract between the client and this intern in order to keep him motivated to attend therapy
sessions. This verbal contract stated that the client was free to discuss with me during each session what was working and what was not working in therapy to improve his quality of life.

The degree of accomplishment to these tasks were measured by:

- client self-reports
- community workers reports of client progress
- my observations
- number of times client canceled or did not show up for his appointments with me

c. Increase level of disclosure with family

The goal was to have client disclose AIDS diagnosis to family (his children and his siblings). This goal was set up because during intake the client presented a high level of discomfort due to keeping his illness a secret. The client felt that sharing his household with extended family without making them aware of his diagnosis was burdensome to himself and to his wife. He would like also to make his children cognizant of his chronic terminal illness. The intervention method used was:

- discuss with client potential consequences of disclosure
- support client in whichever decision he would make (disclosure vs. non-disclosure)

This goal was measured by:

- client self-reports
- wife's verbal report of client's level of comfort in disclosing—checked by this intern five times during intervention phase
- visiting nurse report of her observations during home visits to client—checked by me five times during intervention phase

Stages of Intervention and Recording Plan

The baseline of the client's depressive symptoms was determined by two sessions I had with the client prior to the intervention phase. The Beck Depression Inventory (BDI) was used as a pre-test to measure the client's level of depression before intervention began. The BDI was administered on the first session of the intervention phase.

The most important indicators of client's progress during intervention were (a) client's compliance with assigned homework, (b) number of times client showed up or canceled sessions with me and (c) visiting nurse and wife's reports of client's progress.
The Goal Attainment Scale was designed and explained in detail to the client. The client was carefully instructed to monitor his daily sleeping and eating patterns as well as his mood. The intention was to make the client aware of negative thought patterns in order to decrease initial level of depression.

Aside from client self records I kept a treatment diary with my observations of client's verbal and non-verbal depression cues as well as his visiting nurse's and his wife's observations of client throughout the ten sessions we met.

The Beck Depression Inventory

The Beck Depression Inventory (BDI) was designed to measure the severity of depression in adolescents and adults already diagnosed as depressed. The BDI has been used for the last twenty-five years and has been officially translated and tested into other languages, such as Spanish, Chinese, German, and French among others.

The BDI consists of 21 items with four options per item. It takes the average person 5 to 10 minutes to answer it. The reading level is estimated as fifth grade level with the test designed for ages 13 years and older.
Content, construct, concurrent and factorial validity studies are plentiful. The mean correlation for the concurrent validity studies ranged from .60 to .76. The content validity is substantiated by comparing the BDI to the criteria of the American Psychiatric Association's DSM of Mental Disorders. The BDI correlates with biological and somatological issues, suicidal behavior, alcoholism, adjustment and life crises.

The BDI has demographics correlates. Gender correlates with its scores; women have been found to have slightly high scores than men. Education attainment is negatively correlated to BDI scores. Non-white persons were at times found to score higher than white persons. Beck et al (1988) suggest that although the demographic correlates are statistically significant, they are probably more important for researchers to attend to than for clinicians.

BDI scores read as follows: score > than 25 indicates severe depression; score in the 16 to 24 range indicates moderate depression; score in the 10 to 15 range indicates mild depression; and score < than 10 indicates absence of depression. Please refer to appendix 1 for a
copy of the BDI in both the English and the Spanish language.

Research Design

The general type of research design used for this study is the single-subject design AB. It involves multiple formal and informal measurements of the behavior(s) of a single individual at different points in time prior to and during intervention planned to individual's targeted behavior(s). (Crowl, 1993, p. 222). Withdrawal technique will not be used due to limited time frame to conduct study.

Client Confidentiality

Following the NASW and the Natividad Medical Center Code of Ethics, this intern has changed the client's name to protect his confidentiality and has omitted the client's wife's name as well as of all of those persons directly or indirectly involved in this study.

NMC's Bioethics Committee, headed by Dr. Mark Tunzi, is aware of my study. A verbal approval was given to this student at a Bioethics Committee meeting which was attended by all of its members.
Results

Depression

As stated previously, L. had been presenting depressive symptoms since the time of his HIV+ diagnosis. He had sought neither counseling nor medication to reduce these symptoms prior to this intervention. My client was clear about the type of support he wanted from me.

Luiz’s thoughts regarding his depressive symptoms were linked to lack of a productive activity and unavailability of friends with whom to share his the psychosocial stress of his diagnosis. He consciously chose not to acknowledge the direct link between the terminal condition of his illness and his depression.

