



Positively Aware

The Journal of Test Positive Aware Network

Putting the Pieces Together

- Depression
- Isolation
- Adherence
- Complementary Therapy

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November / December 2001 • Volume 12 Number 6

*Dedicated to the memories of those individuals lost on
September 11, 2001*

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 **UNITED**

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Editor's Note

The Past, The Present and The Future



I'm tired from "tops" who believe they can't contract HIV. I'm tired from "bottoms" who continue to roll the dice. I'm tired from irresponsible HIV-positive barebackers. I'm tired from irresponsible HIV-negative barebackers. I'm tired of the belief that barebackers are always gay men. I'm tired, because it ain't true. I'm tired of condoms. I'm tired for everyone waiting for the results to come back from an HIV test. I'm tired.

I'm tired for intravenous drug users who share contaminated needles. I'm tired for men who refuse to use a condom. I'm tired for the women and men forced to have sex with men who refuse to use a condom. I'm tired for sex workers who can't use a condom. I'm tired for young people who don't have sex education. I'm tired of prevention that doesn't seem to work. I'm tired.

I'm tired from individuals who promote conspiracy rather than care. I'm tired from those who don't believe in re-infection. I'm tired from medications that make people sick rather than well. I'm tired from people who could, but don't adhere. I'm tired for everyone in America, Africa, Asia and Eastern Europe who would adhere, but can't. I'm tired from a system that profits from homelessness, hunger and mental illnesses. I'm tired from illiteracy. I'm tired.

I'm tired from some that believe women and children, the incarcerated and drug users don't deserve our attention. I'm tired because some believe that gay men don't deserve our attention. I'm tired from blacks that blame whites. I'm tired from whites that blame blacks. I'm tired from men who blame women. I'm tired from women who blame men. I'm tired from MSMs, SAMs, "trade" and "on the down-low." I'm tired of categories. I'm tired.

I'm tired of incompetent negatives. I'm tired of unqualified positives. I'm tired of bureaucracy. I'm

tired of cynics. I'm tired of the hypocrites. I'm tired of the dishonesty. I'm tired because I don't know what to do. I'm tired of being stressed, depressed, and overwhelmed. I'm tired because I don't have time to do more. I'm tired because I don't feel like doing more. I'm tired.

I'm tired from Slavery. I'm tired from Emancipation. I'm tired from Jim Crow. I'm tired from Civil Rights, Women's Rights, Gay/Lesbian Rights and now Healthcare Rights. I'm tired from prejudice and hatred. I'm tired from ignorance. I'm tired that mistakes from the past continue to be repeated. I'm tired.

I'm tired from John F. Kennedy, Martin Luther King, Jr., Robert Kennedy and my father. I'm tired from the events of September 11, 2001. I'm tired for this nation. I'm tired for this world. I'm tired for everyone who has ever lost someone to a senseless act of violence. I'm tired for everyone who will lose a loved one in the coming days, weeks, and months.

I'm tired of grieving. I'm tired of remembering. I'm tired of wondering. I'm tired that I still grieve the death of Antonio, who died 15 years ago on October 8th. I'm tired of marking the anniversary of his death. I'm tired of wondering of what might have been. I'm tired of hoping. I'm tired of coping. I'm tired of dates that always remind me of how tired I am. I'm tired of wondering what's next, who's next. I'm tired of this road.

I'm just tired.

A handwritten signature in black ink that reads "Charles E. Clifton". The signature is written in a cursive, flowing style.

Charles E. Clifton
Editor

Send comments and reactions to
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Test Positive Aware Network
1258 W. Belmont Ave.
Chicago, IL 60657-3292

phone: (773) 404-8726
fax: (773) 404-1040
e-mail: tpanet@aol.com
http://www.tpan.com

Editor **CHARLES E. CLIFTON**

Associate Editor **ENID VÁZQUEZ**

Advertising and
Distribution
Manager/

Editorial Assistant **JEFF BERRY**

National Advertising
Representative **RIVENDALL MARKETING**
212-242-6863

Executive Director **DENNIS HARTKE**

Business Director **RICK BEJLOVEC**

Contributing
Reporters
MICHAEL BARNETT
DANIEL S. BERGER, M.D.
ANTHONY CLARK
LAURA JONES
JIM PICKETT
GLEN PIETRANDONI, R. PH.
KEITH WALTRIP, LPC

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Continued Giving Honors Their Memory



As we wrestle with the horrendous events of September 11th, I join the thousands of other writers, editors, columnists, talk-show participants, and everyday Americans asking you to help the victims. Your help, whether in the form of a donation to one of the many relief funds, or by some other means, is a step towards recovery—for them and for you.

The world knows how generous we can be. We have shown it countless times in the aftermath of natural disasters around the globe. We have shown it to ourselves, to our neighbors, to other Americans each time a disaster or calamity has struck. As Executive Director of an HIV service organization, I see it on a daily basis. I see it in the donation of money. I see it in the donation of time. I see it in the letters of support we receive.

In the aftermath of September 11th, there is honest and sincere confusion as to the proper, respectful course of action other charities and causes should take. Should fundraising be halted out of respect for the victims and for the relief funds set up to assist them? Should we stop advocating for causes which just weeks ago seemed so important? Should we “tone-down” requests for public support?

It seems to me that these discussions come in part from a viewpoint that assumes there is a fixed amount of resources, that the caring and giving of Americans is limited and finite; that there is only so many hours to volunteer, only so much money to give. While in an absolute sense this is true, I believe that such limits are very large and that we as a nation, and many of us as individuals, are not at these limits. We Americans are often at our best when the need is the greatest. Let us, a people brought together by tragedy, rise to this challenge.

Before September 11th there were thousands of charities helping millions of Americans deal with illness, tragedy, and injustice. Before September 11th, there were organizations helping women to cope with breast cancer; helping children, women, and men live with diabetes; helping survivors of domestic violence; helping the homeless; and yes, helping people living with HIV and AIDS. These causes still need your assistance. They need the many hours of volunteer time crucial for delivery of services. They need your continued financial support.

The memory of the thousands killed on September 11th needs to be honored. Memorial funds can do this. But so too can your support of your favorite causes. I suspect that among those who died, there was at least one person who supported the same causes you do. Your continued help can be a form of honoring their lives and efforts. And it can help you deal with this enormous tragedy.

Honor their memory while helping others. Assist the survivors, while continuing to help the causes you supported before. Support government funding of relief efforts while also reminding government of its other funding obligations. Let us continue to be the generous nation that sets the standard for others to follow. Let us support the victims of this horrific event while not forgetting those we supported before.

A handwritten signature in black ink that reads "Dennis Hartke". The signature is written in a cursive, slightly slanted style.

Dennis Hartke
Executive Director

Thoughts, comments, reactions? Write me at tpaned@aol.com

Readers' Forum

Positively Aware will treat all communications (letters, faxes, e-mail, etc.) as letters to the editor unless otherwise instructed. We reserve the right to edit for length, style or clarity.

Write to: Positively Aware,
1258 W. Belmont Ave.,
Chicago, IL 60657-3292
Fax: (773) 404-1040
E-mail: posaware@aol.com

TIMES ARE CHANGING

The information that *Positively Aware* has provided me over the years has probably saved both my partner and my life many times over. I will always be grateful. I know that HIV has no preference for any race, religion, ethnic group, etc., and I may not know about other parts of the U.S., but most of your core readers here in Houston are responsible, not “barebacking.” Most are not prisoners, pregnant or incarcerated women, women incest survivors, women with self-esteem problems or IV drug users. In *The Buzz*, Dem Bones? Is this a typo for Them Bones? Or should I be reading up on Ebonics to understand the very obvious cultural differences that have taken place in your publication lately?

What I’m trying to say is, what happened to helping us average black, white, Hispanic Joes out there who are the real core readers of *Positively Aware*? I realize these problems exist and education is essential, but they aren’t seeking *Positively Aware*’s help. We are! Help those of us who can read. I see so many idiots who have no clue what medication they are taking. All they can tell the pharmacy is that it’s a yellow or blue pill. Cut the political crap.

Name Withheld,
Houston

Editor’s Note: In fact, we frequently need to edit letters from prisoners into plain English because their knowledge is so highly technical. Many are sophisticated readers who are obviously obtaining HIV information from a wide variety of sources, including medical journals. There was only one instance of “barebacking” (sex without a condom) mentioned in Positively Aware, and the partners were both

HIV-positive and they quickly switched to condoms. Writing about pregnancy has been near and dear to my heart because I do not expect general newspaper and magazines to provide the details HIV-positive women need to hear. Our magazine is written specifically for ALL positive people, so I provide those many details as they are discovered. I also find some positive former drug-users who read everything they can about HIV, and some HIV-positive white, middle-class gay men who read very little medical information about the disease. That was a big lesson for this writer—don’t make assumptions. Finally, Buzz columnist Dr. Daniel Berger took “Dem Bones” from the title of a song. I was thrilled to see him write a catchy phrase for his column, since doctors can be so boring.—EV

It must be true. The more things change, the more they stay the same. I am growing increasingly disgusted with the HIV-positive gay white men I encounter who feel compelled to express their “retro” views of *Positively Aware*. As a gay white male and a former director of programs at Test Positive Aware Network (parent organization of *Positively Aware*), some who I encounter—when advised of said facts—feel compelled to lament the recent and current—God willing future—editorial direction, content and focus of *Positively Aware*. “Why have they focused so much attention on prisoners?” “Why so much time covering women and children?” “Why so many articles on Africans—and African Americans—living with HIV/AIDS?” “What happened to covering the issues affecting core *Positively Aware* readers?” To all I say: “Because!” Because *Positively Aware* is continuing the long held—and demonstrated—commitment to informing, empowering and educating those

most in need of the same. Because it is right to re-focus and alter course as the need arises. I ask: “Why in God’s name aren’t all of us connected, informed and empowered ‘longtimers’ doing the same?” Why aren’t we all looking back, left and right, up and down to make sure we have left no one—no one—behind in a cloud of fear, confusion and need? Bravo to *Positively Aware*, for holding fast and true to the notion of education, empowerment and advocacy.

JP Womble,
Fort Lauderdale

TREATMENT INTERRUPTIONS

I wanted to comment on a few confusing points in Stephen Fallon’s “Sloppy Treatment Impulses” (September/October issue). By the “newly infected” he is probably referring to preliminary results from studies of treatment interruption in people who began HAART [highly active anti-retroviral therapy] during their acute infection. These studies are the only ones so far to show any promising immune-enhancing benefit from STIs [structured treatment interruptions]. However, they should be clearly distinguished from studies seeking immune control from STIs in people with chronic infection. Those have produced spotty data at best. There also seems to be some confusion about when the maximum impact of new meds can be enjoyed. HAART is capable of suppressing virus at any time after infection, although the recent trend is to delay starting therapy until disease progression has become evident by lowered CD4 counts. It could be argued that the maximum impact of HAART is felt when symptoms have already occurred and one is pulled back from the brink, but that’s too long to wait. Treating during acute

infection is part of an experimental technique to improve immune control after treatment is stopped; few would suggest starting lifetime therapy at that point.

The information about the National Institutes of Health trials of SIT, or structured intermittent therapy, is also confusing. It should be made clear that the NIH is studying SIT to see if virus can be controlled with less toxicity and fewer resources—enhancing immune control is not part of the hypothesis. The latest news from Anthony Fauci is that drug resistance had been observed with the month-on/month-off schedule, but that those on the 7 day on/off cycle have sustained viral suppression while showing improvements in blood lipid levels. These results are promising and should be confirmed with larger studies.

Oddly, despite previous warnings about stopping meds, the article concludes by advising readers to “If you want to reap those benefits, be sure that you stage a structured treatment interruption.” Better advice might be to suggest that readers who are considering stopping treatment for any reason—fatigue, toxicity, stress, or because they think they started too soon—should discuss it with their doctor and consider enrolling in a clinical trial. The message that STIs are experimental and should not be undertaken lightly is reasonable. But this piece mixes up holidays with interrupted and intermittent therapy to warn readers away from the notion altogether.

Bob Huff,
Editor, GMHC Treatment Issues,
New York City

Editor's Note: See “Stopping Therapy” in News Briefs in this issue.

FROM A POSITIVE EX-OFFENDER

I was a prisoner with HIV in New York from 1985 to 1988. The care I received was excellent. In 1985/86 I was incarcerated in Albion Correctional Facility. Our staff physician was Dr. Fernandez. His treatment of me was outstanding. He greeted everyone equally with a “How much more time ya got?” I was allowed to go to the clinic whenever I wanted. He prescribed drugs that I needed, and not just for life-threatening illnesses. We had one inmate with AIDS at that time. Yes, we all knew, but he was treated with respect and concern. He was able to eat extra portions of food and have Ensure [dietary sup-

plement] or whatever he needed. The food here was top notch. In 1986 I was transferred to Mcgreggar Correctional Facility. The food was better than what I used to eat on the outside. We also had great medical care even though the doctors rotated. I was diagnosed with shingles and was quarantined. However, I was offered an HIV test, which came back positive, and after that was offered counseling and the drug available at that time, AZT (Retrovir). Here we had adequate medical care and support groups under the direction of Fr. Peter Young, a legend in the capital region. I was treated with the utmost respect by the prison staff and correctional officers. After my quarantine everyone was aware of my medical condition and treated me no differently—from the staff to my fellow inmates. Although I was discriminated against with regard to employment while there, I attributed this to the ignorance of the lay people at the warehouse where I worked and not to the prison staff or my fellow inmates. All in all I feel that New York has responded well to the epidemic and I thank their programs for teaching me how to live a clean, safe and fruitful life. I hope that all the correctional facilities can live up to the high standards set by Dr. Fernandez and Fr. Young. Thank you for printing a positive piece.

Duke 85C480 (full name withheld),
via the Internet

PRISON LETTER

Your July/August issue was one of the best I've read yet on HIV/AIDS in prison. While it's still true that at many correctional centers (as well as prisons) many inmates are called on to go to the medical units to receive their meds, here at Western Illinois we are fortunate to have Deborah Fuqua, R.N., C.C.H.P. and health care administrator, along with Paula Flesner, L.P.N. and high-risk nurse, as well as Dr. Judith Terrell, in our corner. Through many talks with them, they felt compassion and the need for change, and we now have our meds brought to us and are allowed to keep the bulk of our medicines in our cell. I've also been for nine years the prison peer educator who has spoken to thousands of inmates on prevention. We're not (as Mr. Larry Harris stated) “double-damned.” We educate each other and have a loud voice when it comes to choosing a regimen that works for us and our bodies. *Positively Aware, POZ, AIDS News* and many

other HIV/AIDS information services help us to know how to talk to our health care staff and doctors and tell (or ask) what's new that we can receive. Like Dr. William Rankin mentioned, many inmates cry “wolf” and it's an art to really know what one needs and has to have. We do (in my small opinion) get better care sometimes than people on the outside. We're sent to some of the best specialists out there.

