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Evaluation of a psychosocial intervention in caring for adherence to treatment for HIV/AIDS: a case study

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Abstract

Patient adherence to medication is a central dimension for AIDS programs worldwide. The role of health professionals in adherence, especially with chronic diseases, has been emphasized by studies, including the committee of experts from the WHO, that recommends support to patients and not blame. We conducted a case study using the evaluation approach, analysing a set of four individual assistance sessions of a patient who had problems with adherence to antiretroviral therapy. An “Evaluative Framework” guided the analysis of one database case - audio recordings and transcripts of an overall protocol composed of 44 people cared for by three trained professionals in a specialized service, in the context of a clinical trial that evaluated the effectiveness of a novel modality of psychosocial intervention on adherence health care. Its theoretical and methodological bases are the ‘Vulnerability and Human Rights Framework’; the references of *Care* and *Psychosocial Attention* in the setting of AIDS, inspired by social constructionism. The notions of *convenience* and *practical success* were stressed to suggest a change in focus towards the patient’s perspective, democratizing the relation of care; in the dialogues centered on everyday scenes of the medications taken, seeking to enlarge the mutual recognition of the vulnerability to illness due to treatment failures. The results refer to the instrumentality of the “Evaluative Framework” and the content of the evaluations that focused on the intersubjective dynamics of interactions and dialogues related to the everyday experiences with ART in search of a better way of living with the treatment.

Keywords: Adherence, antiretroviral therapy, psychosocial intervention, health care.

Avaliação de uma intervenção psicossocial no cuidado em adesão ao tratamento por HIV/Aids: um estudo de caso

Resumo

A adesão do paciente ao tratamento medicamentoso é uma dimensão central para os programas de aids no mundo. A atuação dos profissionais de saúde na adesão, especialmente em doenças crônicas, tem sido enfatizada pelos estudos, entre eles o do comitê de *experts* da OMS, que recomenda o apoio aos pacientes e não sua culpabilização. Realizou-se um estudo de caso, de enfoque avaliativo, do conjunto de 04 atendimentos individuais de uma paciente com problemas de adesão à terapia antirretroviral (TARV). Um “Quadro Avaliativo” orientou a análise de um dos casos do banco de dados - gravações em áudio e transcrições do protocolo completo das 44 pessoas atendidas por três profissionais treinadas, num serviço especializado, no contexto de um ensaio clínico que avaliou a efetividade de uma modalidade inédita

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de intervenção psicossocial de cuidado em adesão. Suas bases teórico-metodológicas são: o Quadro da Vulnerabilidade e dos Direitos Humanos; os referenciais do Cuidado e da Atenção Psicossocial no campo da aids, de inspiração construcionista social. Investiu-se: nas noções de *conveniência* e *sucesso prático* para inflexionar mudanças de enfoque na direção das perspectivas do paciente, democratizando assim a relação de cuidado; nos diálogos centrados nas cenas cotidianas de ‘tomadas’ das medicações, para ampliar o reconhecimento mútuo da vulnerabilidade ao adoecimento por falhas no tratamento. Os resultados referem-se à instrumentalidade do “Quadro Avaliativo” e ao conteúdo das avaliações que se centraram na dinâmica intersubjetiva da interação e dos diálogos em torno das experiências cotidianas com a TARV em busca de melhor convivência com o tratamento.

Palavras-chave: Adesão, terapia antirretroviral, intervenção psicossocial, cuidado em saúde.

Evaluación de una intervención psicosocial en el cuidado de la adhesión al tratamiento para el VIH/SIDA: un estudio de caso

Resumen

La adhesión del paciente al tratamiento farmacológico es una dimensión central de los programas de SIDA en el mundo. El papel de los profesionales de la salud en la adherencia, sobre todo en las enfermedades crónicas ha sido enfatizada por estudios, incluido el comité de expertos de la OMS, que recomienda el apoyo a los pacientes y no por su culpa. Se realizó un estudio de caso, de enfoque evaluativo, en un conjunto de 04 asistencias individuales de un paciente con pobre adherencia a la terapia antirretroviral (TAR). Una “Tabla Evaluativa” orientó el análisis de los casos en la base de datos - grabaciones de audio y transcripciones del protocolo completo de 44 personas atendidas por tres profesionales capacitados, en un servicio especializado, en el contexto de un ensayo clínico que evaluó la eficacia de una modalidad de intervención sin precedentes de la atención psicossocial de cuidado en adhesión. Sus bases teóricas y metodológicas son: la Tabla de Vulnerabilidad y Derechos Humanos, las referencias de *Cuidado y Atención Psicosocial* en el campo del SIDA, de inspiración construcionista social. La inversión: en las nociones de conveniencia y éxito práctico para se inflexionar cambios de enfoque hacia las perspectivas del paciente, democratizando las relaciones de cuidado, en los diálogos centrados en las escenas cotidianas de la ‘toma’ de medicamentos, para extender el reconocimiento mutuo de vulnerabilidad a la enfermedad por fracasos en el tratamiento. Los resultados se refieren a la instrumentalidad de la “Tabla evaluativa” y al contenido de las evaluaciones que se centraron en la dinámica intersubjetiva de la interacción y de los diálogos en torno a las experiencias cotidianas con el TARV en busca de una vida mejor convivencia con el tratamiento.

Palabras clave: Adhesión, terapia antirretroviral, intervención psicosocial, atención en la salud.

AIDS Treatment Adherence as an Issue to Health Services

Patients' adherence to drug therapy is considered a crucial dimension to AIDS programs worldwide. Incentive and monitoring actions are always present in technical guidelines aimed at health services that assist people in antiretroviral treatment (World Health Organization [WHO], 2003).

In Brazil, the Ministry of Health has stimulated the implementation of activities designed to promote, assess and control adherence in health services (2007, 2008). Adherence is a part of professionals' concerns and also the object of many activities in health services (Caraciolo et al., 2009; Nemes, *Equipe QualiAids*, & Alencar, 2008). An inquiry demonstrated that 80% (179) of the health services in the State of São Paulo concluded that the adherence/non-adher-

ence approach in the individual care domain is most of the times restricted to the consultation spaces, being conditioned to the performance, to the decision and abilities of the physician, nurse or other professionals who work in the clinical follow-up of the cases (Caraciolo et al., 2009).

The importance of the role of the health professional in adherence, especially in chronic illnesses, has been highlighted by many studies in the area, among them the one performed by the committee of experts from the World Health Organization (WHO, 2003), whose first chapter of technical recommendations for the improvement of adherence is named: “*Patients need to be supported, not blamed*”.

“Guiltifying” approaches, nonetheless, are still reported. Expressions such as “*I’ll be disappointed if you aren’t taking these drugs correctly, is there a problem?*”; “*I fully explained it to you, why don’t you take it correctly*” (Paiva, Leme, Nigro, & Caraciolo, 2000, p. 59) configure scenarios that evidently inhibit the patients from expressing themselves in fear of being disapproved of or reprimanded if he reveals his difficulties in following the treatment.

In Brazil, studies of the QualiAids line of research have pointed out the determining role of the quality of the service in adherence:

Adherence of individuals to the treatment stems from their everyday dealing with dynamic sets of limitations. Coping with these limitations is built and worked out in social daily life, which is, in many intersubjective contexts in which the relationship with the health service is preeminent because of its relevance and constancy (Nemes, 2009, p. 5).

The challenge to professionals who work in individual assistance lies in approaching, with the patient, difficulties of the latter to follow the treatment, among them, those related to social and lifestyle issues; negative beliefs regarding antiretrovirals; and those directly related to the use of medications (Melchior, Nemes, Alencar, & Buchalla, 2007). They are, therefore, difficulties that are concretely expressed in the singular lives of patients, eliciting the need to approach the meanings that they acquire according to their ways of life, sociocultural and political scenarios. This comprehension of the adherence ap-

proach by the health professional is inspired by propositions from the Vulnerability and Human Rights framework (Paiva, 2007; Paiva & França, 2010) which is a reference in the work of this Supplement.

Considering these premises in the context of individual assistance, a modality of psychosocial intervention of adherence support was developed and assessed, inspired by the theoretical framework of Vulnerability and Human Rights, in the notions of *Care* and *Psychosocial Attention* in social constructionist perspective. Named “Constructionist Care Approach to Adherence” (*Abordagem Construcionista do Cuidado em Adesão – ACCAdesão*; Santos, 2010, p. 15)², its affiliation to the social constructionism³ aims at distinguishing it from interventions more inspired by the “behavioral field”, which has a traditional place in literature about adherence interventions.

