Human Immunodeficiency Virus Social Work Program at the Walter Reed Army Medical Center: A Historical Perspective

Guarantor: LTC(R) Stanley S. Piotroski, MS USA
Contributors: LTC(R) Stanley S. Piotroski, MS USA; LTC Mark G. Chapin, MS USA

Human immunodeficiency virus (HIV) infection has become a pandemic concern for many nations. When this disease first presented itself in a global manner in the early 1980s, it was accompanied by fear, denial, misunderstanding, social stigma, and a paucity of available support services. The U.S. Army was becoming increasingly aware of the potential impact HIV could have on the active forces. A tragic event involving the suicide of a young HIV-infected soldier resulted in the development of a comprehensive medical/psychosocial assessment and treatment program for HIV-infected service members and their families at the Walter Reed Army Medical Center. Social work services played an integral role in the development of this program as this profession has done historically in meeting other emerging needs of the military. Special attention is given to the unique psychosocial issues and needs of the HIV-infected service member and the comprehensive and compassionate response of the military medical team with its significant social work contribution.

Introduction

During the early 1980s, a disease leading to enormous medical challenges and dramatic societal changes commenced to rear its ominous head within the United States. In San Francisco, health officials began reporting alarming medical information about a strange new viral illness. This virus was infecting increasing numbers of homosexual men, leaving them weak, debilitated, and immune deficient. The numbers of human immunodeficiency virus (HIV)-infected heterosexual men, women, and children were yet to be identified. Isolated reports of HIV-infected hemophiliac children were surfacing. The case of Ryan White would soon make national headlines, leading to federal funding and program development. The national news media were publishing numerous articles depicting the devastation of HIV and acquired immunodeficiency syndrome (AIDS). These articles served to heighten public awareness but also increased hysteria among the general population. In addition, the lack of epidemiological knowledge relating to routes of transmission contributed to an environment of apprehension and fear. Spiraling anxiety and ignorance prevailed among all walks of society, leaving the newly diagnosed in a state of acute emotional turmoil and social abandonment. Individuals diagnosed with HIV were socially stigmatized and thwarted in their efforts to reach out for emotional and social support that was afforded others faced with a life-threatening disease.

The military was becoming alarmingly aware that HIV had defense and foreign policy implications. A plan of action would have to be developed for the armed forces to establish administrative policy and treatment guidelines for the HIV-infected service members and their families. This was initially accomplished with the Department of Defense publication, *The Department of Defense Guidelines for the HTLV III-Infected Service Member*, in 1986.[1] The current regulation, which directs the care and administrative support for HIV-infected service members, is AR 600-110.[2]

Early in the development of policies and treatment programs for HIV-infected service members, a tragic event occurred that spurred this process along at a rapid pace. HIV-positive soldiers were assigned to the Medical Holding Company at the Walter Reed Army Medical Center (WRAMC) where they would await a medical evaluation for HIV disease. A young, 19-year-old male soldier who had recently tested positive for HIV disease was brought from his unit to WRAMC for medical assessment. This young HIV-infected soldier became despondent and isolated and committed suicide. The Commanding General of WRAMC responded immediately and directed that in addition to the medical evaluation for HIV disease, a comprehensive psychosocial assessment and treatment program for the emotional components of HIV disease be incorporated into the evaluative process. The HIV evaluation program was to be initiated within a medical surgical ward under the auspices of the WRAMC Infectious Disease Service.

Army social work was summoned by the WRAMC medical command in 1985 to assist with this critical mission to develop a comprehensive psychosocial support program and prevent any further suicides. The HIV Social Work Service was initiated with one staff member, which increased to four, and currently has two professional social workers. This program formed the basis for the HIV Social Work Service that was to include the following elements: a psychosocial assessment and follow-up social work intervention; clinical and administrative command consultation; and consultation to Army policy makers. The HIV Social Work Service program culminated in an extraordinary opportunity for the social work profession to display its ability to meet emerging needs of the military establishment and to provide advocacy for a disenfranchised group within the U.S. Army.

This study explores the contribution of the social work profession when presented with an emergent need in a societal disenfranchised group represented within the U.S. Army at the advent of the AIDS epidemic. Special consideration is given to the unique psychosocial stressors experienced by HIV-infected military members. This study will present information recognizing the adaptability of the professional military social worker to accommodate the psychosocial needs of the HIV-positive military member as medical advancements occurred with HIV disease treatment.

The U.S. Army's response to provide comprehensive, compassionate medical assessment and treatment, extensive psychos-

Department of Social Work, Walter Reed Army Medical Center, 6900 Georgia Avenue, Washington, DC 20307-5001.