Kenneth W. Dorsey, #B12192,
P.O. Box 2000,
Mt. Sterling, IL 62353

FACIAL WASTING

The following was among dozens of e-mails sent to The Buzz columnist Dr. Dan Berger.

I am writing with great interest in response to your article regarding poly lactic acid (New-Fill) in the Sept./Oct. issue. I am a 38-year-old female who was diagnosed with HIV in 1995. I have been suffering from lipodystrophy and facial atrophy for about four years. I have been taking human growth hormone for the past three years, with minimal results. I would certainly appreciate any information you might be able to provide, including clinical trials and use in women. This is by far the most promising thing I've heard regarding treatment for facial atrophy.

Thanks for taking the time to research and write this article. With a T-cell count above 600 and a manageable viral load, I am by most accounts a healthy 33-year-old guy. But when I look into the mirror I often feel that my facial features belie my good health, so I was very encouraged by your article. The fact that I live in San Diego made it even more encouraging. I have tried calling the phone number of Dr. Jorge Tagle in Tijuana, 011-526-681-3626, but could not get an answer. Can you confirm that number? I am very eager to find out more on this procedure and whether I can benefit from it. I have been waiting for news like this for a long time.

Dr. Berger responds: Thanks for your kind words. Many individuals have e-mailed me with similar comments. It's especially gratifying to provide so many with the option to a problem that has been so frustrating. Many individuals have worked so hard at maintaining their health; their facial representation has not allowed feeling good about themselves. The number is correct, but know that the office closes for a siesta during mid-afternoon. ☪

by Enid Vázquez



NEW HIV DRUG

A new HIV drug should be in the pharmacy by the time you read this. Viread (generic name tenofovir) is a one 300-mg tablet taken once a day. It's from a new HIV drug class called nucleotide (not nucleoside) reverse transcriptase inhibitors. It does not get processed by the body's CYP450 system, which breaks down drugs in the liver, so it should not add to the liver burden of other HIV meds. Doctors and patients report that it's extremely well-tolerated (with exceptions, of course). It also has activity against hepatitis B, but no studies for this use have been reported. Bone toxicity was seen in animal studies. Viread should be taken with food, so unfortunately, it cannot be taken at the same time the only nucleoside analogue on the market that can be taken once-a-day, Videx (The nukes are included in the vast majority of HIV drug combinations). Although no serious kidney toxicities were reported with Viread (as was seen with an earlier drug from the same company), it was not allowed to be taken with nephrotoxic drugs during the manufacturer's small compassionate access program. These drugs include Crixivan, Viracept, Ziagen, hydroxyurea, Zovirax, Cytovene and Mepron. For more information, see the HIV Drug Guide at www.tpan.com or call 1-800-GILEAD5 (445-3235). Visit www.gilead.com.

40 PERCENT DRUG RESISTANCE?

University of California researchers estimate that in four years, 42% of people with HIV in San Francisco will have some antiviral drug resistance. HIV medications start losing their power against the virus when the pills aren't taken correctly. Therapy options then begin to decrease, although new meds on the horizon may help take up the slack. The HIV drug combinations on the market to date are notoriously unforgiving of lapses in correct dosing. The researchers published their report in the September issue of *Nature Medicine*. They also estimated that a "low" 16% of newly infected

people will have HIV with pre-existing resistance to meds. That's one out of six folks with troubled drug options from the get-go.

HIV "SUPERBUG"?

Meanwhile, well-known HIV researcher Julio Montaner of Vancouver reported finding two newly-infected patients with HIV that had resistance to all three HIV drug classes on the market. (Resistance to at least one of the drug classes is somewhat common among newly infected people.) Of the few documented people with resistance to all three classes, most had an HIV that had been weakened during its successful fight to develop resistance to the meds. These two people, however, went from having no symptoms to very weakened immune systems within months, Montaner reported. Montaner and Dr. John Mellors of the U.S. co-authored an editorial in the *New England Journal of Medicine* discussing this problem. They urged pharmaceutical companies to be flexible in allowing HIV patients to use experimental drugs. Currently, most trials will only allow one experimental drug to be part of a study combination, in order to show whether that drug has an effect. Benefit would be harder to prove if two or more experimental drugs are being used.

WOMEN'S BODY CHANGES

Italian researchers reported finding more body changes in women than men on HIV therapy. In fact, when looking at various factors such as time on therapy, age, and viral load, the greatest risk for developing body changes was being a woman. Women were twice as likely as men to have changes. HIV medications have been associated with bodily changes lumped under the term "lipodystrophy" (which means abnormal redistribution of fat). These changes include increased triglyceride and cholesterol levels, as well as body changes such as loss of facial fat leading to a gaunt look, increased breast size in both men and women and abnor-

mally large abdomens. The researchers reported on 2,258 people with HIV, about a third of them women. In all, body changes were found in 30% of the total group. The findings were reported at the first Conference on HIV Pathogenesis and Treatment, held by the International AIDS Society in Buenos Aires in July.



HIV DRUG PRICE IN BRAZIL

Brazil succeeded in dropping the price of the HIV protease inhibitor Viracept (nel-finavir) by 40%. The country's law ("compulsory license") allows Brazil to produce generic versions of HIV medications if price negotiations are not successful with the companies holding patents to the drugs. Brazilian officials estimated that the country would have saved 40% on the cost of providing the drug to its people had it produced a generic version. The pharmaceutical company Roche holds the patent for Viracept in Brazil, although Agouron Pharmaceuticals does in the United States. Agouron is now part of the pharmaceutical giant Pfizer. See <http://ww2.aegis.org/news/ap/2001/AP010901.html>.

SIDE EFFECTS MANAGEMENT

The HIV Treatment Bulletin in London has an excellent guide to the side effects of HIV treatment, and how to deal with them. Visit www.i-base.org.uk/publications/side/

con.html. However, notice that the British sometimes have different names for their medicines. Check with your healthcare providers.

ACTIVISTS SUE SOUTH AFRICA

The South African activist group Treatment Action Campaign has sued the country's health minister and nine provincial health ministers in an effort to force them to provide Viramune (nevirapine) for the prevention of HIV infection from mothers to infants. Three doses used at the time of labor and birth has been proven to effectively and safely prevent transmission, for very little cost. The studies making this determination included a large clinical trial reported on by a Johannesburg pediatrician at the International AIDS Conference held in South Africa last year, but the government continues to raise concerns over possible toxicity and the development of resistance to Viramune during three perinatal doses. HIV specialists around the world have overwhelmingly dismissed both of

these concerns. TAC was joined in its lawsuit by the Children's Rights Centre and a pediatrician from the South African hospital that participated in the trial presented at the world conference.

MAGIC JOHNSON SHINES...

...in a cover story in the August 20 issue of *Sports Illustrated*, 10 years after his public announcement that he has HIV. The magazine reported that Johnson has an undetectable viral load and normal T-cell count. Ten years ago, Johnson told the magazine that he "was going to beat the disease." This year, he was quoted as saying, "I got turned on when people said, 'It's all over for Magic.' I wanted to show them I wasn't going away." And yes, he still gets in a lot of exercise.

CONDOMS ARE GOOD

In light of a recent report on condoms that caused confusion about their effectiveness against sexually transmitted diseases (STDs), UNAIDS did an outstanding job of

rushing to press with clarifications on issues raised in the report. The analysis of condom studies was put together by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention in the U.S., along with the World Health Organization. They found that condoms are effective against transmission of HIV for both men and women, and gonorrhea in men, but perhaps not as effective against other STIs, such as human papilloma virus (HPV), which can cause cancer.

According to a press release issued by UNAIDS, "In news items following the [report], there appear to have been misunderstandings about the difference between 'lack of evidence of effectiveness' and a 'lack of effectiveness.' Many reasons exist for the current lack of evidence: studies to establish reliably the effectiveness of condoms against specific STIs can be very difficult to conduct in a scientifically valid and ethical manner. Nonetheless, additional studies are already under way and more are planned. Until these or other studies providing additional reliable evidence can be completed, the effectiveness of condoms against some specific STIs will remain a matter of debate."

UNAIDS went on to stress that, "The report underscores the effectiveness of condoms against HIV and nothing in it challenges WHO and the UNAIDS Secretariat's conviction about the importance of condoms in HIV prevention programmes. On the contrary, unclear presentation of the report's conclusions by some commentators may distract from the vital effort to reduce risk of HIV infection through the use of condoms. It is imperative to continue promoting condoms for HIV prevention while undertaking further studies on their effectiveness for prevention of other STIs." In California, state legislators dropped efforts to pass a law that would put a warning statement on condom packages stating that the product may not protect against HPV, listening to critics who explained that such a statement could make it difficult for people to be clear that condoms do protect against HIV. To read the entire UNAIDS statement, visit www.unaids.org/whatsnew/press/eng/pres-sarc01/NOTEcondoms_160801.htm. To see the condom report, visit www.niaid.nih.gov/dmid/stds/condomreport.pdf.

LUBES MAY HELP PREVENT TRANSMISSION

Researchers looking at whether over-the-counter products could help protect against HIV found three lubricants that significantly and quickly lowered the reproduction of the virus from infected cells (by more than 1,000 times): Astroglide, Silken Secret, and Vagisil. Moreover, these products did not irritate mucosal membranes, a process that may increase the risk of infection by creating breaks in flesh. Only clinical studies will show whether all of this can actually lead to a decreased risk of transmission—and that would take years. But meantime, would throwing some Astroglide into sexual encounters hurt? Probably not. The University of Texas Medical Branch at Galveston (UTMB) researchers published their report in the July 20 issue of *AIDS Research and Human Retroviruses*.

ORAL SEX SAFE?

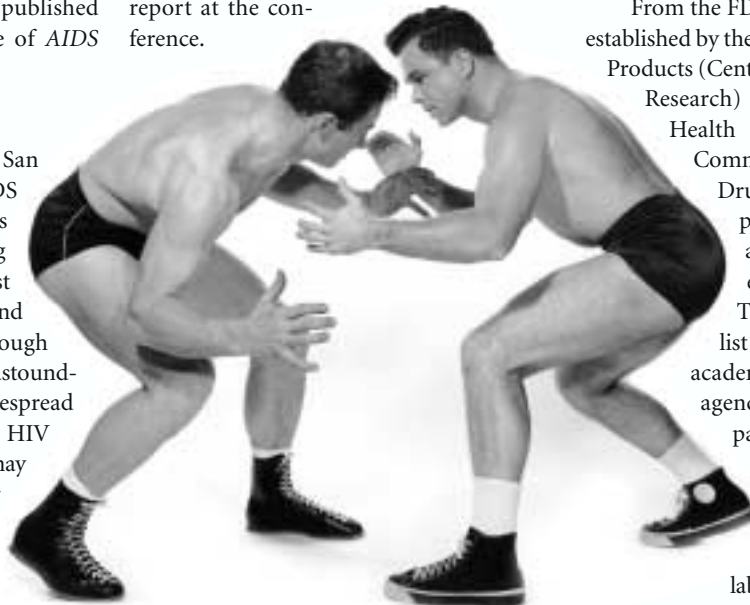
University of California at San Francisco Center for AIDS Prevention Studies researchers reported that the risk of getting HIV from giving a blowjob is just about zero. A report last year found that the risk of transmission through oral sex between men was 8%, an astoundingly high number given the widespread belief of a near 100% safety from HIV through oral sex. (Other diseases may be transmitted, and are especially problematic to people with HIV.) The findings, based on 198 people, were presented at the Second National HIV Prevention Conference, held by the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta in August. The researchers reminded people that there is still a risk, especially as the individual's number of oral contacts increases. Visit <http://hivinsite.ucsf.edu>.

HIV UNDETECTED

Also at the prevention conference, researchers from Kaiser Permanente reported that an amazing 40% of people they surveyed had already progressed to AIDS by the time their HIV infection was discovered. This was despite the fact that they had risk factors or symptoms associated with HIV. The results came from 19,000 people in 12 states. In a press release, Leo Hurley, one of the authors of the study, says, "What this tells us is that patients and doctors need to be

more aware of the possibility of HIV infection and to test more routinely for it. We all need to assess our level of risk on an ongoing basis and seek testing to be sure of our status. Early detection can make better treatment outcomes possible and can reduce the spread of the virus."

Another Kaiser report found that a pilot program offering test results and counseling over the telephone improved the rate of people following up on the results of their HIV test, another big problem in detecting infection. Testing programs report that many people fail to return in person for HIV test results—one of the barriers to detecting HIV that was documented by the Kaiser organization in yet another report at the conference.



FIGHTING INFECTION

Also at the conference, New York City officials reported that syringe exchange programs for drug users was "key" to dramatically slowing the rate of infection for that population. They reported a drop from 50% in 1990 to 20% in 2000. And the CDC itself noted that numbers of AIDS cases and AIDS-related deaths are stabilizing—which signals an end to dramatic drops seen since the mid-1990s. The CDC also released a study showing that a third of the young gay or bisexual men they surveyed said they had unprotected anal sex with a man within the previous three months, and nearly one in five surveyed also had sex with a woman. The CDC surveyed 2,600 young men ages 15 to 25 in 13 cities across the country.

AIDS AND DEPRESSION

The HIV Cost and Services Utilization Study reports that half of the nearly 3,000 people with AIDS whom they surveyed have psychiatric symptoms such as depression and anxiety. The study noted that this was four to eight times higher than seen in the general population. Depression has been shown to decrease survival in people living with HIV (see "Medicine Chest" in this issue). Also, one out of four people (25%) reported using an illicit drug other than marijuana, and 12% said they had an addiction. The findings were reported in the August 14 *Archives of General Psychiatry*.

FDA HIV E-MAIL

From the FDA: "An e-mail list has been established by the Division of Antiviral Drug Products (Center for Drug Evaluation and Research) and the Office of Special Health Issues (Office of the Commissioner) of the Food and Drug Administration (FDA) to provide updates on safety and regulatory issues related to HIV/AIDS products. The purpose of this e-mail list is to give patients, industry, academia, other government agencies and other interested parties one source for FDA HIV/AIDS related information. Information such as product approvals, significant labeling changes, safety warnings, notices of upcoming public meetings and alerts to proposed regulatory guidances for comment will be distributed through this e-mail list. To join the e-mail list, please go to <http://list.nih.gov/archives/fda-hiv-aids.html>."