According to Santos (2010), the intervention prioritizes the “social, intersubjective and programmatic contexts involved in the treatment” (p. 41) and specifically, in the individual plan, it works with

the conception of the subject as a subject of rights or a citizen-subject – subject with the right to information, right to equity in the access to services, right to integral attention to health (Paiva, 2006, 2009, 2010) – with important implications to the other axis of analysis adopted in the Vulnerability and Human Rights framework. (Santos, 2010, p. 40)

One of the main contributions of the social constructionist perspective is in the focus given to the daily life dimension,

² The author clarifies that the denomination was “consolidated in a publishing that followed the formulation and accomplishment of the intervention, aiming to elucidate more directly the referential frame that based the proposal, besides aiding its possible reference in future researches” (Santos, 2010, p. 15).

³ To approach the social constructionist field with the depth that its variety of currents demands outreaches the possibilities of this introduction. Further considerations will be made bellow regarding this matter.

where the concrete, singular and intersubjective experience of the subject is located. Regarding adherence, attention is given to the way the subject lives with the treatment in his daily life, observing the dynamics of medication taking among the interactions that occur in the many intersubjective contexts where the person is located – among them, the health service itself. Thus, the main point is not knowing if the person “is taking his medications correctly” . . . but how he is taking them and what are the particular meanings that the medication acquires in his experience at each taking. (Santos, 2010, pp. 37, 38)

Theoretical and Methodological Bases of Intervention in Adherence: Expanding Traditional Approaches to Promote Adherence to Treatment

The proposals of J. R. Ayres about philosophical and technical changes in health practice scenarios, coalesced in his notion of *Care*, form the main inspirations in the general conception of intervention outlined. Moreover, these proposals have inspired novel comprehensions and definitions of adherence, among them the necessary distinction between adherence adopted in epidemiologic studies, and the notion of adherence adopted in the individual care context (Nemes, Helena, Caraciolo, & Basso, 2009).

Ayres (2009) proposes the notion of *Care* in the sense of deepening the relational and humanistic dimension of what traditionally is understood as treatment, intervention or service, appraising aspects of health work such as: the encounter, the intersubjective communication, everyday knowledge, mutual recognition among professionals and patients as subjects in dialogue and interaction, among others. Care is taken as a philosophical construct,

. . . a category that is meant to designate simultaneously a philosophical comprehension and a practical attitude regarding the meaning that health actions acquire in different situations in which a therapeutic action is demanded, that is, an interaction between

two or more subjects aiming to relieve the suffering or reach well-being, always mediated by knowledge specifically aimed at this goal. (Ayres, 2009, p. 42)

The proposals of the author point out to the need for therapeutic encounters with a more personal tone in the interaction; to the idea that every intervention in health should be based not only on the application of techniques (by the professional), on an object of his action (the patient, the body), but also be oriented to the incorporation of the technical dimension of ethical, aesthetic and affective dimensions (Ayres, 2009).

In the notion of *Care*, the approach to adherence seeks good clinical results (“technical successes”) integrated with legitimate *practical successes*: those more directly related to the aspirations of the patient as to his health, his life project and wellbeing at the moment (Nemes, Helena, et al., 2009). In this sense, dialogue, negotiations, expectations, as well as every aspect taken as “not strictly technical”, decisively participate in the possibilities of technical success (Nemes, Helena, et al., 2009, p. 397).

In this approach, the daily life experience of people with their treatments is evidently fundamental, as well as the search for a better convenience of the treatment in their lives. Effectively, inserting these plans that are complexly individual and social, simultaneously demands that the dialogue with the patient go beyond restrictively technical dimensions, strongly informed by principles of a *psychosocial attention*. This notion has been used in the field of health by different traditions; in the field of AIDS, it has been developed in line with the social constructionist notions by Paiva (2007, 2010).

The constructionist field is, by its own rights, polysemic, tense and polemical (Japur, 2006), configured in domains referred to, along with other names, as “strong” or “weak” (Schwandt, 2006) – which renders impossible its detailed description in the scope of this work. In spite of this, its influence has grown as an alternative to theoretical perspectives in psychology as a whole, and in psychology dedicated to studies and interventions in the field of health, by the

emphasis it gives to the following dimensions: relational, communicational and the shared production of meanings, which involve care interactions between two, but also, group practices (Guanaes, 2006; McNamee & Gergen, 1998; Rasera & Guanaes, 2010; Rasera & Japur, 2001, 2003, 2005). Social constructionism proposes the denaturalization of some concepts, warning us that “meanings that edify our understanding of the world (about person, problem, health, disease, etc.) are social constructions, stemming from conversational exchanges, placed in a specific social, historical and cultural context” (Guanaes, 2006, p. 17).

In the frame in which we are working (Vulnerability and Human Rights), psychosocial attention of a constructionist inspiration implied in Care (Paiva, 2012a) is unfolded in the interaction among health professionals and the people “attended”

and is implied in a notion of person who bears autonomy, liberty and dignity to be respected – understanding that these qualities depend that we consider every person as subjects of rights, assuming that the full exercise of rights is contextual, depends on each interpersonal interaction, of the historic context in their sociocultural, economic and political dimensions. . . . we define as belonging to the psychosocial domain the processes that consider the person in context and the context in the person. (Paiva, 2010, p. 21)

The premise of interacting with a patient, considering him as a person that is socially inserted in a given context, as well as being constituted as a subject from these interactions – hence the expression “context in the person” – opens the opportunity for the development of a specific kind of care. One that integrates the providing of inputs and actions of a technical nature with the attention and valorization of the inter-subjective realities where lives (and, therefore, becoming sick and reaching out for help) are developed.

The core of the dialogue is the daily life of people, which encompasses the experience of their treatments (meetings with profes-

sionals responsible for their care and the taking of medications), but is not restricted to these. The focus of attention is expanded from the body to the person, immersed in culture and integrated to the reference groups; hence the “psychosocial” attribute of attention, an inseparable component of Care.

Intervention Script

The intervention protocol, in four meetings, was organized in the form of a **script** (Table 1) that guided professionals – independent of their specific formation – to put into practice the theoretical, methodological and ethical bases described above.

In short, the **first meeting** presupposes the mutual recognition among professional and patient, reception and, from the unbiased listening of the professional, the conversational exploration of experiences related to “following the treatment” with solidary and non-reprehensive acceptance of difficulties and possible mistakes; in the **second and third meetings**, emphasis is set on conversations about the daily life of the patient (scenes and scenarios where medication taking takes place), using the methodology of scenes (Paiva, 1999, 2005, 2006, 2012): an unfolding of the *psychosocial attention* implied in *Care* that works, in dialogue, as “gateway” to recognizing experienced psychosocial processes and that, therefore, integrates vulnerability with becoming sick. This resource is operationalized through narrative requests made by the professional in the procedure of a “sitcom scene”, lived or imagined (coding) and afterwards, the comprehensive exploration of meanings and circumstances (decoding). In adherence support, scenes are referred to the antiretroviral medication “taking”, circulation in health services and sociability, where the repercussions of stigma, discrimination and rights violation broaden the chance of becoming sick. In the **last meeting**, the intervention experience is assessed along with changes or lack of changes in the process, solutions and strategies and necessary resources to sustaining adherence and better convenience of the treatment to the routine of the person.

Table 1
Psychosocial Intervention Script for Adherence Care

	Session 1	Sessions 2 and 3	Session 4
Objectives	<p>Contract;</p> <p>Identify situations and context of daily life that are obstacles for treatment;</p> <p>Organize priority issues and decide on themes to be part of next conversations;</p> <p>Clarify most technical questions about treatment.</p>	<p>Increase knowledge about treatment;</p> <p>Understand and decodify real life scenes;</p> <p>Amplify daily scene to bigger programmatic and social context;</p> <p>Foster creative and active imagination about daily life;</p> <p>Foster new personal repertoires to face identified obstacles to treatment.</p>	<p>Deeper understanding of feasible and desired changes in context and personal conduct aiming at self-care and enhancement of patient-clinic quality of communication and care;</p> <p>Identify resources to pursue and sustain chosen paths to face difficulties with ARV treatment;</p> <p>Close the process.</p>
Themes	<p>Mutual recognition of patient as experts on daily life and professionals-researchers as technical experts;</p> <p>The overview of patients' social and inter-subjective context;</p> <p>Questions about treatment.</p>	<p>Questions about treatment;</p> <p>Real episodes where treatment is not followed;</p> <p>Paths to face obstacle and "in scene" solutions.</p>	<p>Questions about treatment;</p> <p>Talking about how to face future obstacle and difficulties and sustain changes;</p> <p>Talking about how to face future obstacle and difficulties and sustain changes;</p> <p>Final clarification and orientation on the research process.</p>
Methodology	<p>Talking about the procedure, aim and contract;</p> <p>Free conversation and careful listening about the person's life</p> <p>Focus questions about treatment and on situations and episodes where following treatment is difficult;</p> <p>Use of informative resources(folders, guidelines, adherence kits);</p> <p>Record specific situations and episodes that seem to be more important to cope on recording sheets</p>	<p>Reviewing contract and questions;</p> <p>Looking at typical episodes of non-adherence</p> <p>The participant choses their priority from list of problems;</p> <p>Taking and exploring scenes from real episodes;</p> <p>Decoding the scenes, and reinvent them through active imagination and roleplaying;</p> <p>Talking about obstacles that are beyond individual action, and shared by other PLHIV;</p> <p>Discussing individual and programmatic resources;</p> <p>Professional and participant record and organizing a hierarchy of scenes and situations on recording sheet</p>	<p>Reviewing contract and questions;</p> <p>Taking and exploring scene from real episodes;</p> <p>Decoding the scenes, and reinvent them through active imagination and role-playing;</p> <p>Inform on social and programmatic resources, as well as constitutional rights;</p> <p>Recording decisions and plans for the future on recording sheets.</p>

Note. Table extracted from Basso, Helena, Caraciolo, Paiva and Nemes (2012).

