

# Increasing Christian Social Workers' Basic Knowledge of HIV and AIDS: The Beginning of Competent Practice

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*Rarely will a social worker practice in any setting without encountering clients infected with or affected by HIV and AIDS several times throughout the course of his or her career. As one whose entire social work career has been dedicated to working with and on behalf of those living with HIV and AIDS, the author has had many opportunities to engage in conversations and trainings with a variety of social work practitioners and students. Almost without exception, these encounters begin with well-meaning, eager, and engaged social workers—men and women who are interested in (and often already practicing with) HIV-positive clientele. However, the author is struck time and time again by the lack of knowledge the average social work practitioner and student has regarding both the history and current state of the HIV epidemic. This article aims to increase the social work practitioner's basic knowledge of HIV and AIDS, based on the underlying belief that a better educated practitioner can then become a more competent and confident provider of compassionate social work services—especially focused on the practice of the Christian social work practitioner. The author presents three steps toward competent practice with clients living with and affected by HIV and AIDS: understanding the history of HIV in America, knowing the facts of the current state of the HIV epidemic, and acknowledging the ways Christian social workers and the Church have detrimentally treated those with HIV and AIDS. Then, the author offers some implications for Christians in social work practice aimed to challenge and empower them to more competent practice with the individuals living with and affected by HIV they will inevitably encounter in their varied fields of practice.*

**I**N THE FALL OF 2010, I FACILITATED A DAY-LONG INSTITUTE TRAINING entitled “A Focus on HIV/AIDS: Where are We Now? What are Christian Social Workers Doing?” at the North American Christians in Social Work (NACSW) conference. It was a day of lively conversation with an engaged group of about a dozen seasoned social work professionals who chose my training out of a number of great topics with trainings running concurrently. These social work educators and practitioners sought out this training because of an interest in HIV and AIDS and several of them came into the training with some level of experience and/or exposure to HIV-positive and affected clientele. Because the group was varied in their length of time in the field and previous experience with HIV/AIDS, I began the day with an activity I often use in the classroom and trainings like these to assess my audience. On the whiteboard, I asked the group to collectively create three lists—things I *know* about HIV, things I *think I know* about HIV, and things I *want to know* about HIV.

The results were enlightening. Very few items appeared on the first list. A few more items appeared on the second list. The third list was longer than the first two combined. At first glance, it would seem that this simply shows that I had an interested and eager group of training participants (which was true). However, it suggested to me something else as well; there is much to be learned by Christian social workers about the HIV epidemic—even though many of them are already practicing social work with HIV-positive and affected clientele.

### **Competence in Social Work Practice**

We began the day's training with an overview of the HIV epidemic—its history and its current state. I intended this section of the training to last about an hour; it took the entire morning. As I began to cover the material, more and more questions emerged from the participants. What I realized that morning has become the impetus for this article. Rarely will a social worker practice in any setting without encountering clients infected with or affected by HIV and AIDS several times throughout the course of his or her career. Nearly all of them will be well-meaning, eager, and engaged social workers open to providing services to HIV-positive clientele. However, the average social work educator, practitioner, and student lacks even a basic level of knowledge and training on either the history or current state of the HIV epidemic. Therefore, this article aims to increase the social work practitioner's knowledge of HIV and AIDS, based on the underlying belief that a better educated practitioner can then become a more competent and confident provider of compassionate social work services—especially focused on the practice of the Christian social work practitioner.

Taking the time to educate oneself on fields of practice one might not be familiar or well-versed in, like HIV and AIDS, is not simply a productive

use of time; it is also a professional mandate of the social work profession. The National Association of Social Workers (NASW) and its Code of Ethics (1996, revised 2008) calls for social workers to be *competent* at the work they do. Competence is defined in Standard 1.04 as follows:

#### **1.04 Competence**

- (a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
- (b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.
- (c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

Just as NASW has accurately assessed, competence in any area of social work practice comes only through experience, education, and training. Toward that end, attending trainings like the institute I offered is a vital first step for both seasoned social work professionals and those engaging with issues of HIV and AIDS for the first time. Social workers are called to provide competent services—and also not to provide services in areas in which they are not yet competent. Therefore, this article may be a vital first step for many readers seeking to become competent providers of social work services to individuals infected and affected with HIV and AIDS.