NEW TREATMENT GROUP

HIV treatment advocates from around the country have formed a new group to improve AIDS research, treatment access, and empowerment of new activists in communities most affected by the epidemic. For now, contact is only through the Internet. Visit www.atac-usa.org.

STOPPING THERAPY

U.S. treatment guidelines for HIV were recently updated in August to include more information on viral load before starting

therapy and on stopping therapy. Unpublished data from the Multicenter AIDS Cohort Study (MACS) clarify that while therapy “should be offered” to people with less than 350 T-cells across all viral load levels, those people with less than 20,000 viral load still have a lesser risk of disease progression. (However, the MACS study is only in men and the number of people being reported on are small.)

For stopping therapy, the guidelines—which are produced by the U.S. Department of Health and Human Services—state the following:

“If a decision is made to interrupt therapy the patient should be closely monitored including clinical and laboratory evaluations. Prophylaxis [medicine to prevent certain diseases] should be initiated as needed based on the CD4+ T cell count. There has been interest in what is commonly called structured or supervised treatment interruptions (STI). The concepts underlying STI vary depending on patient populations and encompass at least three major strategies: 1) STI as part of salvage therapy, 2) STI for “auto-immunization” and better immune control of HIV, and 3) STI for the sole purpose of allowing less total time on antiretroviral therapy. As a consequence of limited data, cur-

rently, none of these approaches can be recommended.

“Salvage STI is directed at patients whose virus has developed significant antiretroviral drug resistance and who have persistent plasma viremia and relatively low CD4+ T cell counts despite receiving therapy. The theoretical goal of STI in this patient population is to allow for the re-emergence of HIV that is susceptible to antiretroviral therapy. Although HIV that was sensitive to antiretroviral agents was detected in the plasma of many individuals following several weeks to months of interrupting treatment, the emergence of drug-sensitive HIV was associated with a significant decline in CD4+ T cells and a significant increase in plasma viremia, suggesting improved replicative fitness and pathogenicity of wild type virus. In addition, drug resistant HIV persisted in CD4+ T cells. The observed decrease in CD4+ T cells is of particular concern in this patient population, and STI cannot currently be recommended for this group of patients.”

Auto-immunization STI and STI for the reduction of total time on drugs are directed at individuals who have maintained suppression of plasma

viremia below the limit of detection for prolonged periods of time and who have relatively high CD4+ T cell counts. The theoretical goal of auto-immunization STI is to allow several short bursts of viral replication to augment HIV-specific immune responses. This strategy is being studied in individuals who began HAART during either the very early or chronic stages of HIV infection. STI for the purpose of less time on therapy utilizes predetermined periods of long or short cycle intermittent antiretroviral therapy. The numbers of patients and duration of follow-up are not sufficient for adequate evaluation of these approaches at this time. Potential risks include a decline in CD4+ T cell counts, an increase in transmission and the development of drug resistance.

“Due to insufficient data in the situations discussed, STI cannot be recommended for use in general clinical practice at this time. Further research is necessary in each of these areas.”

Visit <http://hivatis.org/trtgdlns.html> or call 1-800-448-0440 for a free copy. Pediatric guidelines were also updated. New information appears in highlights. ☒

TPAN Takes a New Home



Test Positive Aware Network, publisher of *Positively Aware* and *Positively Aware en Español*, is pleased to announce our upcoming move to a new location.

Effective January 1, 2002
the agency will be located at
5537 N. Broadway, Chicago, IL 60640.

Positive Empowerment

by Tyrone Pittman

I'm a PWA (person with AIDS) who would like to share a couple of thoughts about living with HIV.

In 1994 I learned I was positive. I treated the news as if I had the common cold. By that I mean that from 1994 until 1999 I existed just for drugging and partying. I knew a little about HIV, yet wasn't ready to take care of myself, by learning how to take medications and the right things to do to stay healthy.

On September 25, 1999 I decided to leave my neighborhood and family in order to survive, to deal with my HIV. If I had stayed, I probably would still be getting high. It was a way of life there.

I still can't explain it, why I suddenly decided to leave. I just woke up and said, "That's it," and I walked. I had bus fare but I walked through the neighborhood one last time and all the way over to the Haymarket Treatment Center here in Chicago. With the health coordinator's help and ongoing support I started to make a difference in my drug recovery and health issues. I was finally sober after 23 years of alcohol and two and a half years of crack.

Since then, I'm actually living. Before, I don't remember anything after the age of 18. I got up, I got high. I went to sleep, I was high. Now I eat better. I've gained weight. I've traveled to conferences in San Francisco and Denver to learn about HIV. It's fascinating. If I didn't have HIV I would probably go back to drugging. But learning about HIV is not boring.

Along the way support came also from four very important people I've grown to care very much about, and I ask them questions when I'm confused or angry. I'm now living in a transitional housing organization

that has been the basis of my achieving the things that I didn't think possible. By this I want you to know that means a stable address and someplace where I can take my meds on a regular schedule without shame or fear. I've found that the housing system needs work, but I guess that's to be expected.

I'm an American Red Cross instructor in basic HIV/AIDS and Afro-American training certified by the state of Illinois as an HIV counselor, and I'm the facilitator of an HIV substance abuse group—Positive

problems differently when confronting people, how to be more diplomatic. The staff talked me into going to college, and now I'm in the associates program for substance abuse counseling at St. Augustine College.

I write about my thoughts on HIV/AIDS in poetry and recovery letters to myself. I can express myself better with pen and paper than I can in words. I write about various events and how I feel about them. I write because I'm depressed, but other people find my writing uplifting. I think that's strange.

I still haven't accepted change, the idea that I can't get high anymore. I still feel uncomfortable, but I know I don't want to use. I don't want to sell everything I've gotten in a year and a half of being clean for one bag.

I voice my anger in committee meetings and various other functions such as talking to others at colleges, high schools, and conferences. I let people know that while I have an AIDS diagnosis, by taking care of myself and taking medicine I now have a healthier immune system and wouldn't qualify for an AIDS diagnosis today.

I now know that to make a difference one must get educated and speak to others, positive or negative, but at least try to make a difference or make others aware that the fire is still out there and it will take more than a bucket of water to even start to smolder the flames of ignorance and denial. That it's still a big problem with very few solutions, let alone a cure. I'm Tyrone Pittman and I'm positive about being positive. ☸



Progress—at my second home, TPAN (Test Positive Aware Network, publisher of *Positively Aware*). At TPAN I found support and help which I still haven't gotten where I live and where I help with HIV prevention and awareness. TPAN got me active in the Northside HIV Coalition and got me involved in its Client Advisory Board. TPAN helped me become a facilitator and helped me get past my anger. I learned to address

Small Town, Big Misperceptions

by Enid Vázquez

As she attended the local funeral of a client, the well-known director of an HIV service organization in a small town found people rushing up to her demanding to know, “Why are you here? What did he die of?”

You can get lost in the big city, but in small towns few people go unnoticed, and everyone’s business is open to speculation. “They don’t have much else to do but gossip,” said one rural HIV service provider, who asked to have their name withheld.

It’s not like city folks don’t poke their noses into each other’s business. But the fear of being found out, where everyone knows who you are, and there’s nowhere to hide, adds stress to the lives of rural people living secretly with HIV. Meanwhile, the need to hide adds a false sense of invulnerability to the rest of the local population, who don’t realize that HIV exists in their community.

SERENITY

“People come to the country for the beauty, the simplicity, the isolation. But people talk more. Why is he coming home? Why is he getting skinny? Why does she have a cough?” says Eric Banks, who recently left his position as a public policy associate for the New York AIDS Coalition. The association advances advocacy positions for 200 member organizations, including some from New York City.

Banks, who was born and raised in the small town of Unadilla in upstate New York, has been a longtime advocate for the needs of rural people living with HIV. As a young gay man and a rural person himself, he takes special interest in how HIV messages are being provided to a population that sees itself as invulnerable. “I heard one speaker say that if you took away New York City and the prisons, New York state would still be No. 10 in the country for AIDS cases,” he recalls.

Banks respects the neighborly value of looking out for one another. The questions people ask, he says, are “not so much gossip

but a tradition of people taking care of each other.” Still, he concedes that people are nervous about the potential for breaches in confidentiality, and that they suffer for exposures forced upon them. One of Banks’ clients received an eviction notice as a result of such a breach. He didn’t even know that the receptionist at his health clinic, located in another town, was his landlord’s daughter. The receptionist was fired, and the eviction did not take place while the case was being litigated, but the client died before the case came to trial.

In the August issue of *AIDS Care*, researchers reported finding two types of confidentiality breaches in rural North Carolina health care settings: blatant ones like the one above, and subtle ones where healthcare providers talk about an HIV-positive patient with another healthcare worker at their own clinic or hospital, which is allowed by law. (They’re not supposed to talk about a person’s HIV status with another institution unless given permission.) Of the 15 positive people they spoke with, the majority had experienced a breach of confidentiality themselves or knew of someone else who had.

Banks remembers being unable to leave voice messages or send mail to clients who were afraid that their children might learn of their HIV status. People who saw someone they knew at an educational event would “be a mess” even after the person said over and over that they wouldn’t tell anyone. One client went to great lengths to circumvent the benefits manager of her company, who was a friend of her father. Another woman lives in the same town as an HIV specialist, but travels two hours away to see a different doctor so the word can’t get out about her HIV.

“There may be competent healthcare workers in your area, but they—or their staff—may know your relatives, so your confidentiality is not assured. Even though you have legal recourses, by then it’s too late. No

one wants to be shunned in their own community,” Banks says.

Debra Patterson, who works with the Madison County AIDS Program in rural southern Illinois, says many of her clients are fearful of being exposed. “They’re afraid... of rocks being thrown at their house, of being run out of town, of people not talking to them.”

Banks says people “rightly fear” HIV because they have no exposure to it. “People in New York City are more aware of HIV. They see more billboards. But you can be in upstate New York and never see a single one. Fear comes from lack of exposure.”

MOSQUITOS

Lee Fallon, the director of the Catskills Rural AIDS Services in Oneonta, New York, says she was “amazed at what students didn’t know, and what they thought they knew that wasn’t true. And these were college students. They’re still in the mosquito and deep kissing area. They also have the misconception of a cure, that there’s nothing to worry about.”

Patterson also hears about transmission myths that were long ago dispelled by the US Centers for Disease Control and Prevention. “People ask me how come they can’t get it from mosquitos. When I tell them, they say, ‘The government doesn’t know everything. It’s a new disease.’ No matter how much I try to educate people, they’re still going to believe what they want to believe.”

There are other misperceptions as well. A member of a sorority where she spoke said Patterson “didn’t look it [infected].” “I told her that was the point, you don’t look it.” An elderly woman told her, “You can’t have AIDS. You’re fat, and you’re just getting fatter.”

SMALL, BUT NOT SAFE

For all the concern over gossip and rumors, there wasn’t enough of it to protect Patterson. Ironically, she moved from Los Angeles to rural Illinois, where she got HIV. After learning of her infection, when she told

her boyfriend's parents that he had HIV, they said, "We kinda knew." Patterson's older son, who was in high school at the time, said, "Mom, we had heard that rumor [that the boyfriend was HIV-positive] a long time ago." She now knows of five other women who were infected by this same man.

Yet, when she tested positive five years ago, "I just remember thinking, 'Oh my God. I must be the only one.' The counselor told me, 'You would not believe the numbers that are in Madison County. More than you would think.'"

Last year, when she began working for the Madison County AIDS Program as a treatment educator and advocate, as her new boss drove her around she would point out streets where clients live. "I know someone there and over there and down here," and on and on.

And as she works with positive clients, she hears the stories of risk. One young woman in another town tells her of a group of people sharing needles, and of one guy with HIV sleeping around. Another woman told her of meeting two men through the Internet, traveling to their states and having

sex with them without telling them she's HIV-positive. Patterson herself sometimes finds that men walk away when she tells them of her HIV, but three men still wanted to have unprotected sex with her. She walked away from them.

In the early days of the epidemic, many small town people who had moved to the big city returned home when they became ill with HIV disease. But today, says Banks, "There are still some people 'coming home,' but the majority of infections I hear about now are in people who've never left." ✚

SEEKING HELP

Research has found that compared to urban people living with HIV, those living with the virus out in rural areas are more likely to worry about their confidentiality being broken and have experienced more incidents of AIDS-related discrimination.

Since the early 1990s, Ohio University research psychologist Timothy Heckman has focused on rural people living with the virus, at a time when most studies were still coming out of areas like San Francisco and New York City. He and his colleagues have reported

- High rates of alcohol use (15% of the men and 20% of women in one study used alcohol on more than 25 days during the previous two months);
- An association between high-risk sexual behavior and greater frequency in using alcohol and drugs;
- As many as a third of the people in one sample did not have access to personal or public transportation;
- Rural HIV-positive people have a greater fear of their infection becoming public knowledge; and
- 38% of one group of rural HIV-positive people surveyed had thoughts of suicide in the previous week.

Today Heckman is finishing up the data collection on a study looking at telephone support groups. The groups operate like a conference call. Members are

encouraged to exchange telephone numbers and stay in contact with each other.

In rural areas, coming together in a central location is difficult not only because homes are so spread out, but because poor finances and inadequate public transportation, if it exists at all, make traveling a huge burden.

"The problems in Rhode Island are the same in Alaska. That's reassuring to them," says Heckman. "Even though they feel they're alone, there are tens of thousands of people in rural areas living with HIV. That's helpful for them to know."

And, he says, they also benefit from knowing that there are "a lot of professionals and people who really do care." In one study, he and his colleagues noted the importance of either improving the education and sensitivity of rural medical and mental health providers, or of linking HIV-positive people to providers who would be sensitive to their needs. They noted a study finding that 35% of rural nurses surveyed said they thought gay men were "disgusting."

What's also important about the telephone support groups was learning skills to address problems. The participants learn strategies from one another and from the facilitator of the support groups.

Heckman recommends that people break down their problems two different ways: those which you can do something about and those you can't. In the first case, you try to figure out what exactly the problem is and then what you can do, and in the second case, you deal with your emotions in positive ways. For example, if

you're having troubles taking medication, try to figure out why—too many pills? Too burdensome of a dosing schedule? Side effects? Then you deal with those issues. Getting help from a friend or a healthcare provider is a good idea.