Assessment Method: Instrument Elaboration and Study of a Case Seen in the Context of a Clinical Essay

The intervention of adherence support, named afterwards as “ACCAdesão”, was performed in 2008 by a service specialized in STD and AIDS in the city of São Paulo. Its effectiveness was assessed in the frame of a randomized controlled trial with a six months duration implemented in the service where health professionals applied it to patients of the experimental group. All of them were over 18 years old, with the same antiretroviral therapeutic scheme for at least six months, whose last viral load assessment was higher than 50 copies/ml of blood, indicating possible problems in treatment adherence. The experimental and control group had their adherence measures monitored⁴; respectively, one received the usual service care and participated in the psychosocial intervention; the other received only the usual care (Basso, 2010; Basso et al., 2012; Nemes, Helena, et al., 2009). The three professionals (two psychologists and one social assistant) who performed the interviews individually, with the 64 patients of the experimental group, were chosen by the researchers among the 10 professionals who participated in the 40 hours of training. The theoretical module focused the bases of intervention (Vulnerability and Human Rights, Care and Psychosocial Attention); the practical module aggregated educational psychology (simulation of medication taking for 48 hours with placebos, “roleplaying” of the meetings and how to mobilize narratives in the form of description of scenes), and piloting with volunteer patients in the service, not included in the research. The training focused on troubleshooting the practices traditionally developed in the adherence domain. Critical reflection was encouraged as well

as the mobilization to change in the direction of the theoretical, ethical and methodological principles that inspired the intervention detailed below. The three recruited professionals were also supervised during the period of the intervention (Nemes, Equipe QualiAids, & Centro de Referência e Treinamento em DST e Aids, 2009)⁵.

Different dimensions and components of these interventions were subject to evaluations, two of them already concluded. When assessing the feasibility of the intervention from the standpoint of the three professionals that performed them, Santos (2010) concludes that, even listing specific difficulties, they appreciated the experimentation process of a novel modality of care. They also highlighted outstanding repercussions for their professional activity that surpassed the adherence field. The novel referential “demonstrated the potential of provoking a turnaround in conceptions already strongly rooted among health professionals, based on their former disciplinary trainings – being able to result in important transformations in the paradigms of activity in the assistance domain” (Santos, 2010, p. 83).

Regarding the expected clinical outcomes, there was no statistically significant difference among the intervention and control groups in the adherence measures in the weeks 8, 12, 16, 20 and 24 of the essay. The viral load significantly decreased in both groups, without differentiation among the intervention and the control group. The power to statistically test the existence of differences among groups was impaired, mainly, because the number of patients who matched the criteria to be included in the service was below the expected (Basso et al., 2012).

For a deeper understanding of the results, two qualitative analyses are being performed: one that is based on the interviews with patients of the intervention⁶ and one that focuses on the “intima-

⁴ By the Medication Event Monitoring System, AARDEX, Ltd., Zug, Switzerland (MEMS) of two antiretroviral medications of the participants therapeutic schemes. It is a tool for the storage of pills that registers the frequency in which it is opened for the taking of doses and the respective hours.

⁵ For more details about the clinical essay, see: Nemes, *Equipe QualiAids*, et al., 2009.

⁶ Nasser, A. C. A., & Nemes, M. I. B. (2012). *A adesão ao tratamento da Aids e as possibilidades de mudança do cotidiano dos pacientes: Uma análise qualitativa sobre uma intervenção para melhoria da adesão* (Research project, Faculdade de Medicina, Universidade de São Paulo, SP, Brasil).

cy of conversations” among professionals and patients throughout the meetings that composed the intervention, in which this work is included.⁷ The study of one of the analyzed cases following an “Evaluative Framework” developed to guide the analysis of the extensive material produced by the essay is presented here: the transcriptions of audio recordings of the 44 cases (out of the 64 from the experimental group) whose patients concluded the four meetings anticipated in the protocol. The analysis process has currently been performed on 12 of the 44 cases that are intended to be studied from the existing database; the choice of the case now presented was due to the fact that it illustrates both the potential of the intervention, as well as the difficulties during the process, with general traits representative of the 12 cases.

The “**Evaluative Framework**” was built based on ethical, theoretical, conceptual and technical premises that sustained the planning of the intervention, being composed of dimensions and respective components that were configured in categories of analysis in the case study. It was concentrated on what emerged in the intersubjective dynamics of the dialogical processes between the psychologist⁸ and the person being attended, a woman. The use of this instrument was intended to systematize dimensions and components that allowed to answer questions related to more traditional categories of evaluative studies in health (structure, process and results), among them: What happened in the intimacy of meetings? Did each meeting unfold along the lines of the protocol? Did the professionals follow the script? In the conversations, was the methodology of scenes employed? Several components, grouped in five dimensions, make up the table presented below. In the case study, each com-

ponent was assessed according to the patterns where they were found to be developed between the professional and the person being attended: S = Sufficiently; I = Insufficiently; M = Moderately; N/A = Not Applicable (the component is not applicable in the case); N/E = No Evidence (there is no evidence about the component in the material).

Results

First Meeting: The Unease of Deise⁹ and Daily Life with Medications

Mutual recognition among the professional and the person being attended, and exploration about life history and daily life enabled Deise to be known: a 51 years old woman, employed in the production sector of a company, a widow for twenty years. Her husband died of AIDS, and up to the time of his death, Deise did not know of either of their infections. After three years, becoming sick from opportunistic diseases, she learned about her HIV condition during a hospital stay. Her main support is her 22 year old son, who became fatherless in his early life and to whom she told about her own serologic condition one year ago, endeavoring for years to keep the issue a secret due to the fear that her son might become sad or the victim of discrimination. She is very proud of him.

The professional received her in a compassionate and transparent manner when it came to the initial unease of Deise being informed about the audio recordings or filming.¹⁰ Exploring the meanings attributed to participating in the research, the expression “*to control myself better*” was evidenced, an acknowledgement of the personal relevancy.

As anticipated in the script, conversations were focused on daily life experiences with

⁷ In the domain of a doctoral thesis (of the first author) in the Department of Preventive Medicine of the School of Medicine of the University of São Paulo (USP), under advisory of Prof. Dr. Maria Ines Battistella Nemes (second author) and co-advised by Prof. Dr. Vera Paiva.

⁸ This professional had a significant experience in the assistance in HIV/AIDS, in counseling and care, worked in the team of the specialized service where the study took place.

⁹ Fictitious name adopted for the patient; her lines are in italics. To the professional was given the name Paula, whose lines are in bold and italics.

¹⁰ The information was not present in the Free and Clarified Consent Term (FCCT), although the team decided in advance only to employ audio recordings, being that filming devices were not available during the meeting.

DIMENSION A) Adequacy of the development of the protocol to the objectives, themes and methodology, according to the script: is referred to the components linked to the objectives, methodological procedures and themes approached in each meeting (opening and mutual presentation; explanations about the research/intervention; investigation about the understanding of each activity and the reasons of the participant having accepted the participation; use of free conversation/ attentive hearing; resource and exploration of scenes; joint definition of the “focuses” to dialogue (“list of problems” related to the treatment; accomplishment of objectives and observation of the themes of each meeting, closure and openings).

COMPONENTS

- A1) Development Meeting 1 regarding the script
- A2) Development Meeting 2 regarding the script
- A3) Development Meeting 3 regarding the script
- A4) Development Meeting 4 regarding the script
- A5) On the whole, was the process characterized as a “growth” of this adequacy?

DIMENSION B) Theoretical, methodological and ethical principles and the development of the protocol (P): is referred to the guiding components of the intersubjective dynamics of the dialogue, that is, to what extent the principles that underlie the intervention (defined in advance) were conducted in ways to interact and dialogue.

COMPONENTS

S I M NA SE

- B1) Dialogical interaction of meetings
- B2) Horizontalized interaction
- B3) Valorization of patient’s practical knowledge
- B4) Focusing in everyday experiences of the patient/contextualization of the treatment
- B5) Solidarity spirit and support in the search for solutions/implication of the professional with the patient
- B6) Consideration of the patient’s autonomy and its condition as a subject of rights
- B7) Orientation in the notion of convenience of the treatment to the life of the person.