Results of the Formal Scale

Table 1 demonstrates the results of the BDI scale, which was administered in the beginning of March as a pre-test and again on April 12 as a post-test. L.’s initial score shows a severely depressed state. The post-test score showed an improvement to a mildly depressive state.
Table 1

<table>
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<tr>
<th>Result of Formal Scale</th>
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<tbody>
<tr>
<td>Scale</td>
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<tr>
<td>BDI</td>
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<table>
<thead>
<tr>
<th></th>
<th>Scale</th>
</tr>
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<tbody>
<tr>
<td>pre-test</td>
<td>31</td>
</tr>
<tr>
<td>post-test</td>
<td>24</td>
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Luiz was not compliant with the homework assignment of monitoring his daily mood, appetite, and sleep patterns. Figure 1 displays data gathered from a ten-session period where the client’s verbal report of depressive symptoms improvement was compared to my observations of the client’s non-verbal cues.

Insert Figure 1 about here

Decrease Client Isolation

Table 2 shows the number of times the client attended church events and the number of show/no show appointments with me.
Figure 1.

Client's Report vs Intern's Observation of Client's Mood

Baseline

client
intern
Table 2

Level of Attendance Church Events/Therapy Sessions

<table>
<thead>
<tr>
<th>Month</th>
<th>Feb.</th>
<th>March</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church Events</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Attended therapy Sessions</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Did not attend therapy</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The no-show appointments were not canceled prior to the time of visit. I had to call the client to reschedule his missed appointments. Luiz and I discussed reasons why he was unable to call me ahead of time. Evaluation of reasons for missed appointments as well as increased level of attendance to church events will be discussed later in this study.

Increase Level of Disclosure with Family

The third goal, to increase level of disclosure with family was never attained. In spite of many discussions to probe with my client potential consequences of HIV status disclosure with his family, he never felt ready to
do so. Weekly check-in with his wife and the visiting nurse showed no progress toward accomplishment of goal.

Discussion

Discussion of Homework Assignments

The non-compliance with the daily recording of the his mood variations as a homework assignment was difficult to confront in the therapeutic setting. Luiz gave excuses whenever I asked him to bring in his homework. Part of the difficulty for me lay in the assumption that the assignments were part of the intervention process in CBT. In this respect, CBT has not been effective because my client had great resistance toward accomplishing the daily tasks prescribed, i.e., self-monitoring of his mood, sleep and eating patterns. I attribute his lack of motivation in filling out the daily log to the relatively short time span we had to work together.

In spite of his non-compliant behavior regarding homework assignments, Luiz’s BDI scores showed a significant difference between the initial session with a BDI score of 31—indicating severe depression and the ending phase of intervention with a BDI score of 24—indicating moderate depression. He now seems to be able to identify and control some of the negative thought
processes, thereby reducing the severity of the depressive symptoms.

My client’s self-reports during the intervention sessions (as shown in figure 1) and my own impressions of his improvement varied slightly because I observed non-verbal cues that indicated an underlying depression or anger that my client was not ready to verbally admit in the therapeutic setting.

Church Attendance/Family recreational activities

Attendance at weekly mass increased significantly. Luiz had stopped attending church services nearly two years ago, but with the appropriate assurance from this intern he started taking his children to the Sunday mass and found it not to be as frightening as he had imagined having old acquaintances question him about his health. Again, identification of the negative thought process, which is part of the CBT intervention method, ("I cannot see my old acquaintances now. I am sick and they will be questioning me ") and the paradigm shift to a reality-based cognition of negative thoughts ("I can answer with a brief phrase", "I do not need to explain myself to others", "I am going to the church to exercise my spirituality") were the primary motivational factors of Luiz’s increased church attendance.
Family gatherings are difficult for Luiz due to his health. It appears to me that Luiz experiences a higher level of discomfort around his extended family than around acquaintances from the church and the community where he resides. Although we discussed this matter several times during intervention, he continues to believe that he needs to always be a model family member. Therefore he prefers not to pursue the avenue of increasing recreational activities with his family.

Death and Dying Issues

During our working sessions we concluded that he was not ready to deal with death and dying issues because he felt depressed whenever he thought about it. My client communicated his conviction that to talk about death is very cruel to those approaching their own demise. It is salient that when questioned about his feelings regarding death and dying Luiz's answer to this intern was a message that could be translated into, "Do not talk about death with me because if you do so, you are being cruel."

It is the experience of this intern, who grew up in Latin America, that even when one is on his/her death bed no one talks about the subject in the presence of the dying person. Relatives and friends encourage the dying
to get better, and a terminal diagnosis is never disclosed to the person.