#### **History of HIV and AIDS in America**

The first step toward competent social work practice with persons living with HIV and AIDS is to understand the basic history of HIV and AIDS. One cannot purport to understand the experience of a person currently infected with HIV and AIDS without an understanding of the history of HIV and the evolution it has had since its advent in the early 1980s. An appendix of HIV resources is included at the conclusion of this article; this list of resources includes websites and publications where one can go for more information about HIV history and current trends. Much of the

information presented in this historical overview has been compiled from CDC surveillance reports (Centers for Disease Control, 2012) and HIV awareness websites included in the Appendix.

**Text Box 1: Key Events in HIV History—The 1980s**

- 1981:** “Gay Cancer” or GRID (Gay-Related Immuno Deficiency) blamed for 121 deaths
- 1982:** GRID is renamed AIDS (Acquired Immuno Deficiency Syndrome); CDC recognizes sexual activity and infected blood as causes; 285 cases of AIDS in 17 States and 5 European countries
- 1985:** First HIV blood test; blood banks begin routine screening; Rock Hudson died
- 1986:** Surgeon General C. Everett Koop sends AIDS information to all U.S. households
- 1987:** FDA approves first drug for the treatment of HIV/AIDS—AZT  
Reagan’s first speech addressing HIV; VP Bush heckled for suggesting mandatory HIV testing

In the earliest years of the HIV epidemic, much was unknown about its causes and treatment. Text Box 1 summarizes some of the key events and a timeline for the HIV epidemic in the 1980s. Because the first several patients seen exhibiting symptoms were gay men, the medical community originally believed this disease to be linked to homosexuality; therefore, the first 121 men to become sick and die (quickly) of this new disease were diagnosed with “gay cancer” or GRID, which stood for Gay-Related Immuno Deficiency. A year later, that diagnosis was retracted as it became more evident that the same disease killing gay men was also affecting individuals with no history of homosexual activity. GRID was renamed Acquired Immuno Deficiency Syndrome (AIDS). At this point, the causes of AIDS were identified to include all unprotected sexual activity (heterosexual and homosexual) as well as infected blood transmitted through transfusion, shared intravenous needles, and perinatal transmission.

By the mid 1980s, much progress was already underway in terms of community education, treatment, and prevention. Scientists were able to isolate and identify the specific virus causing AIDS (this virus was named the Human Immunodeficiency Virus—HIV) and the first blood test was made available. The first use for this HIV test was to begin routinely testing the blood in all American blood banks, thereby significantly reducing (and eventually eliminating) incidents of HIV infection via blood transfusion. Perhaps the most significant advancement in the field of HIV and AIDS in the early years of the epidemic came with the introduction of the first medication to successfully manage the symptoms and slow the progress of the HIV virus. This medication, known commonly as AZT, carried with it

some horrific side effects and an oppressive pill burden (upwards of 24 pills in a day); however, it was an incredibly hopeful sign that treatment may be possible. Also in the mid-1980s, the general American public became more aware of and educated about HIV and AIDS due to the widely publicized death of celebrity Rock Hudson and the first nationwide mailing distribution of HIV information. Toward the end of the decade, President Reagan was publicly mocked in a press conference when he first acknowledged the HIV and AIDS epidemic and advocated for mandatory HIV testing of all Americans. While this suggestion never came to pass for a number of reasons, many people at the time certainly believed it might have been a viable preventative measure.