DIMENSION C) Type of approaches present in dialogues (A): is referred to the “general connotation” of dialogues, what was preponderant and what emerged in some sense, among the following approaches:

COMPONENTS

S I M NA SE

- C1) **Educational:** based on instructions, clarifications and technical information; focus in doubts about medicines, effects in general, hours of taking, etc. Predominance of the professional orienting, informing and clarifying features.
- C2) **Practical:** based on suggestions and encouragements to the adoption of strategies such as reminders, alarms, medication assisted by others, etc; focus in suggesting strategies such as the use of alarm clocks, reminders, someone to help and changes of hours of taking. Predominance of the professional suggesting, giving tips, encouraging conducts, using expressions such as: “you could do”, “you would have to do”.
- C3) **Psychosocial:** based on the exploration and centering of the dialogue in aspects of previous life history (including the history of infection and diagnosis, social and affective relations and prejudices in self-care and the difficulties related to living with HIV. Emphasis in care, containment, approach to factors experienced as “sources of anguish” and reflexive enquiries aimed to contributing with understanding about the relationship between these features and problems in adherence.

C4) Clinical/symptomatic: based on the exploration of clinical features of the treatment, other diseases, comorbidities; focus in exploring issues related to the disease, traumas, symptoms, general health conditions, clinical exams, diagnoses, medical specialties, consultations and exams. Predominance of the professional exploring and clarifying biomedical and clinical features, suggesting other specialties and procedures when identifying corresponding needs.

C5) Mark the codes (C1, C2, C3, C4) of one or two of the approaches above that predominated in all the meetings.

DIMENSION D) Management of the *methodology of scenes* (MC): is referred to the performances of the professional in guiding the dialogues and the requests of the patient of elements that integrate scenes of the treatment and of living with HIV/AIDS; terms, ways of beginning, developing and closing the work with scenes (construction and decoding).

COMPONENTS

S I M N A S E

D1) During the meetings, was the methodology used? (Attempts and efforts of the professional in using them, independent of more or less opportune moments)

D2) In the opportune moments to use them, did the use predominate?

D3) When using it, were the initiatives in “mobilizing” scenes adequate most of the times?

D4) On the outcomes of the scripts of each mobilized scene, did the production of meanings about the difficulties in using medication happen?

D5) Besides acknowledging difficulties, are there any reports of the person that express the beginnings or intentions of actions/practices in the sense of improving self-care and adherence?

DIMENSION E) Repercussions of the intervention to the person seen (R): is referred to narratives/reports that suggest possible repercussions of the experience of participating of the intervention, among them engaging in conversation, availability, mentions to changes performed or the intention in performing them, compromises/agreements, acceptance of the illness, coping, decrease of tensions, suffering, insecurities or doubts, broadening of sociability, of the use of the service, among others which express present or future perspective of a more pleasing and less painful experience with daily treatment.

COMPONENTS

S I M N A S E

E1) Was there a broadening of the acknowledgement and understanding of the patient about his own treatment, conditions, obstacles, failures and opportunities?

E2) Movement of passivity regarding engagement, proactivity and autonomy.

E3) Movement from insecurity to confidence.

E4) Movement of restriction in sociability to the broadening of sociability (friends, work, health service).

E4) Movement of non-satisfaction to satisfaction on social and affective relationships.

E5) Movement of a worse to a better living with the treatment.

E6) Movement of misinformation/ignorance/misconceptions about medicine to a better knowledge of the subject.

E7) Movement in the direction of adopting new strategies/“ways” to take medication.

E8) Movement of transformation of negative meanings attributed to the medicine and treatment to more favorable meanings.

E9) Movement of change regarding the service. From a poor use and ignorance of the service to an interest in benefiting more of existing resources in the service.

Figure 1. Evaluative Framework.

treatment, but narratives also emerged about psychosocial repercussions on the occasion that Deise received the HIV diagnosis, emphasizing meanings attributed to circumstances involving the infection itself, that have continued to be shown as very significant. Deise feels wronged, resentful of her husband, whom she *hasn't forgiven*, and sees herself as a *victim* of the situation. Since then, she has not had any intimate or sexual relationships. Initially, Paula does not pursue this subject. The principle of mutual recognition between professional and patient was in part hampered due to the fact that the professional did not introduce herself in terms of work and professional formation, omitting her role as a psychologist of the service.

After the clarifications about the research and activity, Deise brings back the subject of the circumstances of her infection, when the professional becomes explicitly more open to hearing the previous history of Deise, who, in a digression into the past, narrates episodes since the death of the husband, becoming sick and beginning treatment, repercussions among relatives, the fear of prejudice that justifies secrecy about her condition, the personal withdrawal in the affective and sexual domain, her *"struggle"* to treat herself, survive and thus, raise her child. The narrative reveals a progressive construction of her identity as a widow and fighter, which was fundamental to coping with the first years of the disease, enduring treatment and exercising the mother's role, which gave her a meaning to *"go on living"*, *"taking care of myself"*.

The exploration of the fundamental theme of the first meeting (daily life experiences with the treatment) allows information about the current medication schedule (doses at 10 am and 10 pm), when the significant oscillations in the hours of taking the medicine were evidenced. Deise is used to taking the doses herself and leaves them in a closet at her work, but sometimes she takes them after the stipulated hours. The *"agitated"* rhythm, the *"the hectic service"*, do not contribute to remembering and taking the pills, *"all that rush, then I say: 'oh my God, the medicine'"*.

About the nighttime doses, Deise refers to *"tiredness"* as the main difficulty to be adhe-

rent. She repeats this expression several times when describing the general life tiredness and workdays. She comes back home around 7 pm, cooks dinner and sometimes, at 10 pm, when she was supposed to take the medication, forgets or sleeps in front of the television before remembering; by the time she realizes it, the dose has already been delayed one to three hours. The son reminds her to take the medication, but she remembers that for years, she was very worried about hiding the medicine bottles and did not take them in front of him, in order to keep her condition a secret. Her descriptions do not express the production of meanings that associate these circumstances to the problems of adherence; the subject is not elaborated upon.

Besides the delays, both in morning and night doses, adherence difficulties are also associated to experiences of collateral or adverse effects. She complains of being *a little dizzy*. Paula checks if Deise knows the names of the medication, encourages her to remember, differentiate and memorize them, and then explores in which places medication is kept in her house (in the patient's bedroom, in the bedside table) and also the dosage routine during the weekends, with few variations.

Focusing on conversations about daily life and in the search of a more convenient treatment for the patient, both mulled over an eventual change in the dosage schedule, from 10 to 9 am and from 10 to 11 pm. Deise states that she is not able to ingest the pills without eating something at the same time. They also talked about habits regarding treatment in former years, a subject that Deise has trouble remembering.

When closing the meeting, the professional encourages reflection: *"But what could you think, if you don't have the answer now, take the question home. What could you have done and what can you do, isn't it? . . ."* Deise gets interested: *"... I'm going to do my best to improve a lot, that's why I accepted [to participate]"*.

Following the script, Paula emphasized the issue of Deise's viral charge being detectable, an aspect that according to the protocol should be approached the moment the professional presented the reasons of the invitation for the patient to participate in the research, in the beginning of

the meeting. Given the initial unease of Deise, it seemed fitting that the subject be approached closer to the end. At that point, an experience related to the fear of discrimination emerged, when she talks about the worry that friends of her son, when storing beer in the fridge, could identify one of her AIDS medication, justifying her practice of removing labels from the bottles. Paula is responsive in the coordination of the dialogue. It is her who complements the meaning production of the narrative of her interlocutor, verbalizing the expression “*prejudice*” and highlighting that Deise “*is still prejudiced*”. The meeting is closed as the second is scheduled.

Second Meeting: Emotional Expression, Self-Analysis and Decoding Scenes and Scenarios Involving Treatment

Occurring on her 52nd birthday, the inter-subjective dynamics of this meeting is marked by emotionality and reflectiveness. The first conversations are about Deise resigning from her job in the past few days, a theme that will prevail in the meetings. Meanings about this decision are significantly worked through: Deise justifies it because of the accumulated tiredness, to be more attentive and disciplined in regards to her dosage schedule, for her rest and leisure, to “*care more*” about herself, taking walks and going more frequently to the health service for consultations without having to present letters at work, which would expose her to inquiries about the type of disease. She associates her decision to an act of courage. Paula is interested, participative and welcoming regarding Deise’s expressions, and also diligent in the sense of helping her to deal with this change and finding new activities in her life project.

Paula encourages Deise to learn about medication names, clarifies technical aspects of the treatment in accessible language and uses metaphors as examples, for instance, the error of abolishing doses in more than one hour delays, believing that it is not harmful. The tone of the conversation is relaxed and good-spirited. Paula strongly suggests the adoption of alarms and written reminders, among other tips to avoid forgetting and delaying medication doses.

Following the script, she calls the *descriptions of scene* to explore daily experiences with the treatment, when talking about the delays in medication dosing.