In the second case, if, for example, someone you love has died, you deal with your emotions. Heckman points out that ways people use to deal with their emotions may be good or bad, depending on degree. If you go to the movies to give yourself a mental break, that's good. If you do nothing but watch TV twenty-four hours a day or stay online all night, that's bad. In the first instance, you give yourself some breathing space from the problem and help regain your emotional balance. In the second, you don't deal with your emotions at all. Too much alcohol or drugs is a common problem in this scenario, he says. Those behaviors bring other problems of their own—including the destruction of new relationships.

FOR MORE INFORMATION

Rural service providers and people living with HIV say that the best way for positive people to get support is to get involved with an HIV service organization. The Centers for Disease Control and Prevention National AIDS Hotline can tell you what organizations they have listed for your area. Call 1-800-342-AIDS (2437). They can also give you the HIV/AIDS hotline number for your state, which may have additional listings. Providers note that home visits are a "necessity" for serving people with HIV in rural areas.

Detection and Treatment of Depression

by Glen Pietrandoni, R.Ph.

Depression is not unique to any individual or group. Depression can affect the mind, body, mood and behavior of anyone. As in the general population, some HIV-positive patients are at higher risk for clinical depression. Patients with a previous history or family history of depression are at higher risk, as well as those who are dealing with alcohol or substance abuse. Women also are at higher risk, as compared to men.

How do you know if you are experiencing clinical depression or just having a bad hair day? Symptoms of depression include changes in sleep patterns, changes in eating habits, loss of interest in activities, excessive or inappropriate guilt, lack of energy or motivation, inability to concentrate, apathy, agitation, depressed mood, and suicidal thoughts. Most experts agree that to be considered clinically depressed, at least five of these symptoms must be present all day for at least two weeks, and include either a lack of interest in activities or depressed mood as one of the symptoms. Studies indicate that

depression is somewhat difficult to diagnose in people living with HIV/AIDS. Many of the symptoms of depression like fatigue, appetite changes, or problems sleeping can resemble manifestations of HIV. Some opportunistic infections like toxoplasmosis, cryptococcal meningitis and HIV related dementia, as well as medications used to treat opportunistic infections can affect one's mood or ability to function normally. Antiretroviral drugs can have side effects causing agitation, depressed mood (AZT / Retrovir), or sleep disturbances (Sustiva). For these reasons, health care providers must be careful in determining if depression in clients is being caused by medical or drug related issues.

Like HIV disease, depression has stigma attached to it. Seeking help and discussing problems openly is uncomfortable for most people. Even people who have support systems and excellent health care benefits may refuse or be reluctant to seek assistance for depression because of perceived stigma. For this reason, many people turn to self-med-

ication to help deal with feelings of depression.

It is important to be aware that some substances, including alcohol, cocaine, ecstasy, crystal and ketamine, that people use to help cope with depression can exaggerate the condition. In addition, withdrawal from alcohol will have depression-like symptoms. While street and party drugs can provide temporary escape from depression, they can also accelerate progression of HIV disease. Herbal and over the counter remedies can help treat depression, but may have unwanted drug interactions with antiretroviral drugs.

If not treated, depression can impact the course of HIV disease. Stress and depression can result in a slight decline of CD4 + Tcells cells and compromise the body's immune function. Depression can also cause apathy, self-neglect and forgetfulness that may result

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PREVENTING DEPRESSION

by Charles E. Clifton

Nearly ten percent of the U.S. population, or about 19 million American adults, suffer from depression, according to the National Institute of Mental Health (NIMH). A bout of major depression can last several weeks to several years, and have devastating impact on one's health and personal life. Depression not only compromises a person's ability to function normally but can alter relationships with friends and family. The NIMH also reports that depression is the number one cause of suicide.

Depression is not a side effect of HIV disease. However, depression is more widespread in people living with HIV, as compared to HIV-negative individuals, due to higher instances of social discrimination, economic inequalities and a lack of institutional support.

PREVENTION

There is no blueprint to prevent the onset of depression. Biological makeup causes some people to be more susceptible to depression than others, just as the psychosocial issues of living with HIV impact everyone differently. No one's life is empty of conflict, stress and obstacles. The goal is learning how to successfully manage issues when they do arise. Here are just a few suggestions from Shaun Bourget, M.A., M.F.T., a licensed marriage and family therapist in the Los Angeles area, that could potentially help improve the quality of your life when dealing with feelings of depression:

- Try to accept that loss is part of life
- Don't be afraid to reach out and accept help and support from others

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LIVING WITH HIV -A SURVIVOR'S PERSPECTIVE

5



BY DAVID MORRIS

My AIDS drugs make me sick, but I take them anyway. It would be great to take a “drug holiday,” but I don’t dare because I don’t want my viral loads to skyrocket and I don’t want my virus to become resistant to my medications.

Sometimes I get tired of taking my medications, which are little daily reminders that I have a disease for which there is no cure. I miss not being able to drink my morning coffee until I’ve eaten my breakfast and taken my pills. I miss the freedom of being able to come and go as I please without worrying when and where I’ll take my medications. But HIV doesn’t take a holiday, so neither do I. It’s difficult, but it’s worth it, because I’ve seen what can happen when HIV-positive people don’t take their medications [or don’t have access to medications].

THE EARLY YEARS OF THE DISEASE

My 20s and 30s weren’t as carefree as I thought they would be. I suffered while I watched the deaths of more than 50 friends from a mysterious disease that was then called “gay cancer” or gay-related immune deficiency (GRID). I saw them go blind. I saw their bodies covered in lesions caused by the AIDS-related cancer Kaposi’s sarcoma. I saw them die horrible deaths, with no medications to help ease their pain.

When I was diagnosed in 1984, I was scared. Although I had witnessed the power of HIV first hand, I suffered in silence for the first year. I was afraid of letting the world know my status, afraid my co-workers would shun me, and afraid that my medical insurance would drop me.

When I finally got the courage to seek treatment, I had to battle the ignorance and prejudices of the times. In the early days of the virus, there were physicians who were just as afraid of AIDS as the general public. In 1985, I at last found a physician who was familiar with infectious diseases, one who understood my disease and my desire to fight it. That physician prepared me to battle HIV.

PARTICIPATING IN CLINICAL TRIALS

Later that year, I agreed to participate in a clinical trial of AZT (zidovudine), the first antiretroviral medication. For nine months I took 1,200 mg of AZT every day, which was the dosage approved by the FDA in 1987. The side effects were awful. My ears rung, my joints ached, I felt anxious, nauseated and like I was in a fog, but I stuck with it because I knew death was the alternative. I wasn’t ready to die.

It was the experience of patients like myself who eventually gave doctors and researchers the clinical information they needed to determine that the appropriate dose of AZT is 600 mg daily [approved by the FDA in 1990]. I continued on AZT and participated in other clinical trials. I did what I could to keep my viral load down to prolong my life.

CANCER SCARE

In May 1995, I was diagnosed with Hodgkin’s lymphoma and had to discontinue all of my antiretroviral medications. I underwent months of chemotherapy that left me feeling like I was living in a dead man’s body. However, after nearly two years, my cancer went into remission.

I immediately resumed my fight against HIV. After so long without my antiretroviral medications, my T-cells had dropped drastically. In 1997, I resumed the antiretroviral medication that had been working for me before my cancer diagnosis. But, this time, my viral load continued to rise and my T-cells continued to drop. My virus had mutated and become resistant to the drugs. I had to switch medications.

In 1998, I started a new, triple drug therapy and I’ve been on this regimen ever since. I take my medications three times a day, seven pills a day, seven days a week. It’s not easy, because the side effects can be debilitating and the pills are a constant reminder that I have HIV. But I know that I must take my pills everyday for the rest of my life, no mat-

ter what. I know firsthand what it means to have “AIDS battle fatigue,” but I continue to take my pills because I’m not ready to give up. I want to stay alive.

LIVING WITH THE SIDE EFFECTS

My medications cause myopathy, which makes my muscles ache, and neuropathy, which affects my nerves so that sometimes I can’t feel my feet when I walk, and my fingers and toes tingle. I’ve been in pain for the past couple months, but I’ve found ways to ease it with pain medications, acupuncture and regular exercise.

I’m willing to deal with my side effects for now because my medications are working, but there are days when the battle fatigue is so strong I don’t want to take another pill. What keeps me going is knowing that being 100 percent adherent to my medications gives me the best chance of living longer with HIV.

The mental strength to stick with my drug regimen comes from the memories of what I witnessed in the early days of HIV and AIDS. I saw the virus devastate the lives of my friends and my community. I was around when physicians and scientists were frantically looking for something, anything that could help the people who were dying. When antiretrovirals were created, I jumped at the chance to take them. I haven’t looked back and I’ve never missed a dose.

To make sure, I put my medications in pillboxes designed to hold all the pills I need for seven days. I fill these pillboxes once a month so I can have them when I need them. I keep a pillbox next to my bathrobe so that

WHEN PEOPLE
ARE DIAGNOSED
WITH HIV,
THEY HAVE
TWO CHOICES:
FIGHT OR GIVE IN.
I CHOSE TO FIGHT
AND I’VE NEVER
REGRETTED IT.

every day when I wake up, I see them and remember what I have to do.

EMBRACING MY HIV STATUS

Despite the side effects and the schedule for my medications, I try to live as normal a life as possible. I can’t afford to get sick again, because I’ve got to spread the word about HIV at schools and to anybody who will listen. There’s not much publicity about the disease these days—no nightly stories on the news about young men and women who have died a ghastly death from AIDS. People need to be reminded that people still die from AIDS. Today, some young people think HIV is not such a big deal, kind of like high

blood pressure—something you can control and still lead a “normal” life. It’s as important as ever to prevent infection with HIV.

For people living with HIV, it’s important that they know HIV can be treated. HIV-positive people must stop feeling guilty about contracting HIV and seek medical help, including one-on-one counseling to help adjust to a new life. HIV is a tough disease with a lot of rules, but if someone decides to begin antiretroviral medications, then drug adherence is one rule that must be obeyed.

Once HIV-positive people accept their status, I believe it’s important to become involved in support groups. Support groups provide a safe place for us to express ourselves, gain insights from people who are dealing with the same issues, and remember we are not alone. It has helped me to become involved in helping others with HIV and it reminds

me that my life is important and has a purpose. I serve on the board of directors of two AIDS service organizations in Boston, and participate in many AIDS education programs. I feel good knowing that I’m helping others.

When people are diagnosed with HIV, they have two choices: fight or give in. I chose to fight and I’ve never regretted it. ✚

David Morris, 47, has been HIV-positive for 17 years. During that time, he has tried and failed numerous drug regimens—complex and challenging regimens. Despite that, David is a long-term survivor who looks forward to many more years.

Reiki (pronounced ray-kee) is an ancient spiritual healing art. Reiki is the Unlimited Universal Life Force Energy which permeates and sustains our entire world. It is the mysterious source of all creation.

Reiki is a completely natural healing technique that accelerates the mind, body and spirit healing process. Reiki healing sessions naturally encourage holistic health, well being, balance, purpose and spiritual harmony. This divine source of energy can be transmitted through a Reiki practitioner utilizing a gentle, non-invasive touch or by hovering several inches over the body.

The origins of this phenomenal natural healing modality can be traced back to Tibet where it was practiced well over 3,000 years ago. It was Dr. Mikao Usui who re-introduced this ancient healing system in the mid-twentieth century in Japan. It is now becoming increasingly widespread all around the world as we search for a holistic approach which helps us heal our disease naturally with no negative side effects. Although spiritual in nature, Reiki does not require one to follow a specific religion or belief system.

In addition to facilitating the healing process, most people report from their Reiki experience that it boosts the immune system, relieves pain, produces a feeling of profound relaxation, reduces stress and depression, and balances their energy levels so that they feel more energized. Reiki is also a journey of self discovery, a search deep within to access the true hero inside. This hero inside is the true healer within. It delivers a divine message of empowerment. It allows us to realize just how powerful each of us are.

In the cosmic dance of life we are encompassed by a symphony, a symphony in which we are the orchestrator. We all experience high notes, and for some of us, many very low notes. The many low ones may include living with disease, depression, losing loved ones, or dealing with

memories of horror from your past that have been buried deep in your subconscious for so long. Perhaps it is remembering a joyous time walking down the beach with a loved one looking back towards the sunset and seeing two sets of footprints in the sand. And now, there is only one. It is all so overwhelming, you feel like you have just stepped into a Van Gogh painting, swirling around in fear and confusion, because it is all so surreal. Pain and devastation so overwhelming, indescribable, it is perhaps, beyond human comprehension.

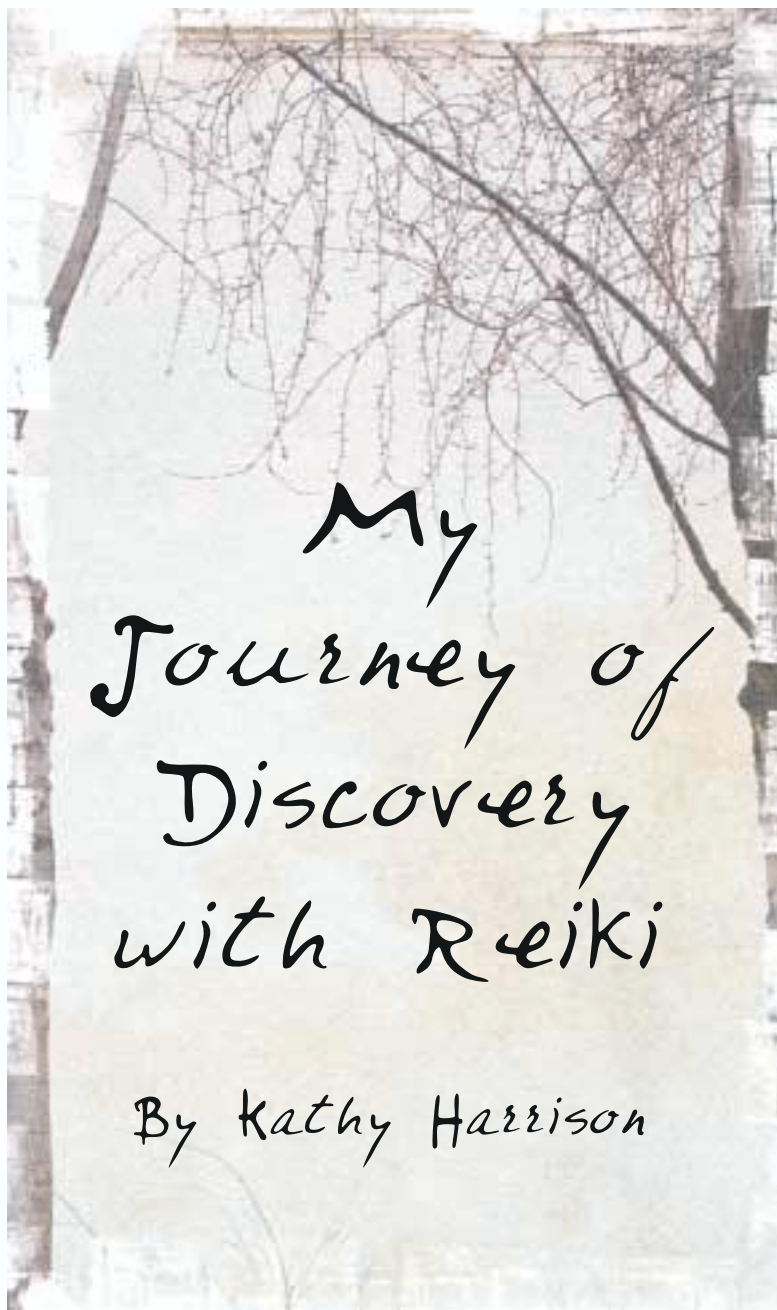
We are the orchestrator of our destinies, the conductor, the decision maker as we are confronted with so much pain and devastation. As we begin to reach out for help, we are confronted by many choices in which to help us deal. The process of choosing which healing modalities to utilize can be just as overwhelming as what we are dealing

with. No one can tell you what to do. It is your search and discovery as you orchestrate which instruments of healing work best for you.