This manuscript was received for review in September 2002. The revised manuscript was accepted for publication in January 2003.

ocial evaluation, and significant administrative support may surprise a civilian community that has long perceived the military as antagonistic to this particular disenfranchised group within the general society. This information will enable the reader to gain an enlightened perspective of the psychosocial challenges and care of the HIV-positive person within the military.

Army Social Work

The social work profession has a long and distinguished track record within the military. The first Army social worker was available for duty on September 1, 1918. Since those early days, military social workers have developed highly innovative programs, provided successful management, and contributed to the professional literature on relevant topics. In summary, they have been very successful wherever they have worked.[3] During the subsequent 80 years, Army social workers have offered a variety of services to military members and their families. During World War I and for the next generation of service members, the focus for Army social workers was the psychiatric care of combat stress casualties. However, as the needs of the Army changed, so did the emerging needs of the service member change. Social workers would become integrally involved in developing programs and providing policy guidance for the following human services programs: inpatient medical surgical discharge planning, drug and alcohol assessment and treatment, domestic violence case management, and Army community services. Social work officers were called upon to serve in senior staff positions guiding commanders in the development of policies affecting the lives of service members and their families. With each passing military generation, the social work profession has had an opportunity to develop services in response to the changing needs of the Army and its membership. The current organization of Army social workers includes uniformed social work officers (active duty and reserve), Department of the Army civilian social workers, contract social workers, and enlisted social work technicians.

HIV Social Work Service

A medical support team comprised of a psychiatrist, nurse, and support staff began the development of a specialized HIV medical ward at the WRAMC in the latter part of 1985. A social work officer was assigned to this team to provide psychosocial assessment and treatment services for HIV-infected soldiers. This opportunity provides an excellent example of the profession's responsiveness and adaptability to meet the emerging needs of a disenfranchised individual needing care, the HIV-positive soldier. A comprehensive social work program was developed with the following components: psychosocial counseling, administrative support, and command consultation program for HIV-infected soldiers, family members, and Army commanders. This was developed and initiated in February 1986. The HIV Social Work Service began to provide much needed support and administrative assistance to these soldiers who presented with a variety of complex needs.

In the early years of the WRAMC HIV program, the "HIV ward" or "ward 52" housed HIV-infected soldiers who remained hospitalized until the medical and psychosocial assessment could be completed and administrative disposition related to assignment would be determined. This ward fostered a milieu environment in which mutual emotional support was encouraged among the patients and staff. A comradery quickly developed among the patients during these early years of the program. Many of the emotional needs of the HIV-positive service members were met by other patients who were experiencing similar difficulties in their lives. The WRAMC HIV program grew exponentially over the next few years. The WRAMC HIV clinical staff expanded significantly and soon included many more clinical specialties, which added to the comprehensiveness of the program. A large research component developed along side the clinical program. The HIV Social Work Service expanded, and during the early 1990s was comprised of four master's level workers and a social work technician who provided clinical and administrative support services to both inpatient and outpatient HIV-infected populations.

Special Needs of the HIV-Infected Service Member

It has been responsibility of social worker to assess the psychosocial needs of these newly diagnosed HIV-positive service members and to provide assistance where needed. The unique psychosocial needs of military patients included the following: concerns related to their ability to carry out the physical demands of military service, need for strict confidentiality and difficulties associated with its maintenance in a military setting, the stigma associated with an HIV diagnosis and military membership, and military/command issues. Command issues center around the commander's concerns with nondeployability, maintaining confidentiality for the service member within the unit, and mission accomplishment. HIV-infected service members would also face the expected psychosocial concerns confronting their civilian counterparts, particularly in the areas of concern for one's own emotional and physical well-being and in dealing with troubled marital and family relationships.

Each patient would be individually assessed by social work service for any psychosocial difficulties and an appropriate treatment plan for the service member would be developed. A critical element of any treatment plan for an HIV-positive service member is the coordination with their military unit and if necessary referral to military/civilian HIV resources for follow-up assistance. An evaluation of potential benefits from the military, Veterans Affairs, and social security agencies proved to be very important should the HIV-positive service member be on a path leaving the military. Social work service performed very closely with the Physical Evaluation Board of the medical center in tracking and assisting the service member with their medical board. Depending upon the progression of the disease, a service member medically retired from the Army would receive a minimum of 50% and a maximum of 75% of their basic pay, entitlement to medical/commissary, and Post Exchange privileges. The service member would also be eligible for veterans benefits, which routinely included tax-free financial compensation, further medical benefits as a service-connected disabled veteran, educational benefits, and more. Should the service member's medical condition not allow the member to work in a "substantial manner," they would also be eligible for social security disability benefits. The combination of all three benefit programs provided substantial support for the HIV-positive service mem-

ber and families. Social workers frequently worked closely with spouses and concerned family members who could provide much needed acceptance and emotional support to HIV-positive service members. In the case of family difficulties, social workers facilitated family meetings to assist in resolving any relevant issues.