The 1990s saw much more intervention at the federal level for the cause of HIV and AIDS treatment and prevention. (Text Box 2 provides a timeline summary of the key events throughout the second decade of the American HIV epidemic.) In 1990, Congress passed the first comprehensive piece of federal HIV legislation. Named in memory of a young boy with hemophilia who died of HIV after a life of advocacy, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act included funding streams for medical research, treatment for uninsured individuals, HIV prevention programs, and much more. By 1991, one million Americans had been diagnosed with HIV and 36,000 Americans had died. AIDS was the leading cause of death for Americans between the ages of 25 and 44 and the 8<sup>th</sup> leading cause of death overall.

#### **Text Box 2: Key Events in HIV History—The 1990s**

- 1990:** Congress passes the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act; Ryan White died
- 1991:** 10 million infected with HIV worldwide, 1 million in U.S.; 36,000 Americans have died; Magic Johnson diagnosed with HIV
- 1994:** AIDS is the leading cause of death in 25-44 year olds; Begin routine AZT for pregnant women with HIV
- 1996:** First highly active anti-retroviral (HAART) “cocktail” passed by FDA; AIDS is the 8<sup>th</sup> leading cause of death in the U.S.
- 1997:** Government spends \$4.5 billion on HIV/AIDS treatment; As a result of HAART, AIDS drops to 14<sup>th</sup> leading cause of death, 5<sup>th</sup> among those 25-44 years-old

With regard to the life expectancy and health outcomes for individuals diagnosed with HIV and AIDS, the mid-1990s can be thought of as the lowest point in history; two major changes in the medical treatment of HIV and AIDS began to dramatically improve both the prevalence of new HIV diagnoses and, perhaps more significantly, the quality of life for those already infected.

First, in 1995, doctors and hospitals began routinely administering AZT to all pregnant women with HIV throughout their pregnancies and during labor and delivery. This significantly reduced the likelihood of perinatal transmission; less than 300 babies have been born with HIV since the mid-1990s. Second, in 1996, the FDA approved a new type of HIV medications known as Highly-Active Anti-Retroviral Treatment (HAART). HAART is a combination of two or three different medications found to be particularly effective in improving the health and lives of individuals living with HIV and AIDS. The advent of HAART is commonly identified as the most significant event in the trajectory of the HIV pandemic worldwide. In the course of just three years, as a direct result of HAART interventions, AIDS dropped from the 8<sup>th</sup> to the 14<sup>th</sup> leading cause of death among all Americans and from the 1<sup>st</sup> to the 5<sup>th</sup> cause of death in those between 25 and 44 years of age.

Therefore, by the turn of the 21<sup>st</sup> century, the course of HIV had been greatly slowed down, HIV testing and prevention measures were underway and working to reduce the incidence of new HIV infections, and resources for those infected and affected with HIV and AIDS were significantly more available than at any point in the previous two decades. Text Box 3 provides a summary of the key events at the beginning of the third decade of HIV and AIDS.

### Text Box 3: Key Events in HIV History—The 2000s

- 2001:** AIDS Drug Assistance Program (ADAP) added to the CARE Act
  - 2002:** AIDS Education and Training Centers are established nationwide to provide education and resources to primary care providers
  - 2004:** First HIV saliva and finger-prick “rapid” tests are passed by FDA
  - 2005:** AZT patent expires and generic HAART drugs emerge
  - 2006:** The first one-pill-once-a-day HAART regimen: Atripla
- CARE Act is reauthorized by Congress with some substantial changes and a new name—The Ryan White Treatment Modernization Act; CDC revised recommendations for HIV testing—routine clinical testing

With the success of HAART, much of the care and treatment for individuals living with HIV and AIDS beginning in 2000 centered around ensuring access to medical treatment. The AIDS Drug Administration Program (ADAP), a federal-state partnership program funded through the Ryan White CARE Act, began to connect the uninsured and underinsured with much-needed access to HAART medications at no cost. With the expiration of the AZT patent in 2005, a proliferation of new medications became available, making the treatment options for individuals living with HIV and AIDS greater than ever before. Because HIV is a virus susceptible

to drug resistance over time, having the ability to switch patients to new regimens of medications greatly enhanced the course of their lives and also assisted doctors in managing side effects in new ways. By 2006, HAART had even advanced to the point of a one-pill-once-a-day regimen (on the market under the name Atripla)—a far cry from the 24-count pill burden of the early days of the HIV epidemic!