Reiki is universal unconditional love, an intelligent energy that does not make judgments on what disease you have or why you have it. Reiki is a compassionate healing process that does not discriminate against anyone, for we are all the same beautiful spiritual beings. It is the life force that belongs to everyone. It can not be trademarked or copyrighted. It is the gift that is everyone's birthright and should always remain accessible to all.

As a Reiki practitioner, I feel very fortunate to have the opportunity to work with clients to access their true healer within. It is a wonderful experience for me to create a peaceful environment infused with therapeutic sounds of healing music and aromatherapy or a peaceful moment whereby clients can begin the journey of self discovery and empowerment.

My client John, living with HIV for more



than sixteen years, credits his survival to choosing his healing options very carefully. His concern is choosing options whereby there are no negative side effects. With a bit of skepticism, he was intrigued by the simple, gentle approach of Reiki. He came to the Reiki session with an open mind. "Kathy had a calming effect on me from the moment I arrived on the premises. A gentle voice and touch, smooth sounds and aromas embraced my apprehension so I could relax for the session. I was placed in a comfortable position and the session began."

"From the very first touch I knew something wonderful was about to take place. It was a phenomenon difficult to describe. I felt unaware of my physical reality and journeyed through a place that at one time was familiar and yet strange. I saw myself as if I was watching a film and noticed how through various activities I was avoiding a very important aspect of my being. I have trusted my instincts over the past 16 years and feel my good health is due to my non-victim attitude and my willingness to accept things I don't completely understand. I do understand that this experience with Reiki has prompted me to search further to see and understand what I have been avoiding. I look forward to future sessions and this discovery."

As more and more people are turning to alternative natural therapy, we will soon be hearing more about the wonderful benefits of Reiki. It is especially helpful for those who require surgery. My client Carlo, living with HIV for over 15 years, received Reiki prior to surgery on his leg, the same surgery he had had on his other leg the previous year. After receiving Reiki, Carlo reports, "I felt unfamiliar sensations throughout my body, however I felt a very profound sense of relaxation and peacefulness." Carlo's surgery required an overnight stay. However, within a few hours after the surgery he was able to walk home. "This time I felt more calm, more relaxed and experienced less pain."

For all the challenges we encounter in our cos-

mic dance of life, it is important to realize you are not alone and help is always available for all of us. There will be people and situations that come along your path. As we should not underestimate just how powerful each one of us is, we cannot underestimate the power of some kind words to each other. It could be the person who tells you that they are not giving up on you, when everyone else almost has, including yourself.

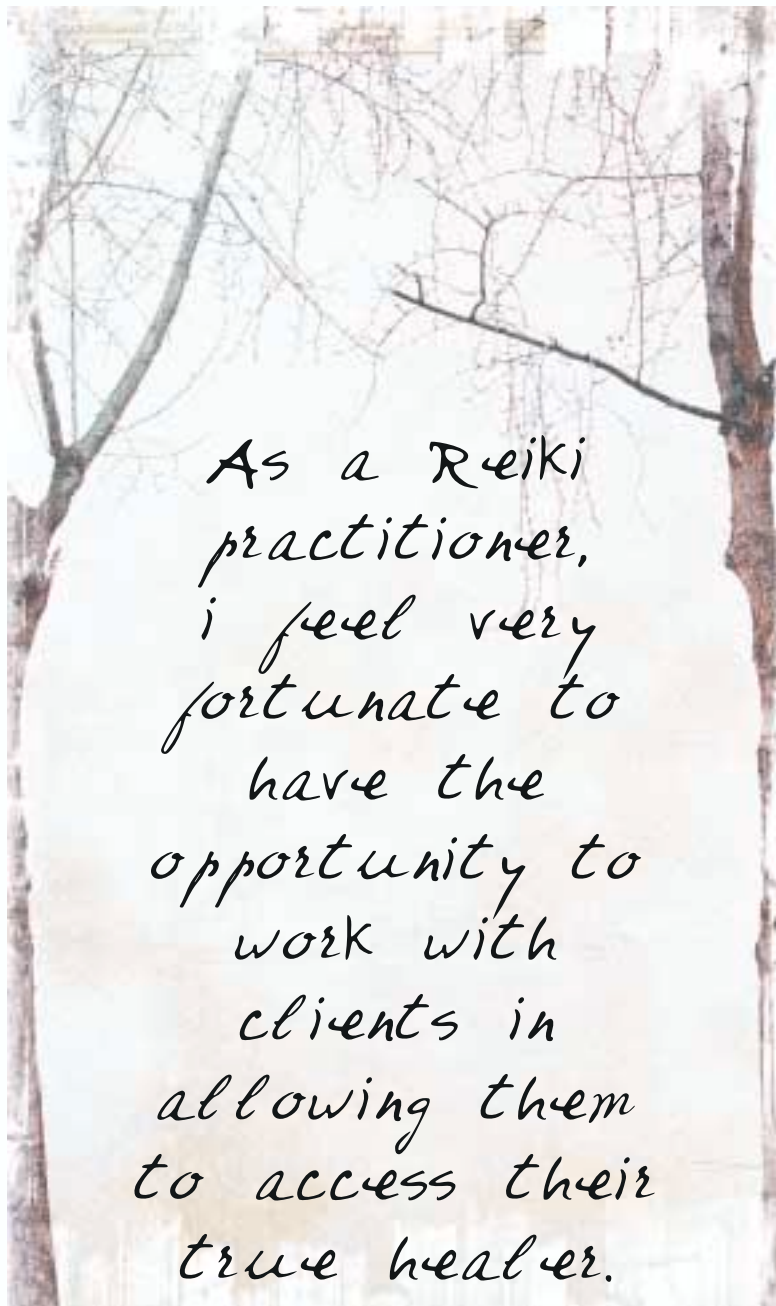
Reiki has been one of the most empowering experiences for me on my journey. I have been fortunate to learn from a very well respected Reiki Master, Louisiana Zinn, whose profound insight, wisdom and guidance I have eternal gratitude for. Louisiana emphasizes the importance of community service by offering Reiki to AIDS patients in hospices and hospitals.

Perhaps those of us who have been confronted and dealt with overwhelming circumstances, AIDS, depression, loss of loved ones or living with disease are most fortunate. Something very beautiful happens during this very challenging process. Each obstacle we are confronted with represents the opportunity to travel down the path, take the journey and discover something wonderful about ourselves. This discovery is a realization of just how powerful each one of us is, powerful and strong enough to discover the true hero inside, the true healer within.



Kathy Harrison is a traditional Reiki Practitioner, business consultant, dancer, writer, and designer. She inspires and empowers others with creative arts therapy. For further information go to: www.reikiassociation.com.

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Sustiva “dirty drops” Put Prisoners in Solitary

by Enid Vázquez

Inmate Efrain Campbell was eagerly looking forward to finishing his six months in solitary confinement following a fight at Illinois’ Pontiac Correction Center (PCC). But then his drug tests kept coming back positive. He was accused of smoking marijuana and it was determined that he should be held another six months in solitary. At the same time, prisoner advocates learned that more than a dozen other prisoners at three different Illinois prisons were found to have “dirty drops” for marijuana, and were being punished by being put in solitary confinement or losing months of good time (which would have reduced their prison sentence). One inmate lost six months of good time and six months of contact visits. Like Campbell, each prisoner was HIV-positive, and each was taking the anti-HIV drug Sustiva (efavirenz).

Sustiva is known to make people wrongly test positive for marijuana use (called “false positive” results). But here the story gets tricky, and the crisis for the prisoners builds. (Remember when you see the word “assay” that it means a test.)

The Sustiva package insert is ambiguous: “False positive test results have only been observed with the CEDIA DAU Multi-Level THC assay, which is used for screening, and have not been observed with other cannabinoid assays tested, including tests used for confirmation of results.” That makes it sound like Sustiva manufacturer DuPont Pharmaceuticals tested the med against all marijuana tests. In fact, the company did not do so, and it did not look at the test used in Illinois prisons, DrugCheck 5. DuPont only looked at three marijuana assays. The other two tests measured were Cannabinoid Enzyme Immunoassay from Diagnostic Reagents and AxSYM Cannabinoid assay from Abbott Laboratories.

This website helps get the Illinois Department of Corrections off the hook for civil rights violations. In a letter to a prisoner advocate group, IDOC Deputy Chief of Institution Operations Larry Sims wrote that, “The Department is currently unaware of any scientific evidence to suggest that the DrugCheck 5 reacts to Sustiva by rendering a false positive. Research conducted by DuPont reflects that only the [CEDIA DAU] assay has been identified as creating false positives. Other assays do not cause false positives. The Department will continue to monitor this situation in an attempt to determine if a further investigation is warranted.” But advocates say IDOC has done nothing.

In the midst of the Illinois crisis, the purchase of DuPont by Bristol-Myers Squibb was finalized on September 26. That left DuPont staff scrabbling, and

allegedly unable to run lab tests to see how the Illinois marijuana test functions with Sustiva. But David Rosen, associate director of public affairs for DuPont Pharmaceuticals, said that the DrugCheck 5 package insert clearly states that a confirmatory test must be used and that it is up to IDOC to run those tests. He notes that even the CEDIA DAU test states that a confirmatory test must be given following positive results. The package insert for both tests states that, “The test provides only preliminary data which should be confirmed by other methods such as gas chromatography/mass spectrometry (GC/MS). Clinical consideration and professional judgment should be applied to any drug of abuse test result particularly when preliminary positive results are used.” Rosen also said it is up to the DrugCheck 5 manufacturer to test Sustiva for interactions. He said DuPont will look into changing the wording of its package insert, which requires approval by the Food and Drug Administration (FDA), and that such a change might be able to go into effect immediately.

In memos, prison healthcare providers reported simply that, “We have been directed from Office of Health Services that positive drug screens are a security issue, and we are not to get involved” and “Per the Office of Health Services, we can confirm for security you are on the medication but **whether it causes false positive is not a medical issue.**” [*emphasis in the original*]

In a letter to IDOC director Donald N. Snyder, Jr., Charles A. Fasano, staff associate at the John Howard Association (a prison reform organization located in Chicago), explained that, “If use of a prescribed medication such as Sustiva, which is essential in AIDS treatment [as they are all], caused any false positive test results, inmates will be placed in a position of having to choose between punishment in segregation and prolonging their lives with a medication that leads to their placement in segregation.” He adds that prisoners refuse to continue taking their Sustiva, “for fear that they will fail further random urine tests.”

Prisoner advocate Dick Helms, also at the John Howard Association, says, “How can all of these people be flunking the test?” That’s too much of a coincidence. Prisoners taking Sustiva can contact Helms at the association, 300 W. Adams, Chicago, IL 60606, or Jackie Walker, National Prison Project, American Civil Liberties Union (ACLU), 733 15th St. NW, Suite 620, Washington, DC 20005. In the meantime, it is obvious that prisoners and others, such as people on methadone, need to reconsider going on Sustiva. ☒

Rescue Regimens: The Value of PI Boosting

by Sonana Segal-Maurer, M.D.,
and Malte Schütz, M.D.

Looking back over the last 20 years, we have seen a great evolution in the long-term management of HIV/AIDS. From the initial stages of only one treatment option to the development of three unique classes of medication, we have witnessed a great change in the landscape of this disease. In particular, during the mid 1990s, we began to see our patients living longer with the discovery of protease inhibitors and the outlook of AIDS shifted from a deadly and unmanageable disease to a chronic condition with long-term options. The current challenge of many physicians in this specialty and people living with HIV is how to choose the right therapy for now while still keeping in mind the need for future options when treatment fails. When you have cycled through the three classes of HIV drugs and treatment fails, the next choice of therapy is what we have dubbed “rescue regimens.”

HAART

In order to fully understand the concept of rescue regimen therapy, we must first identify what necessitates rescue therapy: resistance. Achieving long-term treatment success depends largely upon planned sequential use of multi-drug combinations called HAART (highly active antiretroviral therapy). At this point in the evolution of anti-HIV/AIDS therapies, there are three

classes of antiretroviral drugs approved for the treatment of HIV. The three principal HIV/AIDS antiretroviral drug classes are: nucleoside reverse transcriptase inhibitors (nucleosides), Protease inhibitors (PIs), and non-nucleoside reverse transcriptase inhibitors (NNRTIs).

Nucleosides were the first members of the family of HIV drugs. They inhibit the activity of reverse transcriptase, a portion of HIV needed for the virus to replicate. Nucleosides are often the basis of multi-drug combinations. Protease inhibitors are the latest major addition to the family of HIV/AIDS antiretroviral treatments.

Non-nucleoside reverse transcriptase inhibitors, like their similarly named drug cousins, interfere with HIV’s ability to reproduce. NNRTIs are now being used in combination regimens as antiretroviral therapy to control HIV and slow the development of resistance. NNRTIs should be used only in combinations that are designed to maximally suppress the HIV virus as researchers, clinicians, and patients have learned that the potential for developing high-level resistance to NNRTIs can result from a single change in the HIV virus. Among these, Rescriptor (delavirdine) also has the important ability to increase or boost the drug levels of other medications in combination therapy.

