

Health professional-patient communication and care: evaluation of an intervention for HIV/AIDS treatment adherence

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Interventions to improve HIV/AIDS treatment adherence are often based on cognitive approaches of the *health professional-patient communication* and health behaviors. From a social-constructionist perspective of the *health professional-patient communication* and treatment experiences, it was assessed the implementation process of an individual psychosocial intervention, consisting of 4 encounters and informed by the conceptual frameworks of Vulnerability and Human Rights in the psychosocial dimension of *Care*. Taking all 16 encounters (4 encounters with each participant), the implementation process was considered “moderately developed.” Difficulties were encountered to develop *dialogic conversations* and decode meanings regarding the lack of adherence in social situations integrated with interpersonal and sociocultural scenarios. Despite the predominance of guidelines and motivational incentives for patients, there were also dialogic moments of co-understanding difficulties in adherence in its different meanings in medication intake scenes. This approach to care proves to be productive to enhance adherence practices. Keywords: Medication adherence. Patient care. HIV/AIDS. Communication. Evaluation.

Introduction

Patient adherence to antiretroviral therapy (ART) is crucial for HIV/AIDS¹ programs worldwide. A lasting suppression of the viral load depends on it, as well as the prevention of viral resistance and failure, and the reduction of morbidity and mortality (Rasu et al., 2013), providing healthy and productive lives for people with HIV (Liau et al., 2013).

¹ We have adopted the suggestion of the National Department of STD/AIDS/Hepatitis, Ministry of Health, of spelling “aids” as a common noun, in lowercase, except for “HIV/AIDS”, proper nouns and direct citations.

The adherence refers to how much a person's behavior corresponds to the recommendations **agreed** with the health professional in taking medication, following diets and/or changing the lifestyle. It is, above all, a process influenced simultaneously by many factors, requiring a multidisciplinary and continuous approach, especially in chronic diseases (WHO, 2004).

Emphasizing the health care role, 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 everyday social life, that is, in many intersubjective contexts among which the relationship with the health service is preeminent because of its relevance and constancy" (Nemes, 2009, p.5).

The Brazilian AIDS Program recommends activities where adherence is managed and encouraged by the Brazilian Unified Health System (SUS), among them **medical consultations and individual care by other health professionals, focused specifically on adherence to the treatment** (Brasil, 2008; 2007). There had not been, however, broad evaluation studies of these activities until 2009, when an inquest in the services in the State of São Paulo showed that the adherence approach is predominantly performed by doctors and nurses during regular consultations; and that the majority of other activities which involve adherence is not specific enough, besides being insufficiently protocolled and evaluated (Caraciolo et al., 2009).

Communicational, counselling and educational adherence interventions

Based on the review of 36 qualitative studies published between 1996 and 2005, Vervoort et al. (2007) suggest that adherence interventions explore the barriers and adherence facilitators from the patients' perspective because they act as underlying processes to the appointed factors by epidemiological studies. They also recommend that adherence interventions tackle the methods by which people manage their daily lives when taking antiretroviral. Conversations with patients must cover: the condition of "being someone who lives with HIV," as acceptance improves adherence; the maintenance or display of the secrecy over the seropositivity (opening up may both help adherence and also expose the patient to negative commentaries and discriminations); the clinical benefic answers from ART (viral load decrease, immunity improvement); and which circumstances imply forgetfulness or consciously changing the medication intake. It is recommended: offering information; asking the patients to describe their routine intake; supporting the development of abilities, especially to organize their lives, anticipate risks of failures and access the support network; developing trust in the professionals through open and frank communication. As Vervoort et al. (2007, p.27) state, "adapting medication to life rather than life to medication is the first and most important strategy to promote adherence."

Hence, it is understood that the individual adherence support activities must invest heavily in singularizing and continuous availability of moments of dialogues between health professionals and patients about their experiences with the treatment in different contexts. Different ways should be sought for the patient have a better "quality of life" and "in the way it suits him" (Nemes et al., 2012, p.281).

Based on the five main theoretical perspectives – biomedical, behavioral, communication, cognitive, self-regulative – and the trans-theoretical model identified by Leventhal and Cameron (1987), in works about intervention in AIDS and tuberculosis adherence, the review of Munro et al. (2007) points out that the communication perspective works are based on the idea that a good *provider-client communication* (clear and comprehensive message, adequate content and bonding) will enhance adherence through patient education.

Although since the late 1990s were assigned effects in adherence of certain characteristics of communication and the physician-patient interaction – the patient receiving information about the treatment, being heard and respected, being active in questioning (Roberts, Volberding, 1999) – the communication perspective is the one which has the least categorized number of works (five). Moreover, out of these, only two are review papers (Griffin et al., 2004; Lewin et al., 2001), examining communication effects on health behaviors regarding certain interventions. Therefore, few works examine the effects of communication, specifically about adherence, although communication components are used in many adherence interventions, and rarely in an explicit manner or as the main component (Munro et al., 2007).

A review of 25 adherences to antiretroviral therapy (ART) interventions, published between 1996 and December 2004, concluded that the interventions have been essentially “atheoretical” and of insufficient methodological strictness for assessing effectiveness and generalization capability (Amico, Harman, Johnson, 2006). On the other hand, 18 of those interventions included individual counseling sessions, *counseling support, supportive communication or individualized patient education*. Despite varying in duration and frequency, and whether associated or not to other procedures, those sessions clearly cover conversations between health professionals and patients.

Thus, in spite of being possible to perceive the value of communication and dialogue plan of proposals of a good part of interventions, the conversations that occurred among health professionals and patients constitute a kind of “black box”. There is little or no explanation on which theoretical-methodological basis they were conceived and developed. Additionally, few are the qualitative analyses if compared to the large number of experimental studies which describe more frequently the randomization, allocation and closing procedures than the communicational procedures with the participants. After all, what is understood by *health professional-patient communication*? What is meant by having a conversation or a dialogue?

These questions offered the opportunity for a **qualitative evaluation of an individual care intervention trial** to support patients to improve their adherence antiretroviral therapy, which is the object of this article – complementing other evaluations of this nature (Bellenzani, Nemes, 2013; Nemes et al. 2012; Santos, 2010). Charts 1 and 2 summarize the intervention trial and the research outline of this paper, respectively. Annex 1 contains a summary of the intervention protocol.

Chart 1. Controlled trial of an intervention modality in adherence in a reference service center in São Paulo State

The clinical trial happened in 2008, in a reference service in São Paulo city. The participants had their adherence measures monitored for 6 months, using bottles that stored one of their antiretroviral drugs, with an electronic device stored in the cap to record each date and time the bottle was opened (MEMS - Medication Event Monitoring System). There were invited people over 18, being treated with the same antiretroviral therapy (ART) regimen for at least six months and whose results of the last viral load was higher than 50 copies/ml, thus indicating adherence problems. The aim was to evaluate the intervention effectiveness and, therefore, its protocol of 4 encounters was implemented with only patients of the experimental group between the 3rd and 4th research month.

Conceived as a Care technology supporting adherence, focused on conversations between health professionals and patients in individual encounters, it was conducted in the clinical trial by three staff members: two psychologists and one social worker. They relied on the help of a script prepared according to the original protocol (see attachment) supported by a set of recommendations extracted from review papers on the most effective adherence interventions. The aim was to have an adherence approach different from the approaches usually applied in medical consultations or in the care of each professional center, in an interdisciplinary concept consistent with the recommendations for the work in multi-professional teams carried out in AIDS care.

The three health professionals signed up spontaneously for a training offered by the research team as part of the selective process of the professionals who volunteered to conduct the protocol. The training was focused on promoting a "deconstruction" of the traditional care and adherence approach in 48 hours of theoretical-practical activities based on the problematization methodology of Paulo Freire's pedagogical-critical approach. The activities included: a) role play and real life scenes, followed by group discussions and synthesis of the discussions made by the coordinators; the health professionals were encouraged to revisit their knowledge and life experience in the light of new theoretical frameworks they were being introduced to (and which will be described later); b) simulator experience for 48 hours of taking placebo; c) role play in which the participants simulated conducting intervention with professional actors or colleagues for experiencing ways of managing intervention, alternating themselves between the patient and health professional "roles;" d) "pilot" care with patients of the service (Santos, 2010). In addition to training, there was monitoring of the health professionals with team members while conducting the protocol.

The final quantitative findings showed no differences statistically significant between adherence rates of control and experimental groups. The mean viral load had a significant decrease in both groups, with no significant difference between them. The analysis of the clinical trial was published by Basso et al. in 2012.