Social workers served as patient advocates with command for the HIV-positive service member. This was particularly true if there had been an administrative problem relating to a service member's duty assignment, break in confidentiality, or other problems of adjustment within a military setting. Breaks in confidentiality whether they occurred unintentionally or through ignorance always left the HIV-positive service member in a vulnerable, emotional position. At times, the only feasible option was to relocate the service member to another duty assignment if one were available.

The initial group of soldiers referred to WRAMC for evaluation consisted of 19 young Army enlistees who were identified as HIV positive during their basic training medical evaluation at Fort Dix, New Jersey. Within this initial group of HIV-infected soldiers, there were 18 males and 1 female. They were sent to WRAMC for a medical evaluation and administrative action. These new service members had already received their routine entry military inoculations and there was a concern by military authorities that they could develop these diseases. This group of young soldiers was frightened, anxious, and angry that their lives had taken such a dramatic turn. They were ill-prepared emotionally for what they had to face so early in their lives. They had entered the Army for a "future," and now they were being told their futures were quite limited within the military. Many of these service members were abruptly whisked from their duty stations and transported to interim medical facilities prior to their stay at WRAMC. At these local medical facilities, they were isolated and placed in a state of virtual quarantine from other patients until they could be transported to WRAMC for further medical evaluation. Upon arrival at WRAMC, they were in a state of heightened anxiety, confusion, and distress. It was the task of the social worker to provide the psychosocial assistance and emotional support for them to move through this very difficult time in their lives. Although service members were again placed in a "special ward," during these early years, it provided a "safe place" from the outside world. In this "safe place," they could openly deal with their fears and anxieties regarding HIV disease. Although there was an implicit stigma associated with admission to the ward, this was soon ameliorated by the emotional support from other HIV-infected service members.

Each service member was individually assessed by a social worker for psychosocial difficulties associated with HIV disease. Much of the initial sessions were spent listening to the service member's worries in each of these areas and then assisting them with a treatment plan to ameliorate their concerns. The accompanying fears for one's physical well-being was often the initial and overriding focus. During these early years of the epidemic, both service members and staff universally believed the universal myth that HIV was a "death sentence." These young soldiers who were barely out of their adolescent invulnerability and impervious sense of self now found themselves discussing issues ordinarily reserved for the elderly or very seriously ill persons. It was difficult for them to comprehend the gravity of their diagnosis because many were not "feeling ill." The social work effort was directed at allaying their fears and concerns from the basic social work tenet of starting "where the patient is" and using information that was known about HIV disease at that time. In addition to individual sessions, service members attended weekly HIV support groups where they could express their concerns and receive feedback from others experiencing similar life circumstances. The initial ward support group facilitated by social work and the chaplain's service allowed for an exchange of mutual support and transfer of information vital in coping with HIV. Numerous issues surfaced during these groups, however, one that created significant anxiety for HIV-positive career officers and noncommissioned officers was their concern with career advancement. Their careers had the potential of being halted by a nondeployment clause, which deferred the HIV-positive soldier from overseas assignments. This policy led to the perception of a clear disadvantage for choice military assignments and promotion to the next higher rank. This was especially true for the field soldier whose career advancement required certain overseas and command assignments for them to proceed to the next higher level of responsibility and rank. HIV-positive soldiers were also very concerned with confidentiality maintenance within the unit. This was a particularly sensitive issue for soldiers who routinely deployed throughout the world. These soldiers would now have to disguise the true reasons why they did not go with the unit on a mission. Army commanders were aware of the need for strict confidentiality and would make valiant efforts to protect the soldiers. However, confidentiality could be broken inadvertently, leaving the soldier feeling exposed and vulnerable to scrutiny by his comrades.

HIV-positive soldiers were understandably concerned with the stigma associated with the diagnosis of HIV. The labeling of homosexuality, marital infidelity, and intravenous drug use with HIV disease created an atmosphere of distrust and anxiety for many individuals and couples. In instances where there was an infidelity, service members would feel exposed and vulnerable in a military setting where these realities had significant career implications. These admissions could also lead to the dissolution of a relationship and much needed source of support for the service member as well. Social workers assisted service members in managing these difficult psychosocial realities and helped them regain emotional balance and perspective in their lives.