Also of note in the early to mid-2000s, much attention turned toward HIV prevention and HIV testing in particular. One of the leading HIV testing companies, OraSure, unveiled a new “rapid test” for HIV. This rapid test, called Oraquick, is a finger-prick blood test with results immediately available within 15 minutes. With this new development, the opportunities for HIV testing expanded exponentially because the prior means of HIV testing required patients to return to receive their results up to two weeks after testing. Rapid testing led social service agencies, community-based agencies, and health departments to consider new venues for testing in outreach settings. Outreach-oriented testing coupled with a federal mandate in 2006 for medical settings to institute routine HIV screenings of all at-risk patients meant thousands more individuals were educated about HIV risk, tested, and diagnosed than ever before. Those diagnosed with HIV are now able to access a much-improved set of medical options and receive the care and treatment they need. The focus of HIV care and treatment now centers around assisting individuals infected with HIV and AIDS to learn to *live with* HIV instead of expecting to *die from* HIV—a drastically different and more hopeful place to be!

### **Current State of HIV/AIDS in America**

If the first step toward competent practice with HIV-infected and affected clients is understanding the history of HIV and AIDS, the second step is knowing the facts about the current state of HIV. It is often the case that a presentation of the current facts of the epidemic comes as a surprise to many people, as the epidemic at times does not reflect the myths, stereotypes, and commonly-held assumptions many Americans hold about HIV. All of the data presented in this section comes from the latest epidemiology reports from the Centers for Disease Control (CDC), which is data from 2009. Tables 1 and 2 present some of the most important 2009 statistics and estimates.

As Table 1 shows, the prevalence (meaning the number of total people living with the disease nationwide) of HIV is well over 1 million people. While this is, of course, a shocking and sobering statistic, what is perhaps more disconcerting is the CDC’s estimate that as many as 1 in 5 individuals currently living with HIV and AIDS in this country are unaware of their status. This statistic has been holding steady between 20 and 25% for the past decade. Therefore, one of the major emphases of public health initiatives and federal funding continues to be the need for increased HIV testing, both in outreach and traditional medical settings.

**Table 1: Prevalence and Incidence of HIV in America**

Prevalence	Estimated 1.2 million living with HIV—20% undiagnosed
Incidence	Approximately 50,000 new diagnoses annually

The HIV incidence (meaning the number of *new* diagnoses) in 2009 was about 50,000. Table 2 shows how those 50,000 newly diagnosed individuals are distributed by risk category. Homosexual activity (referred to by the acronym MSM in CDC data) still represents the largest segment of new diagnoses (61%); however, it is important to note that the rates among Caucasian gay men have leveled off and by some estimates even slightly dropped in the past ten years. The fastest growing population of MSM diagnoses is among young (15-30) African American men. Likewise, among the second largest risk category – heterosexual women – the largest increase in new diagnoses over the past ten years is among African American women. While African Americans represent only 14% of the total U.S. population, they represent 44% of all new HIV diagnoses. African American men are six and half (6.5) times more likely than white men to become infected with HIV, and African American women are 15 times more likely to contract HIV than their white counterparts! It should also be noted that the rates of HIV are higher among Hispanics than Whites as well; Hispanic men and women are three to four times more likely than White men and women to become HIV-positive.