Chart 2. Aim and method of qualitative evaluation, the object of this study

Objectives of the qualitative evaluation

- a) Evaluate, according to dimensions and components, how and in what level the conversational moments made possible by the four encounters neared what had been ideally planned as protocol, since the script supporting the health professionals, though relatively, structured the encounters.
- b) Articulated to the analysis of the protocol implementation, analyze "who the participants are," the aspects of their life history, their coexistence with the illness/treatment, and which senses of the failures/problems/difficulties of adherence emerged in the conversations of the health professional with them.

Methods

The conversations elapsed in individual encounters between a health professional (psychologist) and four participants (4 meetings/sessions each, totaling 16 with approximately one hour duration) were analyzed. The material is a part that comprises the database of the original research (recordings and transcripts of 176 encounters of the 44 patients cared by intervention in complete protocol, among the 64 of the experimental group).

Criteria for the selection of the four cases

- a) All participants cared by the same health professional Vera (fictitious name).
- b) Selection of the first two and the last two patients to join the research/intervention, bearing in mind that the intervention development could improve when successively conducting the encounters.

The choice of a specific professional and of the intervention cases she monitored has no methodological justification. The respective material was the first to have the analysis completed within the full assessment, which includes material from the cases of the two other health professionals. The type of analysis carried out requires a wider space for reporting the findings, implying that the present work concentrated on the study of cases of a single professional.

About the health professional

Vera is a psychologist of the AIDS ambulatory of the reference center, the research site. She has been giving psychological care to patients for approximately 20 years. As this service is a usual field of research and training, she has already taken part in numerous operational research studies and works as a training instructor.

Conceptual and methodological basis of intervention

An intervention which emphasizes the psychosocial dimension of illness and *Care*

The evaluated intervention was thought of in the midst of the Brazilian answer to AIDS, whose propositions in the human rights framework, for instance, have been managed since the end of the 20th century. The most recent formulation of the *Framework of Vulnerability and Human Rights* (V&HR) for analyzing the epidemic and propose programmatic actions guided the protocol development. This framework expresses the commitment to “search for new epistemological and technical bases towards the health practices reconstruction proposals” (Ayres, Paiva, Buchalla, 2012, p.12) in the context of the Brazilian Unified Health System, materializing its principles: universality, comprehensiveness and fairness.

Distancing itself from the cognitive and behavioral guidance more frequently present in adherence interventions (Simoni et al., 2010), it was maintained the intervention planning, the notion of *Care* in the adherence field of chronic diseases treatment (Nemes et al., 2009). The capital letter indicates the intention in amplifying the most common meanings of patient assistance or care, considering it “as a reconstructive category” of health practices (Ayres, 2009a, p.62), being inspired by the hermeneutics of Gadamer and Habermas.

Care is defined as

[...] a category with which there is a desire to simultaneously assign a philosophical comprehension and a practical attitude facing the meaning that health actions acquire in diverse situations in which a therapeutic action is required, that is, an interaction between two or more subjects with the objective of alleviating suffering or reaching welfare, always mediated by knowledge specifically aimed at this end (Ayres, 2009a, p.42).

In the more concrete plan of health practices,

looking after someone's health is more than building an object and intervening over it. [...] Projects must be considered and built; [...] a certain relationship between spirit and matter, mind and body must be sustained [...]. Then, it is mandatory to know what project of happiness is in question when assisting [...] (Ayres, 2009c, p.37).

The production of *Care* in a dialogical adherence intervention presupposes “diverse, inter-linked and complex [...] changes [...] from: subject to inter-subjectivities; technical control to practical success; treating to caring” (Ayres, 2009c, p.37). Regarding the communication which constitutes *Care*, there is an advance from the notion of people while individual nucleus of subjectivity (in which their identities were associated to sameness/permanence) to the notion of “dialogic constitution of subjectivities”, taking

inspiration from Habermas (Ayres, 2009c, p.29). In the inter-subjective relationship, the subjects mutually recognize themselves and “constitute themselves one in front of the other [...] [seeking] a sharing of horizons,” during the conversations which aim to produce health (Ayres, 2009c, p.35), from “the linguistic bridges between the world of techno-science and common sense” (Ayres, 2009c, p.34).

From *the V&HR Framework* (Ayres, Paiva, Buchalla, 2012) derives the second conceptual source: the psychosocial dimension implied in *Care*, linked to the social constructionist approach (Paiva, 2012a). Conceptually, the social constructionist perspectives propose

a paradigmatic change in relation to the representational or cognitive perspectives, which state in a universal and essential manner the existence of psychological realities and internal processes, such as thought, memory, attention, motivation and emotion [...] [They differ themselves from] psychological hegemonic theories [which] seek to explain, through these processes, human relationships and behavior. (Guanaes, 2006, p. 22)²

Opposing the perspective which sees the individual as a “*set of intra-psychic or biological-behavioral factors*,” the *Care* which integrates the psychosocial attention of social constructionist inspiration works with “the notion of person *in interaction*, conceived as *inter-subjectivity* [...] and as *subject of rights*” (Paiva, 2012a, p.45). As a methodological derivation, “the subject on the scene is the most interesting door to initiate any dialogue in a psychosocial approach of *Care*, to deal with any of three dimensions of vulnerability on illness” (Paiva, 2012a, p.62).

The “scene methodology in the V&HR framework” (Paiva, 2012b, p.187) incorporated to intervention was developed in the midst of the social constructionist movement – specifically, in the study fields of gender, sexuality and STD/AIDS prevention (Paiva, 2006). The health professionals who conducted it with the participants were trained and supervised on the referential of intervention, including this method, so that during the conversations they would propose the “mapping, description and decoding of *scenes* [specifically, those related to the treatment], and their socio-cultural contexts and

² The social constructionist perspective, framework or field - named, sometimes, in the plural – is heterogeneous, plural and under transformation. Some basic postulates of the social constructionism have been most shared (not always with the same emphasis on each one) by a group of authors considered *constructionists* (see Iñiguez, 2002). Epistemological proposals of social constructionism in Human and Social Sciences have been incorporated by Psychology, especially by Social Psychology, since the 80s (one of the main references is Kenneth J. Gergen) and, more recently, in the Psychology of Health, specifically in the Social Psychology in Health in which Mary Jane Spink is one of the references. However, it would extrapolate the limited space of this paper to evoke this extensive field to situate, in dialogue, **one of the constructionist perspectives of social Psychology in health** – which “thinks the health-illness process in the V&HRs Framework (Vulnerability and Human Rights)” (Paiva 2012a, p.46). We identify convergent points with other Brazilian and international constructionist perspectives, which also deserved to be explored on treating such subjects as *communication, conversation, dialogism, production and negotiation of meanings* in the individual, group, family, institutional and community psychosocial and psychotherapeutic practices. Furthermore, it also deserved attention the notion of *social construction of the self*, central to the debate of practices of psychological care. Therefore, we have opted for referring the reading of some of these authors: Marilene Grandesso, Carla Guanaes, Emerson Rasera, Marisa Japur, Sheila McNamee, Harold Goolishian, Tom Andersen, Harlene Anderson and Lynn Hoffman. The limited space demands us to focus on the references which supported more directly the planning of intervention and were incorporated to the training and supervision with the health professionals who conducted them. The constructionist perspective which supports the *psychosocial dimension of Care*, used in this study, is more strongly inspired by the pedagogic constructionist tradition of Paulo Freire, as well as by George Mead, Jerome Bruner, Erving Goffman, Thomas Luckmann and Peter Berger, in addition to the dramaturgical social constructionist approaches that maintains a dialogue with the production in the field of sexuality and gender, by John Gagnon, Richard Parker and Peter Aggleton.

scenery" (Paiva, 2012b, p.165). The Chart 3 details the incorporation of this methodology to a clinical trial. The objective was to collaborate with the people to critically reflect on their experiences with the treatment, conceiving them as "subjects of their daily lives and subjects of rights" (Paiva, 2012b, p.166-7).