And in these days we haven’t seen each other, when you also worked. Were there some days you delayed or didn’t take your medication? Yes, there were. But only a few. Can you tell me, tell me about those days or moments? No. I slept, really!

The conversation goes on:

At night it’s more complicated for you. You came home very tired, and then you slept, slept and did not take the medication. Was that it? . . . Then, pick a day, without worrying about what day of the week it was . . . but tell me what you remember. What happened, how was it? Well, I arrived home, took a shower, cooked dinner. Then I waited for the hour. Then... I crashed, just like that! Then, when I woke up it was... then tell me what you did, report it to me: “I arrived at that time, got to do that”. Oh, to report... Yes, report, or else in any way you want. Oh. Then, I arrived from work at almost seven at night, then, I went to cook dinner, all right? And then, I sorted something out. Then I cooked and took a shower and sat there watching a soap opera or something else. Then, you had dinner, sat on the sofa to watch a soap opera? Yes, a soap or a movie, just like that and then snap. And then snap what? Then I slept. Then it was too late when I woke up. Then I didn’t take it, because it was too late. Do you remember when you woke up? I don’t know. It must have been midnight-ish, almost one. And you’re used to taking it at ten? Yes, ten o’clock. Ten, midnight... Oh, you could have taken it.

The scene is relatively built, although Deise initially does not understand what the professional means when using the expression “*report it to me*”. There is a lack of clarity in the instruction that should primarily stimulate Deise to remember a day or a specific episode, to report it. In spite of that, repercussions are positive in deepening the dialogue centered on everyday expe-

rience, which allows for visualization by both of them of what took place, and the production of meanings regarding the circumstances of adherence failures: the tiredness at the end of the day, in the case of the night dose; the environment and rhythm of work, as well as the adverse reactions that Deise attributes to the medication in the morning taking dose. A second scene is built in a similar way. Through decoding, meanings of actions emerge: the belief that adverse reactions – “feeling sick”, “getting dizzy” – would occur made Deise suppress doses or delay taking the medication, a type of personal adjustment.

Sensible and attentive to Deise’s description about the medication – “too strong”, “leaves me stunned”, “knocks me down”, “messes a little with our bowels” and their implications to adherence, Paula then explores the scenes to decoding of intersubjective meanings. The expression of Deise, “self-analyzing me” indicates that decoding, in the sense of “analyzing what has been lived through”, was in progress.

*Then, it happened like this; if I needed to do something, go out to a place I have to go . . . then I didn’t take it, because I had to do something. I had to have a very normal life: from service to home . . . I have already taken the medicine halfway and had [diarrhea], having to come back, near home. Then I already know how it is. Then, there are these discomforts. So, when you regularly take the medicine, we feel as if we’re not really feeling normal. There are days in which I’m not tired and want to be very normal, today. Then, it’s been going on... you know? Do you get it? **Ok, but my question is this: do you believe that the fact that you want to feel better, let’s say, tomorrow, you do this? Not taking the medication, to feel better? . . . I feel more comfortable. I don’t know if it’s in my head . . . There was a time when I did this. Not always, but if I had to do something... In the job it was really hectic, yes? Then I forgot . . . Did you forget because you really forgot, or because it was providential and you wanted to feel good, to be able to do the job in a better way? No. I really did forget. It passed, just like that. Really passed. Up to the point that***

*I said: I don’t believe it! **But when you say you didn’t take it, how was it? You want to be good and you didn’t take it. It’s amazing this thing, huh? But it happens, sometimes. We’re all humans and humans do that.***

The remark of Paula that they are talking about a “human issue” illustrates her welcoming attitude. The exercise allows for the comprehension of an additional meaning to adherence failures: of having some degree of decision in “not taking the right dose”, a kind of “self-management” of treatment to cope with the adverse effects attributed to the medication. Although a clear passage between moments is not clear: between the construction of the scene and decoding its meanings and significances, a good development can be observed of the second, relaxation and laughter on both parts.

The *methodology of scenes* is worked through one more time, now in a future perspective, an imagined scene about an eventual stroll that Deise would take with a friend, role assumed by Paula. She employs interesting expressions such as “*make-believe*”, introduces characters, scenarios, situations and inquires of the interlocutor about what she would do: “**What’s in your mind about this stroll? Are you bringing something? . . . How are you going to remember to take the medication at ten?**” Deise answers: “*But I’m gonna have to remember now, huh? There’s no other way*”. The stress is laid on the acts of remembering or forgetting to take the medication or taking it during the stroll. The development of methodology acquires the connotation of a training or guessing game. Deise finds the activity strange and the professional makes a brief summary of suggestions: bringing extra doses, using an alarm or asking someone else to remind her. Deise says: “*But now, even at home, I’ll start scheduling. I’m gonna tell my son to get the cell-phone and leave it on the coffee table*”.

At the end of the meeting, the theme of resigning from work comes back and Deise expresses herself in a more emotional way; cries and shares her preoccupation in feeling “down”, “crying out of the blue”, “without that potency” demanding assistance from Paula. In a digression to the past, the patient narrates several episodes of the time when she was 11 years old;

cries a lot expressing pain when talking about the infection, “*it’s unfair*”, because she “*was not after that, did not look for that*” and the negative outcomes of the descriptions of herself as strong and hardworking. Paula suggests that Deise undergo a psychiatric assessment along with psychological counseling, offering to her find these resources in the service and justifying the former because of the “*organic [nature] of tiredness*” and “*lack of potency*”, to which Deise refers. She welcomes psychological counseling but rejects the psychiatric one.

The meeting ceases with a conversation about the theme of prejudice against people with HIV which had been touched upon in a good part of the narratives, although not being a direct object of the dialogue. Revealing that the meaning of Deise’s suffering was in part related to her trouble in dealing with the identity of a person who lives with HIV, the professional asks a few questions and inquiries demonstrating a reductionist understanding of the issue “HIV acceptance versus prejudice”.

Have you ever accepted the diagnostic, ever accepted the fact of being a seropositive? No. No. All right. No. But up to that, it’s all right, huh? Hm. Of course I accepted it already, huh? There is not what to... I don’t know . . . Actually it’s the prejudice you deal with, isn’t it? . . . when it comes to the matter of the difficulty, of not accepting the diagnostic.

Another meaning with bad outcomes to the dialogue is referred to the belief of Paula that the longer the person knows about the infection, the lesser the “denial” or suffering because of the condition should be. However, this pain was demonstrated in the interactive moment, when Deise was sharing it.

But you still suffer a lot because of it (having HIV)... Yes. Yes... Ok, but you have known that you’re a carrier since when? Since... No. But, well, I, I’m aware of it. And no, no... I don’t know. It’s not like that, isn’t it?

It is as if, non-resigned and suffering because of HIV, Deise should know by intuition that she should accept her condition after so many years.

While crying, Deise mentioned one more time her concern about her life from that point on, without her job, even relieved as she was. Paula is welcoming, valorizes the importance of Deise allowing herself to cry, to express herself and participate in the production of meanings such as: have more time for self-care, being able to be more adherent to treatment. They finish with the repositioning with the subjects “medication” and “adherence”, when Paula stresses the importance of carrying the medication when going out, of using alarms, etc.

Third Meeting: “Keeping the Focus”, Welcoming and Promoting Adherence

The objectives of the work are revised, “[helping] ***to take the medication correctly***”, some inquiries are made about how the last days were concerning treatment, and if Deise put into practice some of the proposals talked through, to which she answers: “*No, I stayed the way I was. I took it in the same hour, all right? . . . On Sunday, I didn’t take it... At night, I didn’t take it*”. About this, the professional asks: “***How was it? Tell me***”. Deise tells that she went out to have lunch with her son and felt sick when she arrived home, vomited and when she went to bed at the beginning of the night, woke up only around 1 am, missing the 10 pm dose. She emphasizes that it only happened once, positively associating it with her general state of the present week, claiming to be feeling better when compared to the previous week. They both associate the “*not feeling well*” to quitting the job, a situation to which Deise is adapting.

The theme of adherence, focus of the intervention, is initially explored. However, the same issues of the previous meeting “invade” the conversation, moving it to the background during a good part of this meeting. Deise, becoming very emotional, asks to be held. The subject that follows for a considerable time is the search for specialists that could handle the episodes of vomiting and feeling sick and again, the suggestion of the psychiatrist, besides accessing extra medical visits, in the service. Although the theme of AIDS medication, in a more direct sense, was moved into the background for most of the session, the

professional brings up the subject halfway to the end of the meeting, redirecting the conversations according to the script. She strives to mobilize the scene, initially in a very inappropriate sense, because she demands that Deise talks about a random day; and then improves her guidance when asking more precisely for the description of a real episode of delay in taking the medication. A scene is sketched, the atmosphere is relaxed and a practical solution is achieved: using an alarm clock.