Protease—a protein-cutting enzyme—is a portion of the HIV virus in part respon-

sible for the ability of the virus to infect healthy cells. Protease inhibitors block the protease enzyme, causing the HIV to reproduce itself in a form that cannot invade healthy cells. To develop resistance to the protease enzymes, HIV must develop many mutations. Therefore, this family of medications may be used when viral loads are very high. Table A lists the medications in each class of HIV drug therapy.

RESISTANCE

The goal of antiretroviral therapy is to completely suppress viral replication and delay—or even prevent—drug resistance. Resistance in HIV therapy is defined as the virus’ failure to respond following treatment and the subsequent active reproduction of itself. An increasing viral load is often the first sign that HIV drug resistance has developed. Below are three major reasons that HIV is able to develop resistance to a given treatment:

- Weak treatment regimens—If the drug combination prescribed is not strong enough to block HIV completely, drug resistance can develop. Higher drug levels may be required from future therapies to effectively suppress the virus.
- Inadequate dosage levels—Different people taking the same dose of the

TABLE A

NUCLEOSIDES	PROTEASE INHIBITORS	NNRTIS
Retrovir (AZT)	Viracept (nelfinavir)	Sustiva (efavirenz)
Epivir (3TC)	Invirase (saquinavir)	Viramune (nevirapine)
Ziagen (Abacavir)	Fortovase (saquinavir soft-gel)	Rescriptor (delavirdine)
Zerit (d4T)	Norvir (ritonavir)	
Videx (ddI)	Crixivan (indinavir)	
Combivir (AZT + 3TC)	Agenerase (amprenavir)	
Trizivir (AZT + 3TC + abacavir)	Kaletra (lopinavir/ritonavir)	

same medicine will often absorb or break down those medicines differently, which may result in low drug levels, which in turn may lead to the development of resistance.

- Poor treatment adherence—Missing doses, taking them late or not following the food instructions with medications can lead to resistance, as it often results in low drug levels. Just a few missed doses of a drug can cause drug resistance. In such cases, a random mutant virus can become the dominant virus in the person's system, causing the body to develop resistance to that drug.

One recent study in Hartford, Connecticut looked at 40 inner-city clinic patients using MEMS caps (computerized medication bottle caps that record each time the container is opened) to measure adherence. Researchers found that as the percentage of doses missed increased, the percentage of viral load increased as well. Specifically, when the percentage of dosage taken fell below 80 percent, the treatment success rate failed to be suppressed in one half of patients. For example, if a group of people are taking medicines twice a day (60 doses per month), and they each miss six days of the medicine in one month, half of them would be unable to suppress their viral load. Less than one third of patients taking less than 70 percent of their dosage had undetectable viral loads.¹ Common causes of non-adherence include forgetting to take medication (57 percent), negative side effects (39 percent), feeling well/not feeling a need for therapy (22 percent), and suspecting that therapy is not working (20 percent).²

One of the results of resistance, which should be considered in planning your HIV therapy, is cross-resistance. Research has shown that some drugs share similar mutation patterns which confer cross-resistance to other drugs within their class. Because of cross-resistance, you can get resistant to medications which you have actually never taken. Despite the large number of approved HIV medications, the number of sequential treatment options that will be effective for an individual patient is sharply limited by cross-resistance. Although each class of drug combats HIV in a different way, cross-resistance should be considered an important factor in selecting each treatment regimen. Knowing

which options will exist for future regimens is critical in the long-term management of HIV.

RESISTANCE TESTING

Once you have experienced a viral load rebounding after HIV treatment, future treatment options may become more limited. The best way to determine which combinations will be effective at this point is through resistance testing. Two methods of testing currently exist: genotype testing and phenotype testing. Genotyping maps out the reverse transcriptase and protease inhibitor genes to determine resistance mutations to specific drugs. By doing this, you are able to assess HIV drug resistance based on genetic indicators, or letters of the code, which have mutated. Phenotyping more directly measures resistance by examining the ability of HIV to grow in the presence of each of the available drugs. Phenotype testing is conducted by growing recombinant HIV virus with the patient's resistance pattern in a test tube in the lab. These tests then measure resistance by adding antiretrovirals to the culture medium to determine which are susceptible to the virus.

Both of these tests have many pluses and minuses. Phenotyping, for instance, offers a direct measurement of HIV drug susceptibility and results, which can be easier to understand than genotyping results. However, these particular tests are expensive, slow, insensitive for minor virus populations and extremely difficult to conduct; in fact, phenotype tests are so difficult to conduct that they are considered an art form. Genotype tests, while quicker to perform and less expensive than phenotype tests, have their own limitations. Primarily, given the fact that more than 100 resistance mutations have been described, genotypic data does not always offer straightforward interpretations and may require the physician to have a lot of knowledge on how to interpret the findings. Despite their limitations, both of these tests can be extremely helpful in evaluating which drugs the virus has become resistant to and considering what future drugs might be effective and if higher drug levels will be beneficial. They also allow us to judge if a new drug class should be introduced.

RESCUE REGIMENS AND PI BOOSTING

Rescue regimen is a term used for therapy alternatives following a viral load

rebound from all three classes of antiretrovirals. What to choose as a rescue regimen can be challenging. As the previous section has outlined, resistance mutations limit these options significantly. The addition of a new class, when available, is a unique opportunity to suppress the virus, but currently only three classes are available. [See "News Briefs" in this issue for new drug]. In addition, higher drug levels are a strong consideration in a rescue regimen, as these higher drug levels may help to overcome resistance. Furthermore, boosting agents can help simplify the dosing of protease inhibitors, such as fewer doses of Crixivan (indinavir) when it is combined with Norvir (ritonavir) or Rescriptor (delavirdine).

To further explain boosting agents' utility in rescue regimens, it is helpful to first understand the way in which all protease inhibitors and NNRTIs are metabolized, or broken down and removed from the blood. Most PIs and NNRTIs are metabolized by the same system, or pathway, in the liver: cytochrome P-450. Some HIV medications slow down the liver enzymes, like a plug might stop the water from going through the drain in a bathtub. This function allows the drugs using those enzymes to be broken down more slowly, boosting the level of these drugs within the body and allowing them to remain in the body longer.

Two antiretroviral drugs—Norvir and Rescriptor—possess this unique ability of inhibiting cytochrome P-450 and, in turn, boosting the levels of other drugs. Norvir has the greatest degree of success as a boosting agent among the PIs; it is an effective agent at boosting the levels of Invirase, Fortovase (saquinavir soft-gel), Crixivan, Agenerase (amprenavir) and Viracept (nelfinavir). Kaletra contains a small dose of Norvir right in the capsule and is also considered a boosted combination. Among the NNRTIs, Rescriptor is the most successful boosting agent with select PIs; it is a valuable boosting agent when used in conjunction with Crixivan, Viracept, Agenerase, Invirase or Fortovase. Rescriptor is the only NNRTI effective in this role, as both Sustiva and Viramune do not boost the levels of PIs.

In addition, when using PI boosters such as Norvir and Rescriptor, certain facts must be considered. First, Norvir is a PI and Rescriptor is an NNRTI. Norvir has been associated with the following side effects: nausea, diarrhea, liver toxicity, high cholest-

terol and high triglycerides. Rescriptor, while only more recently observed for use in PI-boosting, appears to have a better side effect profile; it is free of significant gastrointestinal side effects, liver toxicity or cholesterol elevation but has been associated with an occasional rash.

One recent study, ACTG 359³, evaluated Rescriptor's effect on the drug levels of several protease inhibitor combinations, including Viracept (NFV), Fortovase (SQV), and Norvir (RTV). The following combinations were studied both with and without Rescriptor: NFV + SQV; NFV + SQV + Adefovir; RTV + SQV; RTV + SQV + ADV. In this study, Rescriptor is shown to have significantly increased the drug levels of each combination. The percentage of patients with a viral load less than or equal to 500 who maintained a virologic response at 16 weeks was more than 10 percent higher across the board than those patients not receiving Rescriptor in their combination. At 48 weeks, the trend continued, showing that in the specific case of patients on the combination of NFV + SQV + ADV, the percentage of patients maintaining a viral load of 500 or less more than doubled with the addition of Rescriptor.

Both Norvir and Rescriptor can greatly enhance drug levels in a rescue regimen, with the effect of Norvir being somewhat more pronounced. Knowing when to select which one of these boosting agents can be the real challenge. Table B helps to simplify this deci-

sion with recommendations for when to use Norvir and when to use Rescriptor in PI boosting.

HYPERSENSIBILITIES

Hypersusceptibility can be another reason for the addition of an NNRTI in a rescue regimen. Hypersusceptibility occurs when the virus has become extremely susceptible, or vulnerable, to a medication. Often, a patient who has experienced resistance to nucleosides and protease inhibitors may respond well, in terms of HIV suppression, to the addition of an NNRTI in rescue therapy. Several studies lead us to believe that it is nucleoside-resistant mutations in the reverse transcriptase gene which may confer hypersusceptibility to NNRTIs. One such study is CCTG 575, which indicated that patients who had at least six months experience on antiretroviral therapy, including at least one non-nucleoside, showed hypersusceptibility to the introduction of an NNRTI in phenotypic testing.⁴ In the specific case of Sustiva, those with Sustiva-hypersusceptible virus receiving Sustiva had significantly lower viral loads by month two when compared with those without the Sustiva-hypersusceptible virus. Furthermore, by month four, there were also markedly higher increases in CD4 cells for hypersusceptible patients.

This study suggests that NRTI-resistance mutations may sensitize viral isolates to NNRTIs, making NNRTIs a sound choice for rescue therapy. It also supports the use of phe-

notypic resistance testing in nucleoside-experienced patients, as it may uncover hypersusceptibility for future therapy choices.

WHERE DO WE GO FROM HERE?

PI boosters such as Norvir and Rescriptor can play a significant role in rescue therapy since higher drug levels can help in overcoming resistance. Long-term planning can have an immense impact on future therapy options, which can become critical as resistance mutations limit the choice of medications available in rescue therapy. You should speak with your physician about which treatment strategy and rescue regimens will prove most tolerable and effective. ☩

Sorana Segal-Maurer, M.D., New York Hospital Queens, Division Infectious Diseases Flushing, New York and Malte Schütz, M.D., Triad Health Practice, Advocate Illinois Masonic Medical Center, Chicago, Illinois

¹ K. Abriola, XIII World AIDS Conference, Durban, South Africa.

² Ohmit S, et al. XII World AIDS Conference, Geneva, Switzerland, 1998, Abstract No. 32347.

³ Gulick. 7th CROI, 2000, San Francisco, Abstract 235.

⁴ Haubrich. Antivir Ther 2000; 5(suppl3): 69.

TABLE B

NORVIR	RESCRIPTOR
<p>USE IT:</p> <ul style="list-style-type: none"> • To increase the levels of other protease inhibitors • To simplify dosing of other protease inhibitors • If you do not need an NNRTI to overcome resistance 	<ul style="list-style-type: none"> • To boost the levels of protease inhibitors • To simplify dosing of protease inhibitors • To avoid liver toxicity, stomach side effects, and increased cholesterol in rescue therapy
<p>WATCH FOR:</p> <ul style="list-style-type: none"> • Upset stomach and diarrhea • Increased triglyceride levels • Liver toxicity 	<ul style="list-style-type: none"> • 18% chance of rash during the first few weeks of treatment • Decreased absorption when taken with stomach acid-lowering drugs

Abusive Behaviors and HIV

by Michael Barnett

Since the beginning of the epidemic, HIV prevention advocates have struggled to combat the elusive enemy. We wave condoms in the face of high-risk individuals and try to persuade them to believe that using a condom actually feels good. We display Quilt panels that memorialize lives lost to AIDS. We scream in the face of mainstream society. We expand our vocabulary to include such words as fisting, felching, sodomy, barebacking and sucking.

We see our youth frequenting parks and participating in unsafe sex just to gain acceptance. We hear, "No one dies anymore, if I get infected I will just take a pill." Media hinting to the possibility that AIDS is curable bombards us. We read advertisements from big pharmaceutical companies with HIV-positive people climbing mountains, sky diving, winning marathons, and in their spare time writing dissertations about world peace.

HIV prevention advocates and people living in the age of AIDS have seen, heard, and experienced all of these things. After 20 years of trying to prevent new HIV (re)infections, people are still getting (re)infected. Society continues to stigmatize behaviors that are killing our youth, our brothers and sisters, our friends, and our partners. Do we blame "the other" or do we accept responsibility for the cards we are dealt? How do we move forward?

This is the first in a series of articles to address the issues that everyone living in the age of AIDS face on a regular basis. Why after 20 years are people still getting infected and reinfected with HIV? These articles will articulate concerns, and try to create an atmosphere of open and candid communication about these issues and possible solutions.

The hardest thing
to get over was
being a victim
I am a man.
A strong man.
Men don't get abused.

MEET DEVON

Devon is a 31 year-old gay white male, who lives in Chicago. He knows first hand about domestic violence. "I ended a three year verbally abusive relationship. When I left I was diagnosed with Post Traumatic Stress Disorder," Devon said. After ending the relationship Devon found himself confused, with no concept of self, lonely, scared and with high-levels of self-hatred. Devon was walking through life in a daze, with mental scars as well as physical scars to remind him of what he went through.

He finally decided to break his silence and seek counseling. However, he found that help and professional services for gay men were not so easy to locate. After extensive searches he discovered help from a therapist who lives in South Florida, hundreds of miles away from his home in Chicago. Dr. Judith Wells-Crowley gave him advice and general counseling over the phone and the internet. Together they worked on the life threatening issues confronting Devon, and set the stage for his recovery, which at times was very difficult.

According to Devon, "the relationship was destructive and unhealthy, and physically abusive in the end. The first thing I wanted to do was find my self worth in the form

of someone else's sexual attraction to me, even if that meant unprotected sex." There were suicidal thoughts, periods of deep-rooted depression, anger, and loneliness. All of these emotions he could experience in a single day.

The unreported violence and Devon's reaction is more common than not among gay men and lesbians. According to the National Coalition of Anti-Violence Programs (NCAVP), there were over 3,000 documented cases of domestic violence in 1997, a 41 percent

increase from 1996. Domestic violence in the gay community is very seldomly documented or addressed.