Regarding the care of the person living with HIV, the conversation over scenes of taking the medication sophisticates the dialogue on the dynamics of treatment adherence, which always involves more than one prescription [...] Episodes are raised in which the medication had not been taken, which are the "easy" scenes that guaranteed taking it [...], analyzed together with each person and from different angles – from the point of view of their personal history in the service, of the present feelings in each scene, as well as the comprehension of the discrimination and social stigmatization associated with AIDS in the family and work contexts. (Paiva, 2012b, p.169)

Chart 3 - The *scene methodology*³ in training and supervision of clinical trials

In order for the *dialogues on the scene* to be spontaneous – through which the interlocutors "incarnate" voices and actions of "characters," the health professionals were encouraged to act as "directors" of a movie or soap opera, using requests such as: "Let us think about this situation you are describing: the medication dose you have to take at work... Let us imagine this moment as if it were a scene of a soap opera... How is your workplace...?. Who are the people whom you work with at this time of the day?" Let us imagine that the room was empty. Would that change the events?" After the dense "construction" and "visualization" of the scene, the proposal is decoding the meanings of actions, behaviors, feelings, emotions, and decisions (mainly the spontaneous, less rational ones), involving the medication dose intake. According to the plot, the local context and the broader sociocultural scenario, understandings or ideas of the health professionals that helped to understand what went on should be communicated – not as imposed truths or "interpretations," but as possibilities, with the interlocutor being able to accept it or reject it. Hence, the health professionals participated in the negotiation and production of the comprehensive meanings. Furthermore, beyond the "verbal construction" of the scene, dense or more simple scenarios (as actors "going through texts," i.e., only the characters' speech) could also take place. The methodology sought to facilitate that the health professionals, attentive to the psychosocial dimension of any illness and health behaviors, would help people, through dialogue, recognize their personal difficulties in order to remain adherent and imagine possible changes. Above all, those who depended on "start to act" or interact socially, enjoying their rights as citizens (rights such as not being discriminated, and right to privacy, good quality health care, decide upon the best therapeutic possibility, access to information, materials and resources to assist self-care and adherence). It was incorporated as an experimental and conversational resource in order to expand the understanding that the production of everyday difficulties with the treatment – for example, not searching for the medication in the cabinet at the workplace; not taking the medication in the living room of a friend's house – is conditioned, among other social determinants, to the senses that the actions, the non-actions and the interactions acquire in each social scene. Therefore, it is understood that the individual vulnerability to illness for treatment failures is "inextricably integrated with the programmatic and social" (Paiva, 2012b, p.187).

New dimensions and components for evaluating a psychosocial intervention on adherence: from message transmission to dialogical communication

The references aforementioned described require the implementation of a new kind of psychosocial *Care*, focused on adherence problems to the HIV/AIDS treatment, which consequently

³ The expression *scene conversations* cannot be found in previous publications above mentioned about *scenes methodology*. During this study, it seemed appropriate to name the conversation which asks for scene narratives and analyzes them.

depends on the flux of conversations. Therefore, it is necessary to delineate the perspective of *the health professional-patients communication* adopted in this evaluation.

A “good communication” on health practices is traditionally that whose emphasis is placed on the health professional competence in the use of language and in the clarity of their (informative and prescriptive) enunciations. This conception is an heir of the *cognitive revolution*, processed since the 50s in Psychology, intensified by changes in the scope of Science Philosophy from the 70s (Álvaro, Garrido, 2006). The prevailing paradigm of that period became known then as *the information processing paradigm*, in which the cognitive processes are approached through the computer metaphor in an analogy between the computational and the cognitive processes – including those which involve interpersonal communication: thinking, formulating, transmitting enunciations; receiving and processing messages – as noted by Álvaro and Garrido (2006, p.250), “the mind as a system of data processing.”

This cognitive apprehension of communication was supported in the “old knowledge paradigm” in crisis in the Philosophy of Science, being progressively substituted by “new knowledge paradigms” (Pearce, 1996, p.181), among others, the social constructionism paradigm. Communication in the “old paradigm” supposed

that language referred itself to the world, that is, that language is representational: it tells us about the things which are ‘there, outside’. [...] It establishes that the transmission of a message (that is, managing that messages go from ‘here’ to ‘there’) is the key function of communication. (Pearce, 1996, p.176)

From that paradigm it is easy to understand, for example, one of the criticisms directed towards the communicational perspective in strategies of adherence improvement: ignore the attitudes, the motivational and inter-personal factors that interfere in **the reception of the message** and in its **conversion into behavioral change** by the patient (Munro et al., 2007). Hence, the processes are individually operated by the speakers (in their minds as computers). The health professional “thinks,” formulates and transmits enunciations, while the patient assimilates, processes the messages received, converting them into behaviors. “Negative” characteristics of the patient or “bad quality of the message” transmitted may interfere in the processing and conversion into behavioral “answers” by the patient.

Moving away from the cognitive perspective, the way in which communication was analyzed in the present paper was guided by the philosophical hermeneutic epistemology and social constructionism (Schwandt, 2006). These led the way of conceiving the *health professional-patient communication*, and they guided “how” to listen to the audios and to read the transcripts of the dialogues in the evaluation process of implementation as well. Based on Gadamer, “comprehension is the interpretation [...]; in the act of interpreting [...] the traditions and the concomitant pre-judgments which influence our efforts to understand, [are] conditioning our interpretations [...]; the comprehension is participative, conversational

and dialogical [...], being conquered only through some logic of question and answer [...]" (Schwandt, 2006, p.198-9).

The hermeneutic tradition and the social constructionism value the comprehension of meanings produced in the conversational processes, being concerned about "clarifying the conditions under which comprehension occurs" (Schwandt, 2006, p.200). Although disagreeing on the question of truths to be interpreted either existing or not a priori, both share "the general critic of meaning while object", of meanings "as fixed entities which can be discovered and whose existence does not depend on the interpreter", and both have "affinity with the notion of the birth of meaning" (Schwandt, 2006, p.202). Namely, "meaning and understanding are built socially [...], we do not reach or own [them] until we perform a communicative action [...]" (Anderson, Goolishian, 1998, p.36).

In the psychosocial approach of *Care* proposed in the intervention – and in this evaluation – communication is thought of as mutual comprehensions produced by meanings exchange – that is, "in between" the speakers. Both in the health professional-patient interaction and in the person cared by "those" he/she interacts with and communicates with, performatively and intersubjectively, in his/her everyday scenes. Therefore, they are not about "the existing meanings inside each other, a priori", to be transmitted and assimilated, but about the meanings built and shared in the health professional-patient meeting scene.

In order to evaluate the conversations for investigating whether they materialized the protocol of the proposed psychosocial approach proposed for the intervention, it was necessary to adopt the notion that not all conversations are, necessarily, of a dialogical nature. They may also be of a monological nature, as named by Guanaes (2006), based on the interfaces of theoretical propositions by John Shotter, Mikhail Bakhtin and Harlene Anderson.

Dialogical conversations make possible *multiplicity of voices*, as opposed to monological, in which *one* voice, perspective, tradition or dominant speech is imposed (for instance, the technical-scientific, medical, religious, psychological speeches, etc). Dialogues allow for exchanges, complementation, interactions between *the voices* and, meanwhile, the emerging of innovation and new meanings "from the recognition of the other as a distinct and individual voice," thus creating possibilities of group construction of 'change'" (Guanaes, 2006, p.73).

Thus, from this theoretical and methodological perspectives it was originated a dynamic evaluative approach (as illustrated on Figure 1 and described on Chart 4), systemized in interdependent components and dimensions, corresponding to more "panoramic" or more "internal" approaches (like a "zoom").