Clarifications are also made about CD4 exams and viral charge, as well as about the relationship between viral load oscillations and CD4 cells, according to a higher or lower punctuality in the dosage schedule, besides the encouragement to follow the test results and the alert about Deise's viral load, which "*must be detectable*", once she was recruited to the study. The educative approach is pertinent, given that Deise does not know each exam well, does not know their results, or even when she performed them.

The subject of the new life condition emerges periodically; meanings of the conversations are of hope, plans for the future, valorization of achievements and the willpower of Deise, aspects that make up her identity. The professional is skillful in "situating" the matter of adherence to treatment in the life history of Deise, appraising the description that she gives of herself. "*This will, huh? That you have regarding all aspects of your life, to your son, all your achievements, isn't it? Yes. . . Is it possible for you to associate it or move it to the medication?*" Deise answers: "*Oh, yes, it is. Yes. . . . Because, now, it's my life, isn't it? (Approving sounds). Before, I thought about him, yes? I cared about myself because of him. . . . (Yes.) Now, I don't...*".

Paula guides the closure and the preparation to what will be approached in the next meeting. The final words of Deise show praise of the conversations offered by the intervention, as well as her wellbeing for having been welcomed and cared for.

Fourth Meeting: Engaging in Self-Care. Advances and Problems Toward Adherence

The conversation opens with Deise talking about being in the health service for many days.

She passed by the otolaryngologist and was medicated for labyrinthitis, which would be related to the discomfort she experienced some days ago, and to the fact that she felt "*very dizzy*" the day before. Relaxation predominates during the conversation, unlike the former meeting, which was marked by a lot of crying and pain. There is laughter, the professional comments on the new haircut and Deise's appearance, praises her self-care and her search for wellbeing, as demonstrated by having scheduled exams and consultations with specialists and proposing to be taken on as a patient of Paula herself. Regarding this last issue, the professional shows apprehension because she does not know if it is allowed or not by the research team.

The professional follows the script that foresees the analysis of the process and plans for maintenance of adherence and health in the long run: "*So, let's do . . . a revision of our meetings, shall we? . . . Reflections, looking for new paths, new measures to the . . . issues of medications . . . do you remember?*" Although Deise is more active in her self-care (she reports to have started using the alarm clock in her bedroom to be notified about the dosage times), mentions another episode of suppressing the dose, when realizing it was two and a half hours late. She justifies forgetting the 10 pm dose because she was distracted when caring for her depressed mother over the weekend. The professional again explains that if delays of up to five or six hours happen, even though they should not, the medication should be taken the same way, besides emphasizing that during this time, "*unchecked*", the virus carries on "*multiplying itself*".

Meanings produced in conversations signal that Deise believes her "*following the treatment better*", is associated to her improved emotional state.

No, but I'm, I'm much better now than I was before . . . Because, really, I don't know what was going on . . . I was really feeling down, not in the mood for anything too . . .

The episodes of forgetting the doses have no serious meaning, and remain attenuated by the agreement of Paula, who did not mention them in the sense of problematizing them.

Deise is worried about being seen as somebody who “*doesn’t do anything*” (having left work) and Paula supports her decision, encouraging her choice of caring more about herself and emphasizing that she seemed to be emotionally better if compared to the meeting where she cried a lot. The dialogue signalizes that leaving work and the experience of being in the meetings (listening space, support, containment) has contributed to a feeling of improvement in the general emotional state. “*I was more irritated, nervous, like, that anguish, that awful thing that I had, you know? And I’m much better like this...*” “**Yes**”. The professional explores the conceptions about participation in the intervention and about the resources that Deise judges necessary to move on, to which she answers being in need of psychological care.

... I think that the fact of me coming, like, talking to you, I think this was really good for me. Is it? ... Because, like, I think that sometimes it is good that we talk like this. But it doesn’t seem so, you know? Like, but there is something different, you know?
Hum. *That, that changes in us. I think that it was good these, these talks, you know? Yes. That’s why I wanted to continue...*

In dialogues, a singular meaning about the experience of intervention is produced:

Because it is actually a sort of poke, right? Did you feel like that? Did I poke you a lot? I felt it. [Interviewer laughs]. ... but it wasn’t bad. Really? No. But it was good. Any poke that hurt you? No. ... It was good, a good poke.

In times when referring to what they called *a poke*, Paula and Deise laugh.

But the poke, in the good sense I mentioned it, right? ... that I was like that, a little fallen apart? ... (Approving sounds.) Actually, I didn’t even remember the medicine, anyway. (Yes.) ... I don’t know why I was coming to that point. ... That’s why this helped me [the intervention] ... Because it was after this research that I made the decision ... that I started to realize (Approving sounds) ... that I wasn’t caring about myself anymore... Somehow, you know? Because I ...

. I don’t know what was going on with me. That’s why you ... thought I had a depression, right?

In this meeting, Deise also digressed in her life history – about her mother, who belittled her, and about her husband, though with a more comprehensive, affectionate, and less resentful connotation. Paula welcomes her, praises her availability for psychological care, encourages her to participate in adherence groups and to apply for free commuter tickets from the social service.

The fear of discrimination theme emerges, including that it occurs in health services, when Paula stresses that good care, without discrimination, is a right and not a favor or a blessing from God, as Deise states. The professional proposes that she thinks about how she would act in a case of being discriminated against: “*in shambles, not knowing where to start*” and, then, clarifies for her about the internal affairs offices as coping alternatives.

The conversation about how to keep with short term adherence, one of the main points of the script, occurs in the last meeting through a difficulty in communication:

... regarding the medication, what do you feel as being necessary to keep these solutions? Taking medication without delay, over time? Oh, I think I should just continue this way, shouldn’t I? I see. Continue what? I continue... What, what do you need? ... How am I gonna explain that? ... Do you think you need some support? What do you mean? ... But in what sense do you speak of...

This “stalemate” in communication points to a central issue about the outcomes of the intervention, because talking about “*keeping these solutions*”, although it is written in the script, is not appropriate in the case of this particular person. Though Deise refers to the feeling of well-being, *solutions* to the difficulties in taking the medicine at the right times are not properly produced through the dialogue. Adherence failures persist and in the dialogues no gravity or problem meanings are produced related to them. The predominant meanings in the closure of the activity are referred to the *overcomings* of Deise

throughout her life, to the praise for her current changes in the direction of a greater awareness, compromise with treatment and with healthcare, to the hope and motivation to maintain achievements in the long run.

Discussion: Syntheses of the Assessments in Terms of Dimension and Components

Considering that each component was assessed as “sufficiently”, “moderately” or “insufficiently” – according to the patterns in which they were developed – the assessments of the case study described above will be now synthesized, emphasizing the aspects that resulted in the patterns that were below expected (the latter two).

The “**Adequacy of the development of the protocol to the objectives, themes and methodology, according to the script**” were moderately contemplated in the four meetings. In meeting 1 the register sheet was not used and, therefore, the conjoint definition of the “problem list” related to the treatment was not carried out; Paula did not present herself in terms of her work and omitted her profession as a psychologist of the service. Possibly, the instructions of the research team saying that the intervention should not be configured as a psychological service reverberated in the apprehension of the professional presenting herself as a psychologist. In the meetings 2 and 3: usage fell short of the expected, with little consistency and precision in the *methodology of scenes*; superficial exploration about the previous years when limitations to the treatment were related to the hurried and exhaustive work routine, and about the practice of hiding medication from the son (they were kept in places not easily accessible, contributing to the chances of forgetting, having a possible relation with the former failures in adherence). In meeting 4: repetitions and prolixity in questions about the sustainability of long term adherence, with noticeable difficulties of comprehension by the participant. The professional is excessively stuck in the script, asking and taking notes of the responses of the patient, which hinders the deepening of the dialogue and the acknowledgement that some terms, in the case

of the interlocutor, were not pertinent, for example, talking about “*solutions found to remain adherent*”. Possibly, the difficulties are associated with the limitations of the script itself, to the way some of the questions were formulated as suggestions to the professionals, and also with the structure of the protocol in 4¹¹ meetings, for all participants. It is considered that the objectives and subjects expected in the script for the fourth meeting were, in the case of the analyzed intersubjective dynamics, premature, demanding an additional meeting in the frames of the second and third. Therefore, it would be expected that the episodes and issues could be better explored, especially concerning dosage taking out of the home, at work or in moments of leisure. There were progressive improvements in the development from the first to the last meeting.