HIV status disclosure with family

My client never became emotionally strong or available to speak to his family, especially his children, about his HIV diagnosis. Luiz communicated feelings of insecurity and subdued anger when asked to elaborate his feelings of anxiety.

Toward the end of the intervention phase this intern discovered, via a community worker, that the client might have (and most probably) contracted the HIV virus through homosexual activities. It then became clear to this intern that the Luiz who presented himself in my office had many layers protecting his ego; layers which may take many more sessions to uncover, or may never be uncovered.

Application of Concepts From Literature Review

My client was provided with an ethnically and linguistically matched social worker, namely this intern. However, this intern was never able to garner the rapport necessary to allow for his disclosure of an agenda of homosexual preference. This lack of rapport may be due to (a) the client had an ethnically and linguistically matched therapist but from the opposite sex, aggravated by the fact that this intern is a female Latina or (b) the
client is using denial as a coping mechanism to avoid dealing with his issues of homosexuality and HIV.

In regards to CBT there was success and failure. The success was accomplished via client level of attendance to both the therapy sessions and to church. Latinos have an extremely high dropout rate from therapy, but with CBT both the client and I were able to keep the stages of intervention focused on the presenting problems and the paradigm shift of the negative thought processes. The CBT intervention method failed with regards to the non-accomplished homework assignments, specifically the client's self-monitoring of his mood.

Conclusion

Despite the failure of some of the CBT techniques, overall the CBT intervention appears to have been successful. Luiz is a client who will probably need to be followed up regularly by a therapist throughout the course of his entire AIDS journey. Perhaps he will be ready to let go of the layers which he uses to protect himself and open up to the pain buried beneath it all. But perhaps he will never be ready to do so.

My suggestion to this agency is to keep an ethnically and linguistically matched social worker/therapist available in order to meet the byopsychosocial needs of
the Latino population in this community who are infected with the HIV virus.
APPENDIX 1

BECK DEPRESSION INVENTORY

Name ____________________ Date __

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.
BECK DEPRESSION INVENTORY

(continued)

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry anymore than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.
BECK DEPRESSION INVENTORY
(continued)

15. 0 I can work about as well as before.
   1 It takes an extra effort to get started at doing something.
   2 I have to push myself very hard to do anything.
   3 I can't do any work at all.

16. 0 I can sleep as well as usual.
   1 I don't sleep as well as I used to.
   2 I wake up 1–2 hours earlier than usual and find it hard to get back to sleep.
   3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
   1 I get tired more easily than I used to.
   2 I get tired from doing almost anything.
   3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
   1 My appetite is not as good as it used to be.
   2 My appetite is much worse now.
   3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any lately.
   1 I have lost more than 5 pounds.
   2 I have lost more than 10 pounds.
   3 I have lost more than 15 pounds.
   I am purposely trying to lose weight by eating less.
   Yes _______ No _______

20. 0 I am no more worried about my health than usual.
   1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
   2 I am very worried about physical problems and it's hard to think of much else.
   3 I am so worried about my physical problems, that I cannot think about anything else.
21. 0 I have not noticed any recent change in my interest in sex.
   1 I am less interested in sex than I used to be.
   2 I am much less interested in sex now.
   3 I have lost interest in sex completely.


Notes

This is probably the most widely used depression measure. Revised in 1978, it has been validated as a self-administered, as well as an interviewer-administered, instrument. The depression score is the sum of the weighted responses of items 1 through 21. (The “weight” is the numeral adjacent to each statement.) A score of 4 or less indicates absence or a minimal degree of depression.
Nombre ___________________ Fecha ___________________

Nivel de educación __________

Cuanto inglés habla usted?

- nada
- un poco
- bastante bien
- muy bien

Estaría usted dispuesto(a) a pasar una hora discutiendo este cuestionario con nosotros cuando le sea conveniente?

sí ... no ...

En este cuestionario hay varios grupos de frases. Lea cada grupo de frases con cuidado y escoja la frase que mejor describe la manera en que usted se ha estado sintiendo esta última semana incluyendo el día de hoy. Marque el número de la frase que ha escogido. Puede marcar más de una frase si siente que hay más de una que describe como se siente. Lea todas las oraciones en cada grupo antes de escoger. Si no entiende alguna palabra o frase, márguela en rojo.

1. 0 No me siento triste.
   1 Me siento triste.
   2 Me siento triste todo el tiempo y no lo puedo evitar.
   3 Me siento tan infeliz y triste que ya no aguanto más.

2. 0 No me siento desanimado(a) al pensar en el futuro.
   1 Me siento desanimado(a) al pensar en el futuro.
   2 Siento que no tengo razón porque mirar hacia el futuro.
   3 No siento que hay esperanzas para el futuro; pienso que las cosas no pueden mejor.