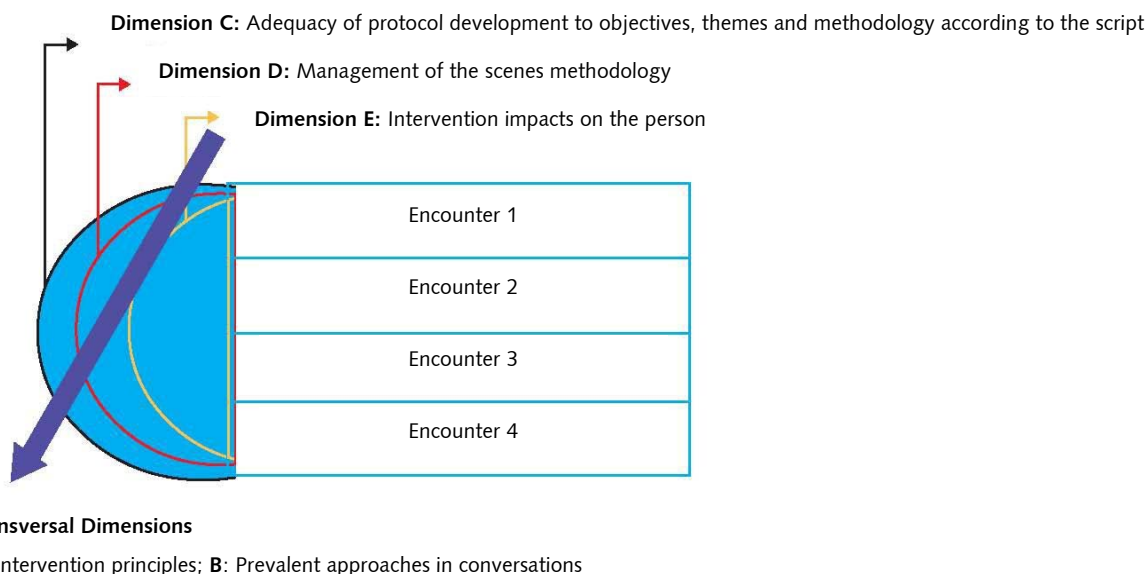


Figure 1. Evaluative approach of intervention

Chart 4. Evaluative approach according to dimensions and components

<p>Dimension A: "General (theoretical, methodological and ethical) principles of intervention"</p> <p>The main theoretical-philosophical principal, more comprehensive and transversal to intervention, is the "production of Care in adherence through a dialogic communicational interaction between the health professional and the cared person." Other six components fundamental to the dialogic communication integrate this dimension (see Table 7).</p>
<p>Dimension B: "Predominant approaches in conversations"</p> <p>The aim is to evaluate if the referential of the constructionist psychosocial dimension of Care in adherence – work with "the person in the context and the context of the person" (Paiva, 2012a, p. 59) – was implemented. Being psychosocial and communicational in the propositive plan, it is necessary to assess if this approach was either predominant or not regarding other possible ones: educational or behavioral-cognitive approaches (see Table 9). Firstly, it is investigated the acceptance process (according to the current acceptance of the Brazilian Unified Health System (SUS) with the National Policy of Humanization) necessary to interventions that presuppose the psychosocial dimension of illness and Care to the contextualized understanding of the self-care experiences, as the adherence. It is evaluated the 'quality of listening' to free narratives of the patient – better when "the normative horizon is broadened to an existential dimension" (Ayres, 2009d, p. 92) – and the health professional responsiveness: to what extent it was implied in the conversation an interested, solidary and supportive responsiveness. Furthermore, it is evaluated if the inquiries of the health professional motivated reflection and increased the possibilities of all participants understand the intersubjectively meanings of what was being shared – feelings, work and family social relations, affective relationships, life/citizenship conditions, projects, and so forth. It is also investigated if the tendency was towards singularization ("answering" to what the person had expressed) and, above all, if it was not being guided only by techno-scientific regularities. Configuring more strongly the constructionist psychosocial focus, it was expected that, while listening to the narratives, the health professional explored them according to the methodology of the scenes. Lived routinely, these "depend on the trajectory and the resources of each person (...), on his/her social condition – of gender, social class, serologic or emotional state and (...) of the programs the person has access to. In other words, they depend on the smaller or bigger programmatic, personal and social vulnerability that is then expressed in each scene" (Paiva, 2012b, p. 199).</p> <p>The psychosocial focus of Care configures in the extent that it is presupposed the cared person, always in the interaction, changing, and not the expression of a "permanent and own interiority" or, still, rather than the expression of "answers" that characterize "the standard of behavior or beliefs" (behavioral-cognitive approach). What is generally understood as patient's beliefs (an individual component of vulnerability) must be worked through dialogue, sending them back to social and relational contexts of the person's production (sociocultural plan of vulnerability). Consequently, decoders dialogues that promote "expansion of consciousness," contributing to the "psychosocial emancipation" of</p>

people in relation to the determinants which oppress them and extend their vulnerability to illnesses (Paiva, 2012b, p. 186).

Dimension C: "Adjusting the protocol development to objectives, themes and methodology according to the script"

Their components are more "operational" (different from those that integrate both previous dimensions: transversal and "philosophic" dimensions). The operationalization of the script recommendations for each encounter is analyzed (see categories in Tables 7 and 8). This dimension covers the three that follow.

Dimension D: "Handling the methodology of scenes and implications"

Formulated to evaluate more specifically monitoring components related to the development of the *conversations on the scene*, foreseen to the 2nd e 3rd encounters. Five components integrate it in the form of assessment questions (see Table 9). With this methodology, it was aimed to enhance the constructionist psychosocial approach in adherence Care. It is analyzed if there was an effort of the health professional to use the resource and which were the implications for understanding through dialogue of the practices and feelings involved in each scene/scenario of the medications intake/non-intake. It is investigated to what extent the intersubjectively meaning of the practices, not very rational, contradictory, or even unrecognizable up to then were communicated between the interlocutors and, in a wider plan, problematized, critically thought, in the dialogue. Above all, when the scenes made explicit conditions and discourses/oppressing social voices, unequal relations and lack of respect to rights. It is also aimed to give dimension to the potential and limitations of *the conversations on the scene* in order to help the person formulate expressive collocations of movement to deal with/face the symbolic and objective barriers that made difficult "being adherent" in each scene/situation.

Dimension E: "Repercussions of intervention for the person"

Formulated to investigate the patient's narratives which made explicit intentions or practices initiated during the period of intervention, movements of change towards improving adherence, self-care, life projects and wellbeing. Ten components integrated it (see Table 9), explaining the normative horizons of interactions of Care: the best co-existence with treatment according to its *convenience* for the patient's life and the search for *technical success* of treatment in the extent that it is simultaneously configured as *practical success*. This is related to the value the actions (for example, taking medication) assume for the person everyday and in his/her future projects "due to material, relational and symbolic implications" (Ayres, 2009b, p. 139). In other words, they are related to intersubjectively constructed meanings, singularly experienced in the form of intelligibility of intentions: "why and what for to be healthy," "not to be ill to be able to do what," and "taking medication for what purpose." The health professional who cares should respect, incentive and support the patient's intention guided by his/her *projects of happiness*, as highlighted by the author.

Opening the "black box"

The comparative findings of the cases will be described in the charts 5 to 9, using fictitious names. We recommend viewing the charts before the Discussion. As a way of complementary information, there is on Chart 5 clinical data and adherence measures from the participants. Chart 6 corresponds to objective "b" from the Introduction, referring to who the patients are and what they said about their experiences involving the treatment⁴. On charts 7 and 8 (corresponding to objectives "a" and "b"), the first to the fourth encounters are analyzed (longitudinal synthesis, reproducing parts), according to dimensions and components, deepening the production of meanings during the conversations.

⁴ As the clinical trial did not allow health professionals to access either hospital notes or adherence measures collected, all this information had exclusively the patients themselves as the source. The first author, who did not participate in the field research, had access to the clinical data only at the end of the qualitative analysis.

From the exhausting qualitative analysis broken down on charts 6 to 8, an objective analysis was made of the development of intervention in the four cases, using an Evaluative Table, which contemplates a scale of pre-established patterns (Chart 9).

Chart 5. Clinical data and patients adherence measures

According to the research protocol, the four participants showed a viral load above the detection limit (50 copies/ ml) in the last routine procedure before starting the research. The viral profile one year preceding the research was consistent with an insufficient adherence pattern (relatively low but constant viral replication), in the case of Álvaro, Deise and Ciro – a pattern which was maintained both during research as in the subsequent year. Three measures of medication intake with electronic monitoring were made: in the 2nd month of research (before the encounters), in the 4th month of research (after the 3rd or 4th encounter), and in the 6th month of research (after the encounters). The three measures of Álvaro and Deise showed insufficient adherence with the maximum value of 82% and minimum of 62%, whereas the three measures of Ciro showed adequate adherence (above 95%). On the other hand, the patterns were different in the case of Amaro. Already in the first research month (before the encounters), his viral load reduced greatly, becoming undetectable before the 1st encounter. For him, the electronic monitoring measures were 91%, 100% and 97%.

Chart 6. The patients and their adherence difficulties/problems

Patients	Narratives produced in dialogues of presentation and over the encounters	Narratives on the treatment regimen, experiences related to both adherence and adherence failures
CIRO	Ciro is 71 years old, retired, homosexual, and lives alone. He has known he contracted HIV for about 20 years and he has been under medical care for 17 years, but he does not show nonconformity or sadness about it. Unlike his mother, “who has no prejudice,” his father drove him out from home when he caught him with a boy at the age of 13, when he started working as a butler in the house of a foreign family. He has been working there for 40 years, but currently only at the weekends, “on the side” . His bosses know the diagnosis. He has little contact with his two sisters and resents the emotional distance of one of them, although they live close to one another. He talks openly in the encounters, laughs, denies “any type of depression.” He mentions a guy with whom he had a steady relationship for 18 years and who he still loves. He has a current relationship with another man, “a 26 years old young man” who ignores his seropositivity. He feels in good health, he is active, and emphasizes that he has never had hospitalizations due to opportunistic diseases.	Ciro reports following the treatment correctly: “I do everything right, the schema is good.” He holds himself as “frank” for mentioning that he has suspended the use of medications in some periods, illustrating such periods with a trip he made with a boyfriend without taking with him the medication. He does not know the names of the medications he takes, referring to them by color or as a cocktail. He takes nine pills a day: five in the morning and four at night. He compares the current <i>treatment</i> to the one in the past: today the medication intake is at home, while in the past it was at the residence where he worked. He adds that at that time he “hid the medication” and “took them hidden” due to the presence of others. He feels good and satisfied with the current regimen, comparing it to the previous one, seen as “bad,” as he had to keep the medication in the refrigerator. The conversation produces a shared understanding that there is no adherence problem with him.
AMARO	Amaro is 36 years old, married, father of a 12 year-old boy. He has a seronegative wife from whom he omitted he got infected in a homosexual relationship. Instead, he explained to her he had contracted the virus using an injectable drug. He avoids sexual relationships with men and he experiences them “only sporadically, when the will is really strong.” He keeps that in absolute secrecy, as well as his diagnosis. He says he was diagnosed two and a half years ago, and adds: “it was a terrible shock,” “I just did not do something stupid” when I found out because my son was with me. The boy does not know about his father being HIV-positive. He sometimes says he got used to being seropositive; others, that he is getting used to it. He has worked at a steel company for	The subject of medications emerges associated to the comment “I am agitated;” “in the beginning, it [the medication] let me a bit annoyed;” “I felt dizzy, with a terrible taste in my mouth.” And he adds: “I am getting used to it, adjusting to it;” “I never liked taking any medication.” Amaro knows the nomenclature of both medications of the regimen (Biovir and Efavirenz; he takes them at 7.00 a.m. and 7.00 p.m.). He complains about the second medication: “It lets me dizzy, anxious.” He says he has “some flaws,” as sometimes delaying taking the medicine at night due to his work routine: when he has to work overtime and arrives at home after 7.00 p.m. He takes no medication with him to work. He