Regarding the dimension “**Theoretical, methodological and ethical principles and the development of the protocol**”, all of its components were evaluated as sufficiently developed, which indicates that the training and the supervision of the professionals, as well as the respective backgrounds (personal and professional) were shown to be effective for a radical reversion of the most prescriptive connotations, as well as ones that place the responsibility solely on the individual. The horizontality of the relationship, the willingness to participate, the effort in eliciting daily life narratives, the posture of hearing, welcoming and solidarity and the appraisal of the history of the life of the person being seen are marks of the meetings. A problematic feature is the biomedical paradigm – historically predominant in western medicine, which separates the organic/physical from the relational/social life (Traverso-Yepez, 2001) – and that influences the understanding of the professional and her production of meanings about the history of the patient and about her present emotional state, when she associates tiredness and the crying to the “*organic*”. This implies handling the situation in a way that prioritizes psychiatric evaluation as a resource to deal with these sensations. However,

¹¹ Since it was a clinical essay, there could have been no changes in the number of meetings.

when answering, Deise remembers the history of her life, from the time she was eleven until the episode of her HIV infection, signified as unfair, a procedure that puts her in the position of unconformity, with significant repercussions on the descriptions of herself: someone who fights for life on a daily basis, but does not easily accept her condition as a person with HIV. It is as if she stated that she was talking about a broader historical, therefore psychosocial suffering, that should not be reduced to a physiological meaning of a *depression*, equated to an *organic* matter, to which the only or main resource is the psychiatric intervention.

Regarding the “**Types of approaches present in dialogues**”, it was considered that the educative, practical and clinical/symptomatic approaches were sufficiently contemplated as to the needs of the participant. This was evidenced, especially, in the clarifications of the technical aspects of the treatment (action of medication and purpose of each exam); suggestions, encouragements and practical tips focused on decreasing the singular difficulties of the participant, such as forgetting the doses, as well as the dialogues around other complaints and clinical complications such as feeling sick, vomiting, fatigue, signs of depression, with pertinent considerations regarding the need to look for other resources and specialties.

The psychosocial approach was moderately contemplated. Even though there was welcoming, emotional support, containment, empathy, some aspects were not worked through in a productive way, such as the approach to themes of prejudice and the acceptance/nonconformity of the condition of carrier. The biomedical reasoning, very present in the formation of the health courses, including in psychology, when interposed in the analyzed relationship, implied that the suggestion of psychiatric consultation at some moments worked as an “interruption”, a “blockage” to the continuity of dialogues where the meanings of suffering and exhaustion expressed by Deise could have been explored more thoroughly. Although the suggestion is guided by the legitimate preoccupation as to a possible depressive state (and the professional emphasized not to be “forcing her” to go, which is coherent with

her autonomy), she states that “*the emotional [state of Deise] was very disturbed in the former week*”. In this passage the professional was referring to the meeting where Deise cried a lot, precisely when they talked about “*not accepting the diagnosis*”; “*Deise’s own prejudice*”, in the terms the professional had put it, about the sorrow and resent caused by the husband who infected her. What is shown to be problematic and marginally productive in this approach is, although, the implicit communication of a belief of the professional, grounded in the biomedical psychiatric paradigm: getting too stunned by such questions, crying when talking about them, reveals an imbalance to be corrected by psychiatric intervention. Therefore, there is a contradiction in guidance: if on one hand, the professional encourages the patient in the sense of accepting her frailty, not to be so demanding in always presenting herself as a strong woman, “*a fortress*”, on the other, when she weakens and cries, “*excessively*” in the interpretation of the professional, this demands a specialist who can handle the “*very disturbed emotional state*”.

Another aspect that accounted for the “moderately” score in the development of the psychosocial approach was the lack of exploration about the senses and meanings of depression, tiredness, nonconformity in having been infected and their implications on the lack of adherence. That is, conversations on these subjects did not occur according to the *methodology of scenes*, proposing, for example: “remember a day when you were really depressed. Describe please, the scene that comes to your mind: where were you; what was on your mind, etc. Do you remember how you dealt with your medication on that day?” To proceed that way, the professional would possibly need more experience or formation in addition to the one that was given to her in the research process. However, it is necessary to consider the “risk” that while doing it, one might “lose the focus”, pairing the psychosocial intervention to a psychological care, a procedure that professionals were significantly alerted to avoid.

It is relevant to note that the “**Types of approaches**” dimension emerged as a category of analysis only during the readings of the meet-

ings of the first cases. It was questioned how the participation of professionals – being sensible to make distinctions among kinds of difficulties with the treatment and profiles of each participant – would be implied in the connotations that dialogues might acquire, such as: informative connotations, analytical connotations regarding the meanings attributed to medication and AIDS or connotations based on a welcoming posture and emotional support, among others. To this, one can also associate the issue of preparation of professionals for the incorporation of this type of intervention in AIDS services in Brazil, since interventions in adherence are on the agenda, as well as the reception are part of the common field for professionals of different backgrounds. In this case, a psychosocial intervention in adherence, and not an adherence intervention performed only by psychologists.

The analyzed case allows us to state that there are strong indicators of the extent to which psychosocial issues are central in the complex web that entangles people in their difficulties with treatment. Among these issues, the one that was shown as more evident in the case of Deise and other cases in the process of analysis, was the oscillation between suffering and nonconformity on one side, and tranquility and acceptance on the other, regarding her own condition: “I’m someone who has AIDS”, “I got AIDS in this or that way”. What is necessary to be taken into account is the need of appropriate formation of the professionals so that they can be able to approach psychosocial issues and, moreover, through a fairly unusual methodology as proposed, conversations about scenes. Another question is that if it would be viable in this kind of intervention to work in a thorough way the matter of “accepting HIV”, among many others – welcoming expressions of suffering and identifying anguishes that have meanings that are not sufficiently understood/explored in dialogues. There is the risk that the intervention loses its specificity: focusing on issues related to treatment to promoting adherence, broadening to dialogues with a lesser constraint on subjects. The free hearing of the professional, when he is drawn by narratives, or the “digressions” to explore other themes of the life of the person being seen, such as in the case

of Deise, the affective and sexual relationships not experienced anymore, would demand more than four meetings, as well as other knowledge and methodologies, going to the extreme of configuring an abdication of the script. On the other hand, there may be people being seen whose “treatment dramas” are related to their relational histories and their life contexts that would imply risks to their effectiveness (low or harmless) if they were not adequately treated during the intervention. In other words, focusing on “more practical/operational” difficulties in managing medication or in technical clarifications when the difficulties of the people are related to subjective and intersubjective features may hinder the results of the activity from the standpoint of technical and practical success. Alarm clocks, reminders, behavioral and cognitive training to decrease forgetting to take the doses, for example, would be insufficient for those whose meanings attributed to AIDS, their own infection or to medication are associated with anguish, punishment, sorrow and experiences of social withdrawal, loneliness, self-protection in the face of risking discrimination, etc.

The “**Methodology of scenes**” (MC) dimension, the most innovative methodological component – whose performances and comprehensions by professionals constituted the main objectives of the training and supervision – was assessed as following: as to the employment of the resource in terms of frequency and attempt by the professional (sufficiently); as to the use in timely moments (moderately); as to the predominance of adequacy in most of the initiatives in “mobilizing” scenes (moderately); as to the production of meanings of the patient about himself and his difficulties in the use of medication (broadening understanding) during the development of scenes (moderately); as to narratives, during all meetings, being able to express intentions to improve or real improvement in adherence (moderately). During dialogues for the construction of scenes, proposition, comprehension and development difficulties were verified; it was possible to point out their beginning in most of the passages, but not their closure or the passage to the stage of decoding elements, in a way that the dialogue with this resource resulted very similar-

ly to the habitual way of talking. Another fragile feature is that the predominant way in which the pair developed conversations according to the methodology of scenes, was similar to a “training” or a “game” where the person anticipates an answer expected by the professional, which shows distinct understanding and development and in parts mistaken, regarding its original conception. Even with these weaknesses, the dialogic resource of construction of scenes showed a potential for the conversations to be centered on the daily life experience of treatment and to decoding meanings.

As to the **“Repercussions of intervention to the person being seen”**, five out of the six components were assessed as sufficiently developed (“movements” of the patient regarding treatment: broadening understanding, larger engagement, self-confidence, convenience and the use of resources of the service). Regarding the widening of sociability and affective and sexual relationships, there were no positive repercussions reported; the participant has had no affective or sexual relationships since the death of her husband and has a few friends, which is associated to the stigma regarding AIDS and the fear of discrimination. This theme was not the object of a deep dialogue during the intervention. Although the professional contemplated the need for clarifications and information, there are no signs in the narratives of repercussions concerning the adoption of new “ways” of taking medication and the production of more positive meanings regarding medication (“no evidence”).

As a whole, although there could be observed a larger understanding of herself and the circumstances in which the failures in adherence occurred, these were still happening at the end of the activity. The stressed encouragement to use an alarm or cellular phone clocks did not seem to be systematic or sufficient to avoid these failures. No meanings were produced about the gravity or the problems regarding situations of adherence failures that happened during the period of the meetings (when leaving home, when enjoying a leisurely program with the son or caring for the mother or when she fell asleep on the couch watching television). Deise’s descriptions of these episodes indicate that in her understanding

they happened occasionally, meanings were of irregularity, although during the period of intervention she related three episodes when the dose was skipped; these meanings were not problematized in the dialogues with the professional.