**Table 2: Breakdown of New HIV Diagnoses by Risk Category**

Homosexual Activity (MSM—Men Having Sex with Men)	61% *only significant increase is among young African American men
Heterosexual Women	23%
Intravenous Drug Use	9%
Heterosexual Men	7%
Perinatal Transmission (Mother to Baby)	Less than 1%

**Detrimental Actions of Christian Social Workers and the Church**

After understanding the history of HIV and gaining knowledge of the current HIV epidemic, the third step toward competent practice with HIV-infected and affected clients requires the Christian social worker to acknowledge the actions and reputation of the Church and other Christian social workers in interaction with men and women living with HIV and AIDS. This acknowledgement is a vital step toward reconciliation between



the Church and individuals living with HIV, a necessity in order to achieve positive rapport with HIV-positive clients, and critical to truly competent practice.

The stigma associated with an HIV diagnosis in America certainly began with the misinformation and faulty assumptions about the virus in the early 1980s, which led to its original name—Gay-Related Immuno Deficiency (GRID). Labeled as a “gay disease” from the onset, men who began exhibiting symptoms were immediately faced with discrimination and judgment by those who believed homosexuality to be wrong, immoral, or both. Even when our understanding of HIV and its causes expanded to include unprotected heterosexual activity and intravenous drug use, the stigma associated with being HIV-positive did not diminish. Especially throughout the 1980s and early 1990s, there was actually much public sentiment suggesting that people with HIV “deserved” their plight because they chose to engage in “wrong” or sinful behaviors. This belief resonated with many within the Church, especially more conservative Christians. Some extremist perspectives even argued that HIV was God’s way of targeting and punishing homosexuals. Even today, though we know much more about the faces of the victims of the HIV epidemic—including young children and married women—many Christians continue to hold tightly to the stereotypical white gay man living with AIDS. The predominant discomfort with issues of homosexuality, promiscuous sex, and drug use among Christians in general and pastors specifically leads most churches to avoid acknowledging HIV among their congregations. The lack of discussion, preaching, and education about HIV and AIDS within the Church only perpetuates the stigma.

And, perhaps even worse than its silence on this issue, the Church also has a long history of directly shunning members who disclose their HIV status and/or their homosexual orientation. It is all too common to hear the story of a man who grew up in the Church, became HIV-positive, and bravely shared his status with a pastor or fellow church member only to be asked to leave the congregation. The lack of support, and at times outright rejection, of one’s church body at such a vulnerable time can be devastating.

While some HIV-positive clients will have such a story of rejection by the Church, still others will have a slightly different experience. Many gay men who have sought support from a Christian church or a Christian social worker have been urged to consider Reparative Therapy. Reparative Therapy (also referred to as Conversion Therapy) is essentially counseling aimed at aiding the individuals in changing his or her sexual orientation from homosexual to heterosexual. At best, suggesting to a HIV-positive gay man that he needs to “convert” leaves him feeling confused, judged, and at fault for his illness. At worst, such a suggestion causes a downward spiral that can lead to further stigmatization, depression, and suicide. While many Reparative Therapy camps and programs are run by churches and

lay-educated people, it is also an intervention occasionally advocated for and conducted by trained mental health professionals, including Christian social workers. It is important to note that both the American Psychological Association (APA) and the National Association of Social Workers (NASW) have drafted official position statements opposing the use of Reparative Therapy, stating a lack of evidence of its success and some preliminary data suggesting its harmfulness (APA, 2009; NASW, 2000).

### **Implications for Competent Social Work Practice**

All of this information about HIV and AIDS (its history, the current state of the epidemic, and the role of the Church) equips the Christian social worker with important knowledge and insight needed in order to provide competent social work services to individuals infected with and affected by HIV. From each of the three steps presented here, there are important implications for the future direction of our social work practice.

First, there may be opportunity for us to educate others around us about the history of HIV and AIDS; perhaps fellow practitioners and colleagues would benefit from the information presented in the beginning of this article. If and when we encounter people (personally or professionally) who hold wrong assumptions about HIV and AIDS or who make inaccurate statements about its history and trajectory in American culture, this article equips us with a starting point for correction. This is important because throughout history we have seen how education about HIV can, in and of itself, begin to change people's attitudes toward those living with HIV and AIDS.