	<p>twenty years. The roles as a man, the father of a family and a worker are highly valued. He describes himself as being <i>"a very agitated person,"</i> relating that with the beginning of the treatment with medication, just over six months. He describes the first experiences as bad, and emphasizes: <i>"I never liked taking medicine."</i> He is very concerned about keeping absolute secrecy over HIV. He fears discrimination at the workplace and that his wife might suffer discrimination as well. It bothers him that people might be afraid of him and that he may be <i>"named"</i> as someone who <i>"did something. [He is worried about people saying: He] 'used drugs or that he had an affair with another man' (...)."</i> Today, he refers to living with HIV in a <i>"quieter, less painful"</i> way. Before, he had thought he would die and that he should not make any plans for the future, but not anymore. He associates this change to chat sessions he has on the web with other people living with HIV and to the support of his doctor, whom he refers to with satisfaction, as a person who guides him on issues which extrapolate the clinical sphere (issues related to his social life and his rights); therefore, helping him deal with the diagnosis.</p>	<p>knows that there is a <i>"little case"</i> (pill box), but he does not have one. He takes a third medication (unspecified) at 11.00 p.m., and it is conditioned to the time he goes to bed. He uses that as a strategy: if he feels bad, he will be sleeping. Bed time varies; therefore, the time he takes the last medication also varies. Underexplored in the dialogues, there are aspects which suggest that some failures in taking the medication are associated to the fact that the medication is <i>"well kept,"</i> meaning it is hidden because of the concern of not letting it visible to others. He has some personal strategies to remember if he has already taken all the doses. He believes he follows the treatment properly and, according to his doctor, <i>"[delays] up to half an hour do not represent a problem."</i> <i>"I try, the best way I can to take it correctly because I know it is good for me."</i> When questioned about not taking the medication to work being/not being <i>"a problem,"</i> he replies: <i>"who is causing the problem is myself."</i></p>
<p>ÁLVARO</p>	<p>Álvaro is 39 years old, retired due to disability. He lives alone, is homosexual and has an <i>"ex-partner"</i> with whom he still has an affair and sometimes refers to as <i>"my boyfriend"</i> along the encounters. He talks a lot about his ex-partner and suffers for suspecting he has a concurrent relationship with another man. He talks mostly about this affective relationship. After presenting himself as a retired person, he adds: <i>"[there is] nothing else about what I can talk about myself."</i> His voice expresses melancholy, indifference and fatalism. He has little initiative to talk, but he answers to questions. Asked about, he mentions having three brothers, deceased parents (his mother, since he was two years old; and his father, since his early teens). He lived in a boarding school; afterwards, in his adolescence, with a foster family, but he left them and interrupted his studies after having a strong argument with his foster parents, as they found out about his homosexual orientation. He started living with his step mother, in the house of his recently deceased biological father. He distanced himself from his foster family, keeping sporadic contacts with them. However, he says: <i>"[they] accept me a bit more"</i> today. He found out about HIV in 1999, when a health professional encouraged him to take a test. Upon receiving the diagnosis, he emphatically says: <i>"I almost threw myself on the subway tracks,"</i> noting that they gave him coldly the result of his HIV test, and compares that experience with the careful current service in the second HIV test. He suffered strong discrimination at the workplace when revealing his seropositivity to his bosses. Due to depression and to HIV, he retired. He suffers discrimination, psychological and physical violence from his brothers, <i>"violent ex-convicts."</i> His <i>"domineering sister"</i> has burned him badly by throwing boiling water at him, what made him spend a month hospitalized. He currently lives in dispute with her because of a piece of shared land where their house lies and where he intends to go back to. However, due to the electricity been cut, he is unable to go back there. He pays rent elsewhere, lives between his house and his boyfriend's house and is in financial trouble.</p>	<p>Álvaro believes that the Medication Event Monitoring System (MEMS) is helping him to remember to take his medication and to <i>"take more responsibility,"</i> and emphasizes that he follows the treatment correctly, <i>"ninety-five percent of the time."</i> He mentions a few episodes that have already happened, when he did not take the doses in the morning when he went out the night before and came back home at six the next morning. He then slept during the day and, when he woke up, he decided to take the medication only in the evening. Delays in the medication intake in the evening, varying from one to one hour and a half, are not seen as failures. Suppressions of doses occur on trips at the weekends (first, he states that he takes the medication bottles with him, but afterwards he recognizes that he sometimes forgets to take them with him). Two relevant pieces of information are unexplored: one that he <i>"mixes up"</i> his medications and the other one that he has already consumed a lot of alcohol, associating that with episodes in which he abolished taking some of the medication – the latter meaning a problem. Showing concern, he says he is drinking again after one year abstinence. He believes he follows the treatment <i>"properly"</i> at the moment. His current regimen: 2 pills of Kaletra and 1 of Lamivudine every 12 hours, and 1 pill of Viread in the evening. His current routine is to sleep over a few days at his boyfriend's house and often wake up around 5 in the morning, accompany his boyfriend to work, return home, have breakfast between 8.00 and 8.30, and take his medications. Evening failures in taking the medication are usual, varying up to two hours, but he does not see that as a <i>"difficulty"</i> or as a <i>"problem"</i> because the time to take the medication is inconvenient, for example. His current understanding is that the failures in taking all the medication prescribed happened in the past, but they are sporadic now.</p>

DEISE	<p>Deise is 51 years old and works in the production sector of a company (she resigned between the first and second encounters, justifying: "[I did that] to take better care of myself." Widow for twenty years, when she learned about her husband's HIV, who died of AIDS. She did not take the AIDS test, got ill three years after his death and was hospitalized. She was diagnosed as having AIDS and started the antiretroviral therapy (ART). Her 22 years old son, fatherless and still a kid, is her main support and her "reason for living." She told him a year ago about having HIV. She struggled for years to keep secrecy about it for fearing her son would get upset or suffer discrimination. She suffers from the diagnosis, feels herself "wronged" and is resentful that her husband infected her. After him, she did not have any intercourse.</p>	<p>Her current regimen of 12/12 hours includes four different medications: five pills prescribed to be taken at 10.00 a.m. and four to be taken at 10.00 p.m. However, the time she takes them varies greatly. In the morning, the intense workplace makes it difficult for her to remember taking the medication, or she postpones going to the cabinet to take the pills in her bag. Delays in taking the medication in the evening are seen as consequences of fatigue that make her forget to take the dose, or falling asleep while watching TV, before 10.00 p.m., and then waking up until three hours later. Sometimes, she is late to take the dose; others, she suppresses it. Underexplored, she has a history of hiding the medication bottles and not taking them in front of her son, suggesting a relation between that and forgetting to take the medication. The adherence difficulties are also associated with side effects, as "get groggy," resulting in not so very conscious decisions of suppressing certain doses when she has some appointment and "wants to feel well [without side effects]."</p>
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Chart 7. Analysis of the conversations by dimensions and components/1st Encounter