The most evident consequence in the “movement” of Deise towards wellbeing was that from the first to the last meeting she experienced a process of subjective change. From saddened to tired, she started experiencing new sensations (ease, self-confidence, security and wellbeing) and to better understand the implications of her former state on the way she followed the treatment. The production of wellbeing is also associated with the decision of carrying out an important change in her life, during the period of intervention: her resignation request, signified as a hard decision, although necessary and liberating.

Conclusions

The Evaluative Framework developed was shown as appropriate to describe and orientate the analysis of the case. It was possible to systematize interdependent dimensions and components, subject to few analyzes, precisely because a good part of the performed interventions in adherence are not characterized, or are insufficiently appraised by those who developed them, usually not very familiarized with the social constructionist perspective and with the notion of Care. The specification of patterns and/or criteria in some of the components of the Framework (Figure 1) is necessary, therefore, to improve the analysis of the remaining cases in the database. For example, in the **“Methodology of scenes”** dimension, where the component **“In the opportune moments to use them, did the use predominate?”** lacks precision (what are these opportune moments?). Refinements of this kind would contribute so that the framework would advance from a descriptive approach to the direction of a more analytical approach.

Each component regarding the **“Principles”** dimension was well developed in the analyzed interaction. This is expected, given the fact that the intervention occurred in a research context (standardization of procedures, constant supervi-

sion, etc.) to which the professionals were chosen by the researchers, a fact that underlined the expectation of a good progress related, specifically, to the “spirit” of the intervention.

Moreover, the core of the intervention is composed of the components related to the **“Methodology of scenes”**, which even though moderately developed, were relevant. It is important to note the difficulty that the professional faced when operating with a methodology very different from her professional practice.

The dimensions of the **“Principles”** and the **“Methodology of scenes”** are evidently the great **“novelties”** of the proposal and the ones with the most considerable potential to promote inflections in the models of attention in adherence. The studied case noted the positive potential mainly of the following aspects: the implication of the professional in the establishment of a horizontal interaction; the appreciation of intersubjectivity in the professional-patient conversation and in the stories of the “life in scene”, including scenes of treatment; the openness to listening and effectively including in the conversation the “guidelines” that the patient finds important.

The components regarding **“Theoretical, methodological and ethical principles and the development of the protocol”** should be contemplated. Moreover, the ones that pose a methodological nature accept an amount of malleability - they can be subject to changes in order and emphasis (subjects/procedures advanced or delayed, emphasized or not among the meetings or in the closures). However, the following procedures should be followed more precisely: mutual presentation; clarification and awareness of the reasons a patient is invited to participate (for example, unsatisfactory results of exams and poor clinical conditions) and, additionally, conveying a list with the main problems involving adherence. They serve as an aid so that the person elaborates practical meanings and of a personal need from the conversations.

As to the **“Approaches”** to be contemplated, they are conditional to the intersubjective dynamics (of interaction and communication) that are produced in the pair and also, to the demands, the profile, the history of life and current

reality of the person being seen, that is, they bear a singular character, situational, according to the demands. Besides recognizing, the professional should be capable of dialoguing about how these issues conform diverse experiences with the treatment, contributing with understandings on the part of the person being seen and with the development of new repertoires, with a minor dose of suffering, damage and respecting his condition of a person with rights. The case study suggests that, regarding **employed approaches, the more articulated and coherent with the demands – a mix – the better they are to the success of the activity as a whole**. This is precisely because adherence/non-adherence is being taken as a (practical) outcome that involves synergic features, not as an outcome of isolated features.

From the standpoint of the **“Repercussions of the activity to the person being seen”**, its components are the most expressive of the theoretical inspiration of the intervention in the notion of *practical success* of J. R. Ayres. The analyzed case shows how plural and distinct can be the repercussions (this explains the large amount of items in the Framework; Figure 1), if we have other horizons besides the strictly technical success of the activity. If this is the exclusive orientation, the criteria of success of the intervention would be the patient describing considerable improvements in adherence, with decreased delays in taking and forgetting doses, which was not the fact in the case of Deise. Nevertheless, she came up with new narratives about herself, her own life, the failures in treatment, her feelings regarding her husband and mother, possibly useful in her future paths. Since childhood she was regarded as *“strong”*, *“enduring”*, *“hard-working”*, *“raised without the mother”*; when received the HIV diagnosis, she saw herself as a *“victim”* and *“wronged”*, aspects of the identity that are not very productive in coping with the disease and living well with the treatment. In the interactive moments with the professional, Deise also started to become *“a woman who doesn’t work outside of the home”*, who *“will take more care of [herself]”*, and who does not need to be *a fortress*, being able to cry and be fragile, and who is learning not to heavily fear prejudice. About the treat-

ment, the *self-analyzing* movement is representative of the production of new meanings about the failures in taking medication: from slips to the auto-management of doses; from “meaningless” failures to abandonments of the treatment in times of sorrow and exhaustion. Deise is surprised with the supposed contradictions, tries to understand the circumstances in which the failures occurred, but does not understand them as “grave”, “very problematic” or “very frequent”. From the strictly technical standpoint, we could question the success of the intervention, given that Deise oscillated between rationally acknowledging that medication should be taken correctly and frequent episodes of delays and even suppression of doses. That is, the intervention did not “transform” a “non-adherent” patient into an “adherent” one. And this could not have been its objective: adherence is strictly dynamic. Strictly speaking, there are no “adherents” and “non-adherents”; there are only people who are in that moment, following the treatment with more or less difficulty (Nemes, 2009). On the other hand, in the intervention, it was possible to identify successes of a subjective and intersubjective order, that when developed with a good approach to the principles, illustrated the potentialities of the proposals of *Care* and *Psychosocial Attention*. The intersubjective dynamics that predominated during the interactions of Deise and the professional express the development of a *Care* relationship in fact, once “the technical aspect [was] active and consequently in contact with the non-technical at each moment of assistance . . . ” (Ayres, 2004, p. 585). According to the author

Beyond the management of regularities of the middle-end relationships . . . there is, in every therapeutic action . . . an authentic encounter between subjects, where inalienable interests of understanding and simultaneous construction of the self and of the other will be present . . . such interests will be instructing . . . a continuous and mutual reconstruction of identities, conceptions, values and, therefore, positive projects of happiness and health in the (and from the) therapeutic encounter. (p. 585)

The analyzed meetings approached in a large measure the notion of *encounters between subjects* aforementioned, which strengthen the thesis of the good quality of *Care* when this is more inclined to the integrity pole and complemented with the notion of *practical success*. The scope is broadened when it comes to what is important to be talked about: the person and his treatment, in its different dimensions (meanings, affections, place that is occupied in the life project) and in his various sociability scenarios (hence the *psychosocial* attribute of attention). “*The social constructionist psychology will almost always be approaching the subject in his daily life as the proper space for psychosocial attention*” (Paiva, 2007, p. 10), that is, “the person in scene” is appraised when conversations are centered on everyday intersubjective experiences (actual or former ones) of dealing with HIV and treatment. The conversations that “build scenes” constitute the methodological resource for that purpose. Its use, even rudimentarily as the analysis has shown, was enough to prompt the emergence of “Deise in scenes” – in the development of several roles: worker, widow and mother, user of the *Sistema Único de Saúde* (SUS), citizen with rights and autonomy to make decisions about her life, as for example declining the visit to a psychiatrist or quitting her job. The scenarios and characters of the script (environment and pace of work, the mother, the deceased husband and the son) interacted in the production of affections, meanings and performances in her broader life and, especially, in the domains related to the treatment (how and where to keep medication, the meanings of having been infected, the silence or disclosure about the diagnosis, etc.).

The social constructionist inspiration therefore, is operationalized in the dialogues about scenes and scenarios, a method to explore the intersubjectivity of the daily life in the course of *psychosocial attention*. It is affiliated with the “constructionist conception of social psychology” that operates “with the notion of *person in interaction*, conceived as *intersubjectivity*” (Paiva, 2010). In this sense, constructionist proposals of other authors dialogue with and complement this inspiration, such as: the *rela-*

tional production of meanings, signified as *co-ordinated actions* during conversations, product of dialogical relations, of the “between” people, and not “as something that lives in the minds of individuals” (Gergen & Gergen, 2010, p. 41). These social constructionist perspectives, in a general way, support the dialogical interventions in adherence to be configured as *Care* and *Psychosocial Attention along with the persons*, radically valuing the intersubjective dimension, either in the way of thinking about medication taking in the daily life, or in the way of conceiving the communicational processes of production of meanings during the *Care* relationships. In this sense, it is pertinent that we reflect upon the need of interventions that draw subjects into fruitful conversations, capable of building new ideas, new understandings about “problems” and new performances to daily life.

New interventions in adherence in the field of AIDS with theoretical bases not usually disseminated contribute to the construction of a scenario of practices that are more committed with the mitigation of vulnerability associated to becoming sick from AIDS and with the promotion of the right to integral and qualified care. As interventions in these domains are disseminated, there will be the challenge of also developing innovative ways of assessing them, without losing coherence with their principles.

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