Service members were confronted with telling significant others and family members. Elderly parents and children were often not told. HIV-positive service members were concerned that they could create more harm for these family members. They were worried that family members would reject them. It should be noted that in many cases, both the spouses and other significant family members were quite understanding and loving. Generally speaking, soldiers were provided with much needed emotional support by their family members and friends. In those instances, where there had been rejection from the family, the social worker would assist the HIV-positive service member in locating other sources of support within the community.

Social workers provided end of life psychosocial assistance to the very ill HIV patient whose disease had progressed to AIDS. Families were not always aware of their family member's diag-

nosis and would learn of the AIDS diagnosis during the course of hospitalization for the service member. Feelings of despair, anger, fear, and bewilderment accompanied the acknowledgment of the medical status to the family. It was the task of the social worker to assist the family in accepting the diagnosis as well as making discharge plans for the patient. This could involve the adult child moving back into the parent's home for end-of-life care or locating a facility in the service member's hometown for either custodial or skilled nursing care. Social workers communicated closely with the military legal section of the medical center to assure that patients had completed all necessary legal documentation, i.e., durable power of attorney, living will, wills, etc. Social workers would also coordinate all follow-up military and civilian HIV support services. The social worker educated the service member regarding their military, veterans', and social security benefits and provides assistance in completing the documentation. These benefits were substantial and decreased the financial and psychosocial distress upon the HIV-infected soldier and family.

Current Trends and Issues

Sixteen years have transpired since the inception of the HIV Social Work Services for HIV-infected service members and families at the WRAMC. Significant medical and therapeutic advancements have taken place during the passage of time, which dramatically changed the manner in which social work has provided psychosocial assistance for HIV-infected service members and families. "Since the beginning, there have been frequent flurries of excitement based on rumors, anecdotal stories, clinical trials, and our deep longing for hopeful news to sustain us. Treatment alternatives have developed that ended in disappointment, or at least fell short of initial expectations. Riding this roller coaster has always been part of the picture for people living with HIV as well as all those who provide care for them."[4]

During the 1980s, military social workers focused on assisting HIV-infected soldiers with dealing primarily in "getting your affairs in order for end of life issues." In 2002, with the onset of the triple drug cocktails and a resurgence of hope for longer life, social work interventions are focused on "getting your affairs in order to get on with your life." Although social stigma and ignorance about HIV remain, there have been significant changes of attitude within the general population, in part due to the educational strides achieved in most parts of society. This holds true in the military where HIV-positive service members continue to receive the cutting edge in medical care and psychosocial assistance. An increased command understanding of HIV disease has also led to an increase in the quality of life for an HIV-positive service member. Challenges remain for HIV-infected service members, many of whom are now completing a full military career and moving on to second careers in the civilian sectors. The role of military social work will have to change with HIV medical advancements and the emergent psychosocial needs of the population, which they serve. If a "cure" could be achieved through medical advancement, a role for social workers will remain to provide psychosocial assistance for a post-traumatic adjustment process. Happily, that day will arrive in the not-too-distant future.

Discussion and Conclusions

Army social workers have developed programs and services during the past 80 years to meet the emerging needs of Army service members and their families. When the AIDS epidemic surfaced in the early 1980s, the profession once again had an opportunity to create programs necessary to alleviate the distress of the HIV-positive soldier. At the same time, Army social work services have remained current with medical advancements in the treatment of HIV and AIDS. From the provision of death and dying services to the acceptance of living with a "chronic disease," now treated by both Army infectious disease and primary care physicians, social work services have been there to assist the service member with their emotional and psychosocial adjustment. The HIV Social Work Services continues to provide effective and comprehensive services, which often exceeds their civilian counterparts. It has been a vital element of the role of social workers within a military setting to assure that the HIV-positive service member has been informed and has received all benefits associated with their medical status. The programs developed in this setting once again display the capacity of the social work profession to meet the emergent needs of society, to advocate for the disenfranchised populations, and to create innovative programs for the relief of distress. The Army has supported a program of compassionate treatment for the HIV-positive service member and their families for over 16 years. Perhaps some day, the course of treatment for HIV-positive soldiers will not require the level of provision of services as it does today. Until that time, HIV-positive service members and families continue to be afforded extensive medical assessment/treatment and social work support.

References

1. HTLV III Policy Guidance. Department of Defense, 1986.
2. Army Regulation 600-110: Identification, Surveillance, Administration of Personnel Infected with Human Immune Deficiency Virus (HIV), June 1, 1996.
3. Daley JG (editor): Social Work Practice in the Military. New York, The Haworth Press, 1999.
4. Rose A: Back to the future: survival, uncertainty, and hope. In HIV and Social Work. Edited by Aronstein DM, Thompson BJ. New York, The Harrington Park Press, 1998.