CASES	CIRO	AMARO	ÁLVARO	DEISE
1st ENCOUNTER (the patients' talks are in italic and bold)				
Meanings produced in the intervention presentation	<p>Except for Ciro, there was a predominance of meanings favoring the positive understanding that the encounters would be for care and not for research: <i>"care," "helping people handle with their medications," "let us think together," "an exchange."</i> On the other hand, for Ciro, the predominant meanings were: <i>"a research," "a kind of interview."</i> The patient even added: <i>"I already gave an interview once to VEJA."</i> With him, it was emphasized the use of <i>MEMS</i>, the counting of pills by the researchers and the Free and Clarified Consent Term (FCCT), without properly appreciating the specificity of the encounters as an activity of Care (the amount of encounters and their objectives, for example), although that was part of a more extensive research. That implied in a difficulty in producing, between the health professional and the patient, a dynamic of Care that was secondary to their interaction.</p>			
Meanings about the research participation and the use of MEMS	<p>Both cited the health professionals of the service with familiarity, as if they had answered the invitation of friendly people. Amaro gave altruistic justifications, agreeing with what the health professional had told him, <i>"to help others,"</i> but he also said: <i>"It is good, sometimes, to talk [...]. It is good to talk with someone,"</i> suggesting the sense of need or personal relevance, the opposite of Ciro who basically came to answer a request. Ciro believed that he <i>"had always taken [the pills] properly,"</i> although he had had <i>"one or two failures"</i> while traveling in the past. Questioned about expectations on the research, he wished to have a new vaccine <i>"for us to take less medication and get physically healthier."</i> Although asked about MEMS, he does not comment on it. The use of an electronic device is not explored with Amaro. It emerges by chance in</p>	<p>First, he says it was <i>"out of curiosity,"</i> when the health professional questions him (negotiation of meaning) as if that was not enough. Then, a personal meaning is produced: <i>"[That] I start to take, to take the medication properly."</i> He recognizes his failure regarding the continued use of medications, especially after breaking up with his partner: <i>"I did not</i></p>	<p>Meanings were produced: <i>"to keep a better eye on myself ;" "to improve our lives [...] and to find other solutions."</i> Deepening the dialogue about the experience of MEMS enabled the emergence of the scenes of medication intake at the workplace scenario, as Deise explained that it was not possible to take the bottles to work <i>"because they would stay in my bag, [...] in</i></p>	

	the second encounter, when he justified not using a pill box in his daily life to carry the medication from his house to work.	<i>take it with such regularity [...] I had lost the will to live.</i> He believes the research is already helping him, possibly referring to MEMS: <i>"Because it is helping me to take the medication more regularly."</i> He refers to the electronic device as an aid resource to remind him of taking the medication at the right time, seeing that as a beneficial control.	<i>some cabinet [...] If someone wants to open the bag, he/she will open it [...] [You] avoid that because of fear? Yes!"</i>	
Conversation about the detectable viral load as a justification to call for intervention	It was not developed in the first encounter, only in the second one. Amaro said that, being for almost six months under the antiretroviral therapy (ART), the doctor had told him that the results of his latest tests were better (also referring to CD4). He did not know the values, but he understood the function of each one. Ciro, on the other hand, had more difficulty regarding this matter. For him, it was incomprehensible the reason of this detectable viral load, as he believed to take the medication <i>"properly."</i> He said: <i>"The doctor tells me off,"</i> and he thought that the <i>"bad results"</i> were because of his age (he is 71 years old).	Although it has not happened in the initial conversations that presented the intervention, it happened at the end of the first encounter with Álvaro and Deise. With him, amid the investigation on failures in taking the medication and explanations of the health professional about the relation between the increase of the viral load and the delays or suppressions of the doses, encouraging him to be more adherent. As for her, the approach at the end of the encounter was providential and, possibly, a consequence of the health professional's sensitivity in not tackling the issue about the viral load in the beginning, since Deise felt quite uncomfortable with the information of the Free and Clarified Consent Term (FCCT) about the possibility of filming and recording the intervention, besides being resentful with her seropositive condition, as she felt it was unfair having a sexual infection caused by her husband.		
CASES	CIRO	AMARO	ÁLVARO	DEISE
Mutal presentation	The health professional almost did not introduce herself to the four patients. She positioned herself generically as the <i>"psychologist in research,"</i> or she did not say anything about her, contradicting the principle of mutual recognition for the development of a dialogical communication. With Deise, at the end of the intervention, she stated that she would rather not mention that she was a psychologist in the service, thus going against protocol.			
Free conversation	It was well developed with the four patients, enabling the possibility of emerging both their past and current personal stories. The focus on the treatment routines allowed to see the everyday, the scenarios in which the treatment occurs, despite the frailties in specific conversations about the treatment regimen of each one, possibly hampered by the medication nomenclatures or due to the complexity of the treatment regimen (Ciro). The confusions and doubts came not only from the patients, but also from the health professional. Incipient with the four was exploring possible differences in the routine of current medication intake with MEMS, and previously without the electronic device.			
Listening to the presentation narratives and to the experiences with the treatment	There was an effort from the health professional to identify <i>"issues, difficulties, problems"</i> with the	Amaro had a more inviting, exploratory talk, being more specific in his questions about the treatment.	The dynamics of interaction with both were similar in a given aspect: the theme of the treatment turned secondary during a good part of the 1st encounter and also in the following ones. They	

	<p>treatment. There was a predominance of questions such as “do you take [the medication] properly?”, “you are taking [the medication] properly, aren't you?”. Thus, the use of a directive non-dialogical style (“checklist”) which did not favor meanings exploitation. Checking, timeless, generic questions invited very mildly the recollection and analysis of specific situations.</p>	<p>He could explain clearly about the circumstances of up to 3 hours delays in taking the medication. He stated that they happened quite rarely, and that meaning was transformed along the dialogue: he recognized that the overtime work occurred more frequently; therefore, he delayed taking the 7.00 p.m. medication; and he also recognized that, sometimes, he slept without taking the last medication, that should be taken at 11.00 p.m. Then, understanding the treatment regimen was impaired. He complains about side effects: <i>“The Efaviren mixes me a bit up. Then, I don't take it.”</i></p>	<p>expressed themselves significantly about other issues beyond the treatment with a strong suffering. Deise, regarding her recent decision of resigning her job, the circumstances of the sexual infection she got from her husband, the embarrassment of having AIDS, and the “obstacle” in her sexual life that reverberated in dialogues about feeling herself depressed. Álvaro, on the other hand, recognized as problems in his life: the breaking up with his boyfriend and his effort to continue the relationship, the suspicion of being betrayed, the debts, the house built on a piece of land that was shared with his aggressive sister, and the violent brothers who discriminated him. The communicational dynamic that was produced was, therefore, characterized by the health professional's ability of listening, accepting and being emotionally supportive. By respecting the needs of Álvaro and Deise, she inserted properly the theme of the treatment and in possible circumstances. The psychosocial complexity of their lives had implications on the dialogue and on the intervention as a whole: the “tension” between restricting or expanding the focus of the conversations; the pertinence, or the lack of pertinence, of guiding them to a psychologist and a psychiatrist (if they desired that or agreed to it) and, in the case of Álvaro, the long interval of 60 days between the 1st and the 2nd encounters, resulting in their difficulties of remembering the previous talks. In spite of that, the health professional could value and reposition the theme of the treatment experience amid talks on other themes. It was possible to identify the circumstances of adherence problems and, although with not so much clearness, the treatment regimen.</p>	
CASES	CIRO	AMARO	ÁLVARO	DEISE
<p>Free conversation</p> <p>Listening to the presentation narratives and to the experiences with the treatment</p>	<p>Ciro faced difficulties to describe the regimen (he replaced the nomenclature of each medication by its color). There was no association of the treatment with meanings of problem and difficulties (terms used by the health professional according to the script), but to other issues of his life, such as toothache, missing one of his sisters and lack of money. On expressing them, the health</p>	<p><i>It gives me a bit of anxiety, do you understand? [...] So, I avoid [taking it]. It makes me dizzy [...], giving me a bad taste in the mouth [...] That medication gives me the worst reactions. Apart from that...</i>” A relevant but unexplored aspect was the association that the patient made between his moods and his better or worse adherence (irritation, agitation, anxiety, “being on the verge,”</p>	<p>Difficulty of prioritizing the treatment amid life problems (quarrels, affective relationship, housing). By trying to understand the whole “plot”, Vera listed “the sister's prejudice” and asked: “Does that affect your life, in terms of treatment and of taking your medications?” Álvaro denied it and then the subject faded. However, it emerged again when he admitted his failure in taking the medications</p>	<p>Failures (delays and doses suppressions) occurred in the morning at work. When the production line stopped to the worker's coffee break, at 9.30, Deise took the dose regularly, at 10.00. However, when the work schedule was changed for 7.30, it led to the inconvenience of stopping to work for taking the medication, and the fast work pace made it difficult. In the evening, delays of up to 3 hours are meant as a</p>