3. 0 No me siento como un fracaso.
   1 Siento que he fracasado más de lo común.
   2 Cuando repaso mi vida, solo veo fracasos.
   3 Siento que soy todo un fracaso como persona.

4. 0 Siento la misma satisfacción por las cosas como antes.
   1 Las cosas ya no me satisfacen como antes.
   2 Ya nada me satisface realmente.
   3 Estoy insatisfecho(a) y aburrido(a) con todo.

5. 0 No me siento culpable.
   1 Me siento culpable frecuentemente.
   2 Me siento culpable casi todo el tiempo.
   3 Me siento culpable todo el tiempo.
0. 0 No siento que me estén castigando.
1 Siento que quizás me están castigando.
2 Estoy seguro(a) de que me van a castigar.
3 Siento que me están castigando.

7. 0 No me siento decepcionado(a) conmigo mismo(a).
1 Me siento decepcionado(a) conmigo mismo(a).
2 Me repugna mi persona.
3 Me odio.

8. 0 No siento que soy peor que los demás.
1 Me critico por mis faltas y mis errores.
2 Me culpo todo el tiempo por mis faltas.
3 Me culpo siempre por todo lo malo que pasa.

9. 0 No pienso en suicidarme.
1 A veces pienso en suicidarme pero nunca lo haría.
2 Quisiera suicidarme.
3 Me mataría si pudiera.

10. 0 No lloro más de lo normal.
1 Lloro más que antes.
2 Ahora lloro todo el tiempo.
3 Antes podía llorar, pero ahora, aunque quiera, ya no puedo.

11. 0 Las cosas no me irritan más que antes.
1 Las cosas me irritan un poco más de lo común.
2 Paso irritado(a) o molesto(a) casi todo el tiempo.
3 Paso irritado(a) todo el tiempo.

12. 0 No he perdido el interés en otra gente.
1 Estoy menos interesado en otra gente que antes.
2 He perdido casi todo el interés en otra gente.
3 He perdido todo el interés en otra gente.

13. 0 Tomo decisiones igual que antes.
1 Ahora me tardo más tiempo en tomar decisiones.
2 Ahora me cuesta más tomar decisiones.
3 Ya no puedo tomar decisiones.

14. 0 Siento que me veo igual que siempre.
1 Me preocupa que me veo más viejo(a) y menos atractivo(a).
2 Siento que han habido cambios permanentes en mi apariencia que me hacen ver menos atractivo(a).
3 Creo que me veo feo(a).

15. 0 Puedo trabajar igual que antes.
1 Me cuesta más esfuerzo empezar a hacer cualquier cosa.
2 Me tengo que esforzar mucho para hacer cualquier cosa.
3 No puedo hacer ningún trabajo.
16. 0 Duermo igual que siempre.
1 No duermo tan bien como antes.
2 Me despierto una o dos horas antes de tiempo y me cuesta volver a dormir.
3 Me despierto varias horas antes de tiempo y no me puedo volver a dormir.

17. 0 No me siento más cansado(a) de lo normal.
1 Me canso más fácilmente que antes.
2 Me canso al hacer cualquier cosa.
3 Estoy demasiado cansado(a) para hacer cualquier cosa.

18. 0 Mi apetito está igual que siempre.
1 Mi apetito no está tan bueno como antes.
2 Mi apetito ahora está peor.
3 Ya no tengo nada de apetito.

19. 0 Mi peso se ha mantenido igual últimamente.
1 He perdido más de 5 libras.
2 He perdido más de 10 libras.
3 He perdido más de 15 libras.

20. 0 No me preocupa mi salud más de lo usual.
1 Me preocupan varios problemas físicos como dolores de varios tipos en varias partes del cuerpo o estreñimiento.
2 Estoy muy preocupado(a) por mis problemas físicos y se me hace difícil pensar en algo más.
3 Estoy tan preocupado(a) por mis problemas físicos que no puedo pensar en nada más.

21. 0 No he notado ningún cambio en mi interés por el sexo.
1 Tengo menos interés en el sexo que antes.
2 Ahora tengo mucho menos interés en el sexo que antes.
3 He perdido completamente el interés en el sexo.
Bibliography


Critical Care America (1992). Cytomegalovirus (CMV) [available at the Natividad Immunology Division Outpatient--NIDO, Salinas, CA].


Ward, M. (1993). Program evaluation of the social work department at natividad medical center, a research project presented to the College of Social Work at San José State University, San José, CA.