Second, recognizing the current trends of the HIV epidemic may yield newfound opportunities for social work practice interventions. For example, given the fact that at least 1 in 5 individuals living with HIV is currently unaware of his or her HIV status, social workers may begin to consider ways to increase community awareness about the importance of HIV testing; we may even want to consider partnering with a local HIV agency to provide opportunities for HIV testing within the context of our current practice. Another direction for social work intervention in light of the data presented on the current HIV crisis in America—specifically, the disproportionate rates among African Americans—might be to seek ways to work specifically with African American churches on issues of HIV prevention and community education.

Finally, as already alluded to in the course of discussion about the Church's role in promoting and perpetuating the stigma of HIV and AIDS, Christian social workers must consider how to acknowledge and overcome the harmful effects of previous treatment received by many HIV-positive clients at the hands of Christians. The literature on best practices for working with the LGBT population in particular emphasizes the importance of establishing an atmosphere of "affirmative practice" (Amadio, 2008;

Tan, 2012). This type of practice requires the Christian social worker to acknowledge the hurt a client might have faced by other Christians in the past and then to set their own relationship with the client apart by creating a safe, judgment-free space. I used to practice within the context of a faith-based organization where I would often begin an intake session with a gay HIV-positive client by saying, "I'm not sure if you have been treated poorly by Christians or the Church in your past, but I want you to know that if you have been, I am sorry." By taking the initiative to acknowledge that past, an important dialogue can be opened for the future.

Regardless of the setting or field of practice, every social worker will at some point encounter a client infected or affected by HIV and AIDS. For some, HIV will be the presenting problem (i.e. a client seeking counseling after receiving a new diagnosis). For others, HIV may be a secondary concern (i.e. an HIV-positive client seeking housing assistance). In any case, armed with information about the history of the epidemic and knowledge about what is currently happening, the Christian social worker can begin to establish compassionate, competent practice with those clients in their time of need. ❖

#### REFERENCES

- Amadio, D.M., & Perez, R.M. (2008). Affirmative counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients. In C. Negy (Ed.), *Cross-cultural psychotherapy: Toward a critical understanding of diverse clients* (2nd ed.), pp. 217-240. Reno, NV: Bent Tree Press.
- American Psychological Association. (2009). Resolution on the appropriate therapeutic responses to sexual orientation distress and change efforts. Retrieved from <http://www.apa.org/about/governance/council/policy/sexual-orientation.aspx>
- Centers for Disease Control. (March 2012). HIV in the United States at a glance. Retrieved from [www.cdc.gov/hiv/resources/factsheets/PDF/HIV\\_at\\_a\\_glance.pdf](http://www.cdc.gov/hiv/resources/factsheets/PDF/HIV_at_a_glance.pdf)
- National Association of Social Workers. (approved 1996, revised 2008). Code of Ethics of the National Association of Social Workers. Washington, DC: Author.
- National Association of Social Workers. (2000). Position statement on reparative/conversion therapies. Retrieved from [www.naswdc.org/diversity](http://www.naswdc.org/diversity)
- Tan, A. (2012). Working with LGB clients: Promising practices and personal challenges. In T. L. Scales, & M. S. Kelly (Eds.), *Christianity and social work* (4th ed.), pp. 235-253. Botsford, CT: North American Association of Christians in Social Work.

**Appendix: Resources for Further Information on HIV and AIDS**

- Shilts, R. (1987, 2007). *And the band played on: Politics, people, and the AIDS epidemic*. New York, NY: St. Martins Press. Investigative reporting on the development and spread of AIDS in the 1980s.
- Avert: Averting HIV and AIDS – Website [www.avert.org](http://www.avert.org)
- The Body – Website [www.thebody.com](http://www.thebody.com)
- Centers for Disease Control and Prevention – Website [www.cdc.gov/hiv](http://www.cdc.gov/hiv)
- National HIV Hotline – 1.800.342.AIDS

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**Key Words:** History of HIV, Social Work Practice, Christianity and HIV/AIDS