	<p>professional had investigated if they had the sense of experiences that jeopardized the treatment – which he denied. According to him, he had failures regarding the past treatment (in trips when he had decided not to take the medication with him not wanting to expose himself to his friends), and he believed he would act in a similar way in the future, i.e., he would only travel either alone or with friends who knew the diagnosis. Insecure, Vera found no means to problematize the claims that he had no problem with the treatment. She even commented on her doubt about the real need of Ciro to take part in the intervention, as if she were “thinking aloud.”</p>	<p>“hyperactive,” “[someone] who sometimes fights”); and that he has never liked taking medication. It was not exploited the possible implications of these descriptions of himself towards the treatment, or if they represented repercussions of living with HIV. Facing these collocations, the focus was closed: “Then, our major objective is thinking about the medications, isn’t it,” what made impossible to continue the conversation.</p>	<p>continuously after breaking up with his boyfriend and going into depression. Vera did not criticize him; rather, she explored the meaning of the statements “today, I take [the medication] regularly,” “ninety-five percent of the time.” Even though, the dialogue on the scenarios of the failures was secondary concerning the psychosocial problems. Taking medications seemed to be “the least” compared to the urgency of getting back together with his boyfriend, living together again in Álvaro’s house. Speeding the night at the boyfriend’s house implied in failures (as he did not always take his medications with him) – an aspect which was not thoroughly examined.</p>	<p>consequence of fatigue: she falls asleep watching TV and she only takes the dose if she wakes up until 1.00 A.M. Sometimes, she does not take it. She makes “self-management” of the medication (suppression or postponement) according to commitments. So, she believes to avoid side effects – what will be detailed in the analysis of working with scenes.</p>
<p>Closing List the failures, problems or difficulties. Shared registering</p>	<p>In general, it was a flawed process to list jointly the issues, problems and difficulties identified in the conversation and written down as a shared register of the four patients. Whether due to low clarity/specificity (with Álvaro), or to start but not conclude it (with Amaro), or even for abdicating it (it seems to be forgotten with Deise and left aside with Ciro, for not making sense once he did not have any problem with the treatment). In order to illustrate that, the register with Amaro could be: “he delays taking the medication when he works overtime,” what did not happen. When asked about what problems could be listed, Amaro did not identify them and, usually, he answered: “in my case, who’s causing the problem is myself.” Vera neither disagreed nor proposed new formulations, and that was harmful because it allowed self blame. In a positive attitude, Amaro, at the end of the first encounter, had already mentioned possible solutions: “I can buy a little case” (pill box) to take the doses to work – what turned out to be an extremely difficult intention to be practiced (and then it was postponed) in the course of the encounters.</p>			

Chart 8. Analysis of the dialogues by dimensions and components/ 2nd, 3rd and 4th Encounters

2 nd and 3 rd ENCOUNTERS – Management of scenes methodology and meanings coproduction (the health professional's lines are in italic and bold)	
WITH EVERYONE	<p>Except with Álvaro, with whom the <i>dialogue on the scene</i> did not happen, the health professional struggled to develop it with the three other participants, although having problems to conduct it and, in general, in a quite unique and relatively distinct assimilation to the theoretical frameworks of the protocol. The methodology was developed under a 'more cognitivist' and of behavioral learning approach - a weakness present in all cases. Two aspects are worth being scrutinized: 1) the scene methodology assimilation occurs as a sequential narrative of actions throughout the day, as if it were a movie and not a scene. In Deise's case, a walk at the weekend, with emphasis on the cognitive aspect (to remember the time to take the medication) and on the practical aspect (what to do: use alarm clocks, use written reminders); 2) the issue of the AIDS stigma and the possibility of exposure to discrimination crossed the narratives without either being directly tackled or deepened. The tendency was to name this issue under the term "<i>prejudice,</i>" interpreting it in a reductionist (a strictly cognitive plan) and individualistic way: "<i>in fact, it is how much prejudice you have, isn't it? It is. Prejudice towards the issue of the difficulty, of the diagnosis denial.</i>" Positively, it was identified a progressive improvement along the encounters, both in the first cases (Amaro and Ciro) and in the last one (Deise) to join the intervention.</p>
2 nd and 3 rd ENCOUNTERS – Management of scenes methodology and meanings coproduction (the health professional's lines are in italic and bold)	
CIRO	<p>The dynamic was not predominantly characterized as of care, but as a research dynamic, what may have favored the production of meanings which expressed "<i>I do everything right in the treatment,</i>" because this is the expectation. Vera privileged working the scene regarding past episodes, that is, the adherence failures in trips, what would not be a frailty in itself if she would not have done it with low consistency and specificity – she did not require him to remember a particular situation and to share it. She made confirmatory and closed questions: "<i>but do you follow the medical prescription...? You have delays, don't you?</i>" The proposition of the incipient scene: "<i>and let's say you need to travel again,</i>" without developing the elements. She used many times the expression "<i>tell me.</i>" The treatment during the trips was the only window of opportunity identified by Vera to work a scene. The <i>dialogue on the scene</i>, from the active imagination or from role-playing, did not unfold completely. Despite the relevance of working a past scene, preparing the patient for future situations (co-identifying resources and possibilities to cope with the difficulty without sacrificing the medication), Vera did not invite the participant to imagine a scene specifically, neither extrapolated the trip scenario, encouraging reflections on how to deal with the treatment while living with friends and acquaintances who did not know the diagnosis, how to find ways of preserving privacy without sacrificing the medication intake, etc. In fact, the scene construction did not occur. What happened was a description of Ciro, encouraged by Vera, of a sequence of actions that he would have in future trips, going from packing his luggage (in which the health professional insisted on checking if he would remember to put the medication bottle in the luggage) till the arrival at the hotel. Continuing, she asked him about the time to take the medication in a corresponding time if it coincided with the period of the walk. The health professional realized that the main difficulty faced by the participant was "to remember to take [the medication]," rather than "how to" take it in social situations, associated with the fear of questionings that culminated with the condition exposure of a person with AIDS. Suggesting improvement of the <i>dialogue on the scene</i>, there was a recognition, though tenuous, of stigma and discrimination risk as important elements. Then, the health professional commented that she understood Ciro's fear of people finding out about his HIV and acting with prejudice. She asked him if it was that fear that made him "<i>leave the medication,</i>" with what he agreed. "<i>Yes, it was. I didn't take it because of that. Fear of comments, fear of criticism, fear of any embarrassment. Then, I said to myself: '- I won't take it'.</i>" Nevertheless, that was all, without further reflection, decoding and expansion to the sociocultural context, thereby hindering the supportive recognition of personal fear of discrimination as a psychosocial experience associated with the stigma of AIDS (the social plan of vulnerability). The imagination of other outcomes was not unfolded with the coproduction of intent about new repertoires. The dialogue was limited to the acceptance of the outcome proposed by Ciro of either only travelling alone (what perpetuates social isolation) or with people to whom he would tell in advance about his HIV, with the sense of a moral obligation of people who have HIV.</p>
	<p>The health professional strived to stimulate the <i>dialogue on the scene</i>, enabling to emerge the main difficulties of Amaro's adherence in the work scenario. As well as with Ciro, the methodology operationalization of the scene was marked by the effort for producing linear and continuous reports,</p>

AMARO

from start to finish (from waking up to the end of the day), during which the patient was asked if the medication intake occurred at times corresponding to the prescribed times of the doses; if the patient "fit" the medication in his narrative. The objective was to help him remember taking the medication and memorizing "how" he should do it in future situations. The questions were repetitive; sometimes, not clearly enough, although the effort in having a dialogue in this way has strongly contributed to the emergence of a daily experience with the treatment. The health professional was engaged in working with the scene more than in the intervention with *Ciro*.