"The hardest thing to get over was being a victim," Devon stated. "I couldn't admit that to myself. I am a man. A strong man. Men don't get abused." Because domestic violence is defined primarily as a heterosexual problem, many gays and lesbians do not recognize domestic violence even when it is happening to them. Like Devon, many people internalize the belief that domestic violence only occurs in heterosexual relationships. This belief is further reinforced by domestic violence public education campaigns. These campaigns assume universal heterosexuality and exclusively address male-female relationships.

After a year of therapy and multiple support groups Devon now understands the signs that were present during the relationship, as well as how he was, at high-risk for HIV infection. "We never practiced safe sex, it really wasn't an option. And when the relationship was over, it still wasn't an option." Devon knew about safe sex. He had vast knowledge on HIV and how it is transmitted. He knew what a condom is. He understood what to do and what not to do. He also recognized how to negotiate sex with his



partners, yet, for a period in his life, these things fell by the way side.

“On a daily basis I was humiliated, disempowered, verbally abused, for three years. I left the relationship believing everything he said. I was a worthless person that was nothing without him. Safe sex wasn’t an option. If you believe you aren’t worth saving, then how does the practice of safe sex coincide with that? What about you is worth keeping safe or saving?”

Although his recovery is ongoing and at times traumatic, Devon believes that acknowledging and ending domestic violence is part and parcel of preventing other self-injurious and self-destructive behaviors. Protecting oneself from HIV and STDs requires the same self-protecting skills and behaviors as protecting yourself from domestic violence. If you allow yourself to be a victim in one situation you are likely to allow yourself to be victimized in another.

Devon eventually received the assistance that he needed, however for some people

that help never arrives or comes too late. He is now an advocate for gays and lesbians who may suffer from domestic violence. He emphasizes that most gays and lesbians are not aware of local services that may exist or where to go to get help. Devon also stresses that gay men can be victimized. “They need to know signs of domestic violence. They need to be able to recognize that it is happening to them. And then, they need to have the courage to say, ‘I am a victim, and I need help.’ I can take steps to protect myself. Protection of myself is my responsibility.” A motto that saved Devon’s life.

PROFILE OF AN ABUSER:

- Overly jealous
- Tries to isolate partner (victim of abuse) from friends and family
- Attempts to control partner

- Severe mood swings (Jekyll and Hyde personalities)
- Explosive temper
- Tells partner that problems are partner’s fault
- Directs verbal assaults toward partner
- Blames others, especially the victim for their actions
- Low self-esteem

If you or someone you know is the victim of domestic violence please seek help. If you are an abuser or think you may be an abuser, STOP and get help immediately.

National Domestic Violence Hotline
1-800-799-SAFE (7233) or 1-800-787-3224 (TTY) ☎

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God Breast Ye Merry Gentlemen

by Daniel S. Berger MD

OLD BUSINESS

Today writing my usual passionate, intense, buzzful column was a difficult, arduous task. Writing generally comes easy for me. However, I, like many, have been experiencing an unfamiliar character of pain from the recent national tragedy that began in New York City. I have unsuccessfully tried to make sense of the loss of so many and the crumbling of our financial capital. I have received differing perspectives on the events from my sister-in-law who was nearly trapped in her work place. My brother is co-director of the Intensive Care Unit at Bellevue Hospital; he witnessed these events from the hospital windows. His thoughts were that his wife was dead until he found out differently several hours later that day. During the evening he stayed up all night in the hospital so that he was available and prepared to help. Waiting and hoping for survivors, they never arrived. Hearing from him personally on a daily basis made it more real and different than the perspectives provided to me by television. These factors left me shaken, with much difficulty focusing on elective tasks. Also, cancellations of various conventions occurred. Specifically, an important international infectious disease and HIV-focused meeting, the Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) was postponed till December. I originally planned to use this column to discuss this (now cancelled) ICAAC meeting.

In regards to the last Buzz, I want to thank everyone who has commented on my article. [See *Readers' Forum*] Our office has been bombarded with inquiries from all over the country. The rapid rate and tentacles of news disseminating like wild fire is spectacular. We've been truly happy to provide New-

York City with fill treatments for those individuals with facial wasting. The filling treatments have been a tremendous morale booster for patients stricken with this form of lipodystrophy. Thus far there have been no complications and patients are generally gratified with their early results.

Now on to the meat of this article...

BREAST IS MORE

Introduction to Gynecomastia, Mastitis, and Breast Fat Accumulation

Some men have developed abnormal enlargement of breast tissue, often referred to as gynecomastia. When this occurs, the ducts and periductal fibrous tissue of the chest increase in size and amount; under the microscope, it resembles those breast tissues that are induced by estrogen, the female sex hormone. No wonder many gay men often call themselves "Mary!" Alveoli and breast milk occur only in rare cases. But fortunately or unfortunately (depending on your point of view) the term gynecomastia often refers to feminization, or as many may say, a queen-like texture. Perhaps a better term is hypertrophy of the male breast. Alternatively, deposits of fat in the pectoral region can give an appearance of abnormal breast accumulation, often seen as a complication of lipodystrophy in HIV disease. Breast fat accumulation bears little relationship to gynecomastia. Finally, some individuals develop an inflammation of their nipple area, known as mastitis, without developing the much-feared womanly breast tissue. Many of these conditions can be treated with varying success.

There are many types of gynecomastia and multiple circumstances in which they occur. It is not the intent of this article to review all of them. If I had to evaluate the

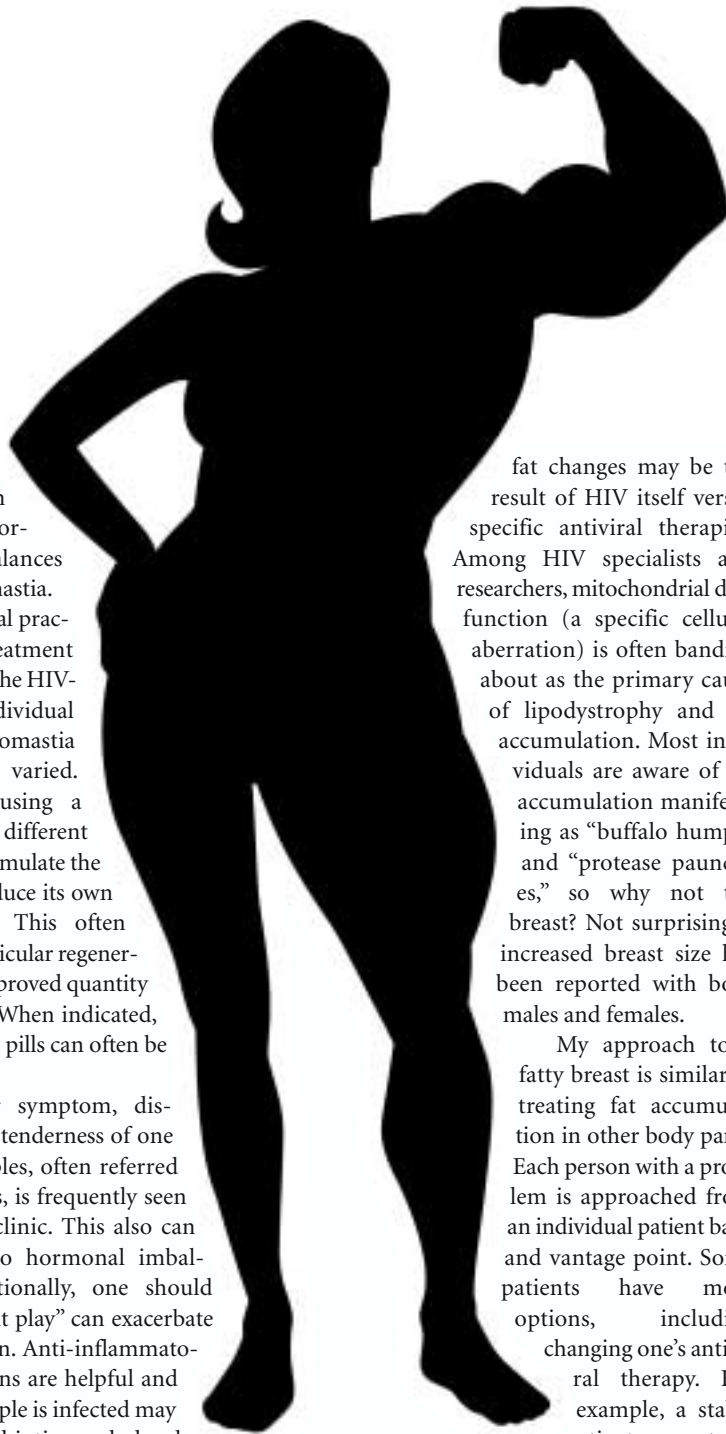
entire classification, an entire chapter could be easily written. I will therefore try to stick with HIV-related situations.

THE BREAST IS YET TO COME

(Gynecomastia and Mastitis)

Gynecomastia can come from a variety of origins. An excess of estrogen, the female sex hormone, causes proliferation of female ductal (glandular) tissue and can induce the same growth for the male breast. There is also evidence that androgens (male sex hormones) can cause changes and abnormal breast tissue enlargement. Also, androgens can be converted to estrogenically active metabolites; this is especially seen in abnormal testicular function. So how does this apply to patients who are HIV positive? Well, many HIV-positive individuals have a syndrome called hypogonadism. This condition is associated with increases in production of pituitary gonadotropins (hormones produced by the brain); the pituitary hormone then sends messages to various glands in other parts of the body to either produce or shut off production of various sex hormones. Thus hypogonadism can lead to overproduction of estrogen or underproduction of testosterone, both by the testicles.

Also, many individuals with HIV are being treated with a plethora of hormonal drugs: testosterone, decaborabolin, oxandrin, Anadrol, AndroGel, and testosterone creme. Some of these drugs can potentially lead to estrogenically active metabolites and/or affect the message system of various sex hormones. In a majority of instances, these agents improve sexual libido and potency; however, sometimes these same drugs can cause sexual dysfunction, often seen with testicular atrophy and a loss of ejaculation capacity. Thus, over-doing it with



these agents can lead to hormonal imbalances and gynecomastia.

In clinical practice my treatment approach to the HIV-positive individual with gynecomastia has varied. Sometimes using a variety of different agents can stimulate the testes to produce its own testosterone. This often improves testicular regeneration and improved quantity of ejaculate. When indicated, anti-estrogen pills can often be helpful.

Another symptom, discomfort and tenderness of one or both nipples, often referred to as mastitis, is frequently seen in the HIV clinic. This also can occur due to hormonal imbalances. Additionally, one should know that "tit play" can exacerbate this condition. Anti-inflammatory medications are helpful and when the nipple is infected may require antibiotic and local treatment.

A FAT BREAST IS A HAPPY BREAST?

The Breast Fat Accumulation of Lipodystrophy in Males and Females

Fat accumulation has occurred in various areas of the body in HIV-infected individuals. Controversial and debated, research is attempting to identify the cause. Abnormal

fat changes may be the result of HIV itself versus specific antiviral therapies. Among HIV specialists and researchers, mitochondrial dysfunction (a specific cellular aberration) is often bandied about as the primary cause of lipodystrophy and fat accumulation. Most individuals are aware of fat accumulation manifesting as "buffalo humps" and "protease paunches," so why not the breast? Not surprisingly, increased breast size has been reported with both males and females.

My approach to a fatty breast is similar to treating fat accumulation in other body parts. Each person with a problem is approached from an individual patient basis and vantage point. Some patients have more options, including changing one's antiviral therapy. For example, a stable patient on protease

inhibitors who has developed a higher propensity for fat accumulation may benefit from switching to a non-nuke (Sustiva or Viramune). Another option that should be on the table for consideration is treatment with growth hormone (Serostim). Serostim improves the growth of lean body mass while burning body fat. In some individuals it has been shown to decrease or improve fat accu-

mulation syndromes, such as buffalo hump and abdominal visceral (organ) fat buildup. Finally, a recent report from Paris has discussed using a testosterone derivative called Andractim or DTH (dihydrotestosterone) topically for gynecomastia. The report is not clear whether the breast enlargements being treated with this modality is due to fat accumulation or is of hormonal origin.

CONCLUSION

One would hope that one never has to face breasts against one's will! However, with the evolving field and treatment of HIV and its related complications, breast tissue can emerge as a challenge for both patients and their physicians. The widespread use of hormonal agents to combat hypogonadism and wasting has added to the frequency of gynecomastia. Alternatively, lipodystrophy has increased fatty breast tissues in some HIV-positive individuals. Patients should be aware of treatment options, as well as the risks of using and over-abusing testosterone. Holidays from hormonal replacement treatment are encouraged and anti-estrogens can improve and avert the onset of gynecomastia. As mentioned in many of my articles, discussing treatments mentioned in this column with your personal physician is always prudent. I encourage comments and questions. ☩

Daniel S. Berger, MD is Medical Director of NorthStar Healthcare and Clinical Assistant Professor of Medicine at the University of Illinois at Chicago and editor of AIDSInfosource (www.aidsinfosource.com). He also serves as medical consultant for Positively Aware. For further inquiries Dr. Berger can be reached at DSBergerMD@aol.com or (773)-296-2400.

Pickett Fences

My Greatest Hits, or How to be a Moulin Rogue

by Jim Pickett

It's my party and I'll die if I want to, die if I want to, die if I want to.

You would die too if it happened to you.

Oh, wait, my bad. That's rather gloomy, no? Beg my pardon, I believe I did promise you a rose garden. The sun'll come out tomorrow? No! It's out today, just look, will you? Silly! AIDS is not a death sentence! It's a life paragraph, it's a command to go out, shake it, have a little fun.

do that can't be done. There's nothing you can sing that can't be sung. All you need is AIDS. All you need is AIDS, AIDS, AIDS is all you need. All together now. Everybody.

When I find myself in times of trouble, HIV comes to me, speaking words of wisdom, HIV. And in my hour of darkness, it is standing right in front of me, whispered words of wisdom, HIV. Let it be, HIV. Let it be, HIV. There will be an answer. HIV.

now I long for HIV. Love was such an easy game to play. Now I need a place to hide away. Oh I believe in HIV.

Workin' hard to get my fill. Everyone wants a thrill. Payin' anything to roll the dice, just one more time. Some will win, some will lose, some were born to sing the blues. Oh, HIV it never ends it goes on and on and on and on. Don't stop believin'. Hold on to the feelin'.

Oooh, I've been to Nice and the Isle of Greece, and I've sipped champagne on a yacht. I moved like Harlow in Monte Carlo, and showed 'em what I've got. I've been undressed by kings and I've seen some things that a woman ain't supposed to see. I've been to paradise, and I've been to HIV.

Sometimes the snow comes down in June. Sometimes the sun goes 'round the moon. Sometimes the very thing you're looking for is the one thing you can't see. But now we're standing face to face. Isn't this world a crazy place? Just when I thought our chance had passed, you go and save AIDS for last.

So I chose freedom. Running around, trying everything new, but nothing impressed me at all. I never expected it to. And as for fortune, and as for fame. I never invited them in, though it seems to the world they were all I desired. They are illusions, they're not the solutions they promise to be.

The answer was here all the time. I love you and hope you love me.

Don't cry for me HIV ☚☛



No! A lotta fun! Stop the whining! Start the shaking! Make a tall pitcher of Crystal Light and invite that cute baby queen next door over for a disco break. And whatever you do, be upbeat! Think happy face! Think exclamation marks!!! Think pink! Not stink. Pink!!!

Wink, wink. I mean, where would I be without HIV? You got that right, nowhere! At least not anywhere nice. It is my sunshine, my only sunshine, it makes me happy, when skies are grey. It lifts me up, to the top. It lights up my life, it gives me hope, to carry on. It fills up my night with song. It's so beautiful to me, can't you see?

AIDS, AIDS, AIDS. AIDS, AIDS, AIDS. AIDS, AIDS, AIDS. There's nothing you can

There's still a chance that you will see. There will be an answer. HIV.

I don't need your sympathy, there's nothing you can say or do for me. And I don't want a miracle. It'll never change for no one. Now hear your reasons why. Where did you sleep last night? And was it worth it? Was it, worth it?

You betcha! I'm strong enough!

HIV. All my troubles seemed so far away. Now it looks as though they're here to stay. Oh I believe in HIV. Suddenly, I'm not half the man I used to be. There's a shadow hanging over me. Oh HIV came suddenly.

Why, he, had to go I don't know, he wouldn't say. I said something wrong and

Detection and Treatment of Depression continued

continued from page 26

in poor adherence to antiretroviral drugs and complementary therapies.

None the less, there is hope for individuals living with HIV/AIDS who are also coping with depression. Treatments are available to reduce symptoms of depression and improve the quality of life. Psychotherapy (counseling), pharmacotherapy (drugs) and a combination of both are the standard of care. However, the goal of medication—prescription and alternative—used to treat depression is intended to return you to “normal” rather than make you numb to your feelings.

The most common class of drugs used for depression today are called SSRIs (selective serotonin re-uptake inhibitors). Drugs in the SSRI class are Prozac, Paxil, Zoloft, Luvox, Celexa, and Anafranil. Sexual side effects are common with some of these drugs, and may include delayed orgasm, problems getting an erection, and decreased interest in sex. When people are depressed, a decreased interest in sex is not uncommon. If the antidepressant drugs are effective, the sexual side effects may subside. Viagra does seem to help reduce the erectile problems caused by the antidepressant drugs. Cyclic antidepressants are also used today to a lesser extent. These drugs include amitriptyline (Elavil), nortriptyline and doxepin.

Amitriptyline is also used to treat peripheral neuropathy. Sedation, dry mouth and constipation are often seen as side effects with cyclic antidepressants. Wellbutrin, Serzone, Effexor and Remeron are other drugs effective in the treatment of depression in HIV-positive individuals. Wellbutrin (bupropion, Zyban) may be prescribed to help stop smoking. Weight gain often occurs with antidepressants, but can be a welcomed side effect.

Treatment of depression with prescription drugs in HIV may be slightly different than in the general population mainly due to possible drug interactions with the antiretroviral therapies. Most of the antidepressant drugs are safe to take with antiretrovirals with a few exceptions. Ritonovir (Norvir) and Lopinavir/r (Kaletra) may increase blood levels of Wellbutrin. This interaction may lead to increased risk of seizures and should be used with caution. Other side effects include insomnia, agitation, or sedation. This can get confusing because depression itself causes these problems.

Because all of these drugs have side effects, your doctor may need to try different combinations to find one that is both effective and free of unwanted adverse effects. It is important to communicate any benefits and problems you experience to your health care provider, so that they may be able to fine-

tune your treatment. Talk to your physician or health care provider if problems get worse or are difficult to adapt to. Antidepressants are usually started at low doses and then increased as necessary. In most cases, improvement of side effects and benefits of these drugs can take between two-to-six weeks before full effect can be assessed. After six months of successful results, your provider may want to discontinue the medication. If depression reoccurs, the drugs can be restarted.

Other drugs can also be used to improve feelings of well being in depressed individuals. Stimulants like methylphenidate (Ritalin) and androgens like testosterone can be prescribed. Benefits include more rapid results and fewer side effects over antidepressant drugs. Androgens can help put weight on patients who have wasting syndrome. However, stimulants can also cause unwanted weight loss and anxiety. As with any form of therapy, talk with your physician or healthcare provider before taking any medication for depression. ☩

Glen Pietrandoni is director of Clinical Pharmacy Services for the Walgreen Specialty Pharmacy, focusing on HIV, located in the Howard Brown Health Center of Chicago.

PREVENTING DEPRESSION CONTINUED

continued from page 26

- Accept that we can't control everything around us
- Make better, more informed choices that create less turmoil for you
- Stop being so critical of yourself, and of others
- Acknowledge the good in you, stop beating yourself up
- If you're good at caring for others, add yourself to that mix

THErapy—“JUST GET OVER IT.”

For most people depression is a passing mood. And with time, most people do “just get over it.” However, for others, depression is a debilitating chronic illness with potentially severe consequences. Popping a pill a couple times a day may help shorten episodes of depression, but they do not help you understand

the causes or cope with situations. Professional counseling (therapists and psychiatrists) can help evaluate and reduce symptoms, shorten episodes of depression, and prevent relapse. Sometimes medications are not needed at all. The most common goals of therapy are:

- provide a safe environment
- assess the need for medication
- improve problem solving and coping skills
- resolve issues of loss and correct irrational/negative thoughts
- improve self-esteem
- improve eating and sleeping patterns
- educate and encourage involvement of support persons

TPAN Calendar of Events

All events held at TPAN unless indicated otherwise.

For additional information on these events please contact Keith Waltrip, Program Director, at (773) 404-TPAN (8726)

NOVEMBER 2001

Date	Time	Event
Thursday, 1st		Board of Directors Applications available For details call (773) 404-8726 or write TPAN, 1258 W. Belmont, Chicago, IL 60657
Tuesday, 6th	6:30 – Food 7:00 – program	Playful Sex & Control – Safer Sex & Adherence Steven Fallon & Mark Gagne (one man comedy act from Second city) Theatre Building – 1225 W. Belmont RSVP's encouraged to Keith Waltrip at (773) 404-8726
Tuesday, 13th	6:30 PM	Client Advisory Board (CAB) Meeting
Tuesday, 20th	7:30 pm	TPAN Board Meeting
Wednesday, 21st		Deadline for Board of Director's Applications
Thursday, 22nd		Agency closed for Thanksgiving Holiday
Friday, 23rd		Agency closed for Thanksgiving Holiday

DECEMBER 2001

Date	Time	Event
The annual Holiday Party will be the second week of December. Call Keith Waltrip at (773) 404-8726 for more details.		
4th – Annual Election – Ballots for the election of new Directors to the Board of Directors available for in-person pick up at the TPAN office or for delivery by mail. A ballot will be provided only to members who make such a request, there will be no general mailing of ballots. Ballots must be returned to TPAN no later than December 18, 2001 at 7:00 PM.		
Tuesday, 11th	6:00 PM	Research Update - Hep C - New treatment Updates
Tuesday, 18th	Social: 6:30 PM Meeting: 7:00PM	TPAN Board Meeting and Annual Meeting Election of Directors to the Board of Directors Matters from the prior year will be reviewed, the election of new Directors concluded, and any other business that may be properly brought forward for consideration and/or action will be handled.
Tuesday, 24th to Friday, 28th		Agency closed for Christmas Holiday and to move agency to the new location 5537 N. Broadway, Chicago, IL 60640

Programs and Meetings

All meetings held at TPAN offices unless otherwise indicated:

1258 W. Belmont Ave., Chicago.

Office hours: Monday–Thursday, 9 am–8 pm. Friday, 9 am–6 pm

phone: (773) 404-TPAN (8726) • fax: (773) 404-1040

e-mail: tpanet@aol.com • www.tpan.com

Support groups sponsored by the Chicago Department of Public Health
Peer Support and Buddy programs sponsored by the AIDS Foundation of Chicago

MONDAY

TPAN DAYTIMERS

A group for people with HIV who prefer to meet during the day. Mondays and Thursdays at 10:30 am.

NEWLY DIAGNOSED

A group for newly diagnosed individuals. Mondays at 7:30 pm. 2nd and 4th Mondays includes HIV 101 education.

NEGATIVE PARTNERS

The Negative Partners of Positive People. 3rd Monday at 7:30 pm.

TUESDAY

T.R.I.B.E.

An educational discussion group for Gay Men of Color focused on maintaining a healthy lifestyle. 2nd and 4th Tuesday at 7:00 pm.

LIVING POSITIVE

HIV-positive gay men discuss how being positive affects relationships and deal with the impact of HIV as single men. Tuesdays at 7:30 pm.

POSITIVE PROGRESS

A group for HIV-positive people in recovery. Tuesdays at 7:30 pm.

WEDNESDAY

MEDICAL CLINIC

See description in Friday's listing. Wednesdays 3:30 pm–7:30 pm.

STRAIGHT TALK

A group for HIV-positive heterosexuals. Wednesdays at 7:30 pm.

NEEDLE EXCHANGE PROGRAM

Free, anonymous, legal syringe exchange and HIV/AIDS prevention. Every Wednesday 5:00 pm–7:00 pm at TPAN offices. In association with Chicago Recovery Alliance.

YOGA

Wednesdays at 7:30 pm.

THURSDAY

TPAN DAYTIMERS

A group for people with HIV who prefer to meet during the day. Mondays and Thursdays at 10:30 am.

MEDICAL CLINIC

See description in Friday's listing. Thursdays 2:00 pm–5:00 pm.

NEEDLE EXCHANGE PROGRAM

See description in Wednesday's listing. Thursdays 2:00 pm–5:00 pm.

BROTHERS UNITED IN SUPPORT (BUS)

A group for HIV-positive gay and bisexual men of African descent. Thursdays at 7:00 pm.

BERLIN HIV-POSITIVE SOCIAL HOUR

Berlin, 954 W. Belmont, Chicago. Thursdays from 6:00–10:00 pm.

FRIDAY

MEDICAL CLINIC

Free medical care provided by a nurse practitioner. This program is in conjunction with the Needle Exchange Program and is offered by Access Community Health Network. Call for an appointment. Fridays 2:00 pm–5:00 pm.

NEEDLE EXCHANGE PROGRAM

See description in Wednesday's listing. Fridays 2:00 pm–5:00 pm.

MEDITATION

Fridays at 7:00 pm.

SAFE PASSAGE

A group for young adults (ages 18–24) who are HIV-positive. Fridays at 7:00 pm.

SCHEDULED BY APPOINTMENT

FAMILY AIDS SUPPORT NETWORK (FASN)

A group for family, friends, and caregivers. Call Betty Stern at (773) 404-1038.

WOMEN'S GROUP

A group for HIV-positive women. Call Sylvia at (773) 404-8726 for more information.

SPEAKERS BUREAU

Individuals are available to community groups and organizations to educate on HIV, safer sex, harm reduction and experiences of living with HIV. Call Sylvia or Keith at (773) 404-8726.

PEER SUPPORT NETWORK

Provides one-on-one support for recently diagnosed individuals. Volunteers provide support, information and referrals. Call Derek at (773) 404-8726 to get a buddy!

POSITIVE BUDDY

Volunteers provide individuals living with HIV/AIDS one-on-one emotional / physical support. Call Derek at (773) 404-8726 to get a buddy!

CHRIS CLASON RESOURCE CENTER

Find the latest news in the Chris Clason Resource Center. Open Monday through Thursday 9:00 am–8:00 pm., Friday 9:00 am–6:00 pm.

MISCELLANEOUS

CHICAGOPos18to24 AT AOL.COM

AOL chat room for young adults (ages 18–24) who are HIV-positive. Hosted by TPAN's Young Adult Program. Go to AOL town square. Monday through Friday 3:00 pm–6:00 pm, except Thursdays 4:00 pm–6:00 pm.

Positively Aware's 2001 Reader Survey

We are interested in knowing why you read *Positively Aware*, and how we can improve the journal. Please take a few minutes to complete this survey and provide comments and/or suggestions.

You can fold the survey and return by mail,
or by Fax at (773) 404-1040.

Gender

- Male
- Female
- Transgender
- male to female
- female to male

Age

- 24 or younger
- 25-29
- 30-39
- 40-49
- 50-59
- 60+

Race/Ethnicity

- White/Caucasian
- African-American
- Puerto Rican, Mexican or other Latino descent
- Asian/Pacific Islander
- Native American
- Other _____

HIV status

- HIV positive
- HIV negative
- Do not know

How do you identify?

- Straight/heterosexual
- Gay/homosexual
- Lesbian
- Transgender
- Bisexual
- Other _____

Describe the city/town in which you live

- Urban
- Suburban
- Rural
- Zip Code _____

Living arrangements

- Alone
- With roommate
- With spouse/partner
- Living with parents/family
- Head of household (with children)
- Homeless
- Live in shelter/temporary/group housing

9. Annual income (before taxes)

- Less than \$4999.00
- \$5000.00 to \$9999.00
- \$10,000.00 to \$19,999.00
- \$20,000.00 to \$29,999.00
- greater than \$30,000.00

10. Primary source of income (check all that apply)

- Full-time work
- Part-time work
- Unemployed
- Disability/SSI/SSDI
- Public aid
- Other source of income _____
- No source of income _____

Where do you receive healthcare services?

- Private physician/clinic
- Public clinic
- Hospital emergency room
- Not currently under physician care
- Community Health Center
- Other _____

Are you currently taking anti-HIV therapy? Yes/No

If yes, what kind? _____

If no, why not? _____

Are you currently receiving alternative/complementary HIV therapy?

If so, what type? _____

How do you receive *Positively Aware*?

Is the information provided in *Positively Aware* beneficial to you?

Why or why not? _____

What could be done to improve *Positively Aware*?

What additional topics would you like to see covered in *Positively Aware*?

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World AIDS Day December 1st

fold along this line

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