Notwithstanding, the difficulty was also to extrapolate them to the wider sociocultural context, which would help to elucidate the differences of meaning between taking medications at home, taking them at the workplace, taking the pill box with him or postponing this practice. It did not unfold decoding intersubjective meanings also related to Amaro's significative fear of discrimination at work, which was processed in an ineffective intention of taking the doses with him. Consequently, he always chose to take the medication at home (a protected environment), even with substantial delays. The patient's narratives suggested that he rationally knew how to solve his problem (he said that it was easy to buy a pill box); nevertheless, some meaning he was either unaware of or that was unreasonable complicated the effective practice of the intention. This was the "window of opportunity" to be explored by the health professional. However, as she positioned herself in the dialogue motivating him, above all towards helping him to find practical solutions, what emerged in the discussions outcome in the scene construction was: "*going back home in the middle of the day to get the medications*," which did not help to expand the recognition of the intersubjective symbolic barriers in question. The produced meaning to use the little case was "to do what the health professional wanted", as he said: "*but I can try to use the pill box [at work] as a test, if you want. If you find it interesting. What do you think?*" If these lines, on the one hand, puts in evidence the bond and cooperation intersubjective dynamics, on the other hand it was not enough to broaden the recognition of issues involved and for the construction of new repertoires. In a second attempt, the health professional explored a work scene, a scene of the moment he found out that he had to work overtime. Then, both practiced different situations and behaviors that solved the impasse before unusual situations she proposed (which were not completely bad): it was changed the time he found out he would work overtime and she asked him to ascertain if Amaro's answer corresponded to some intention towards taking the medication. After several interpellations, such as "*what if... [something happens]?*", it was understood that the warnings for working overtime were more often than they looked like until then, and so it was outlined a new intention from Amaro: "[I'll] *try to use the pill box as a test*." The professional conceptualized the intention: "**a commitment you are establishing with me**," and then she encouraged him to comply with it. In the third scene construction, there was the improvement of her guidance. The *dialogue on the scene* unfolded with the explanation of the constituent elements and the preliminary decoding of meanings involved in the practice of taking the little case with the pills with him to work: "**How do you act? Who is there? Who is there at the time you go to work, with the little case, who is going to be there? Who is going to be there with you at work?**" She even asked him how would it be taking the pill at the company's water cooler, if there would be people around. He replied that it would not have any problem, as "*nobody knows about the HIV*." The issue of the risk exposure was present throughout the dialogue, but it was not a specific subject of the dialogue. In spite of having just said that he would use the pill box every day, as he was often warned about working overtime, only at the end of the day, in some moments, Amaro retreated and reasserted: "*If I go, let's say, if I'm sure - There'll be no working overtime today, - No working overtime?*" - *No.* - *Great!*, then *I don't carry anything with me and, when I return home [from work], I'll follow the right time to take [the medication]*." His narratives expressed ambivalence. Continuing, the health professional identified the need to tackle the meaning of not taking the pill box with him to work, but she did it superficially: "**What is your concern in relation to the pill box?**" Later on, she made a motivational and directive approach encouraging him with the "the commitment to the pill box". Amaro was evasive in his answer, what suggested the production of other meanings around the term "worry," differing from the ones the health professional rehearsed. Thus, the dialogue did not continue. The theme was present throughout the intervention with meanings of retreat, delay. At a certain moment, Amaro justified not adopting it because of the use of *MEMS*, saying that "it would disturb the research", which was not considered by the health professional. On the contrary, she agreed requesting that he did not previously take the medication out of the bottle in the evening to put them in the pill-box; however, contradictorily, insisted that he did it at other times.

Vera did not produce any lines in the sense of distinguishing with the patient between the peculiar present situation of being in the research and future situations, with the possibility of adopting the resource. At a certain point, she asked: "**What is missing for you to buy the little case?**" And he replied: "*Shame*", when both laughed. And he proceeded: "*Shame. Seriously. Seriously, because it is something so simple! I told you, you can find it in a 99 cents store! It is lack of...*" And she added: "**Sometimes we don't remember, do we?**" What is not talked about is that one of the possible meanings when using the pill box at the workplace is the fear of being identified as a person with HIV. That would need to be explained and humanized. It is necessary to recognize that this fear is felt by many people who live with HIV, and not be seen as "shame" which, once more, individualizes the problem, blaming those who live it and not opening space for the understanding of intersubjective aspects. The health professional, in turn, offered a cognitive connotation to the difficulty - reaffirming the meaning that he did not actualize his intention by not reminding himself to buy the utensil - by suggesting that he checked the availability of the utensil at the health service pharmacy. After that,

	<p>Amaro said that the "little case" should be more "subtle," so that nobody "associated it with anything," meaning, the illness. The fear of discrimination was not only related to being HIV positive, but also to the homosexual practices. The health professional then named the "question of prejudice," which was positive; however, she did it using the terms "you have already overcome this," as if trying to compliment him. He then told her a long story of a HIV positive friend who revealed his condition at the workplace and suffered bad consequences, thus justifying his own efforts of keeping it secret. He reminded his own fear and angst when facing the risk of being identified as HIV positive in a job application medical examination, adding that he had not revealed his diagnoses to the health insurance doctor where he goes frequently, among other comments about the fear of discrimination. This suggests that the motivational approach "muffled the voice" which was trying to express itself, besides having putting in check the meaning of the health professional that "the question of prejudice" was a thought/belief (cognition) that can be overcome, rather than an intersubjective process lived in each scene in the different social scenarios; especially, if it counterposed the meaning that "Amaro's prejudice" was overcome. Given the health professional's commentary, the subject cycle concludes without the production of new voices, as Amaro gave answers to what was socially expected – when she asked him "But you have overcome everything, right?", he replied "<i>I have. Thanks God!</i>" The implication of this type of communication is that space was not produced for a dialogue about real and present living of insecurity which processed subjectively in this "come and go," in the delay of an apparently simple practice (using the pill-box at the workplace), but which kept underexplored meanings communicatively, remaining "silent," but active. Facing the health professional's incentive, Amaro, as if recognizing his own movement of procrastinating something "easy," answered: "<i>I will follow the times correctly [...] and buy the little case. I'll check at the pharmacy if they have it,</i>" and laughed.</p>
<p>DEISE</p>	<p>The scene methodology was improved with the introduction of more specificity and, also, in the reflexive conversation (decodification stage): "<i>So, choose a day, without worrying which one, if you don't remember, but tell me what you remember, what happened, how it was.</i>" The first scene worked on is the one of sleeping on the sofa, while watching TV, and waking up almost three hours after the time of the medication intake, at 1.00 in the morning. The construction of a second scene, of the medication intake at work, in the morning, allowed beyond the recognition that the intense rhythm of the production line made it difficult for the 10 a.m. intake. It allowed the decodification of some meanings related to the way she dealt with regarding the adverse effects attributed to medications. Facing the health professional questions, it emerged that, foreseeing possible indisposition, Deise made adjustments (suppressing or delaying the medication intake) which were until then meant as involuntary lapses. According to the decodification, the practices gain additional comprehension: of having some degree of decision in "<i>not taking the right dosage</i>" as a self-management treatment to cope the side effects: "<i>Then, sometimes it happened like this: if I needed to do something [...], then I didn't take it because I had to go [...]. Then, when we take the medication right, we don't feel good. Some days, I am not tired and I want to be normal [...]</i>" <i>Then, [...] you believe that the fact you want to feel better, say, tomorrow, you do this - not taking the medication - to feel better? [...]</i> "<i>There was a time I did that [...]</i> <i>It was hard pretty hard at work, right? Then, I forgot [...]</i> "<i>Did you really forget because you really forgot, or because it was providential and you wanted to feel well, to do the job better? [...]</i>" The dialogue that followed was very productive in the sense of problematization and reflection - in Deise's terms, she made an "auto-analysis" on how she dealt with the treatment.</p>
<p align="center">4th Encounter (the patients' lines are in italic and bold)</p>	
<p align="center">Evaluation of encounters / Adherence sustainability at long run</p>	
<p>WITH EVERYONE</p>	<p>Generally, on making an effort to faithfully follow the script, the conversations acquired a less dialogical and more inquisitive, directive dynamics, following a "checklist" style. The script recommendations were not sufficiently personalized in the conversations - for example, taking each one's subjects as a starting point. So, the recommendations were generic, the questions were too abstract, causing great difficulties in mutual comprehension. On answering some questions, it was as if they did not make any sense, questioning the obvious or over-repeating them.</p>
<p>CIRO</p>	<p>The prevailing meaning was making a revision of the meetings. They retook the scenes on trips and did not explore enough "the how" to deal with the risk of being socially exploited and possible solutions. Even if Vera imprinted a more reflexive and open tone to the conversation about the meetings process and the identification of resources to keep him adherent in the long run, Ciro gave very specific answers. In many moments of the conversation, he did not understand the questions, leading communication to be "truncated" and boring. He did not know how to respond to her expectation or did not understand the situations to be carried out: "<i>I don't know how to explain, but I think that I should continue doing correctly, right? [...]</i> <i>I think there isn't a lot [I can do] [...].</i>"</p>

AMARO	Amaro said he had bought the pill-box and brought it to show to the health professional, valuing the utensil in terms of practicality. The health professional encourages him to incorporate it in the routine, when not using the MEMS anymore. The idea of making a summary about the previous encounters helped the process evaluation and the reflections. Nevertheless, along the encounters, it started occurring less conversation and more of the "checklist" tone: <i>"the issue of arranging the pill box, you have already arranged it, right?"</i> [Yes.] <i>"And the future maintenance which we had thought about... so we could be reinforcing, today, couldn't we?"</i> It could then be noticed repetitive questions and sudden change of subject by the professional. The dialogue dynamics was characterized by the presupposition of answering adequately, answering the expected, showing what should be memorized and "reinforced." Life experiences and their meanings were not explored enough. His answers were too short, sometimes only 'yes' or 'no', while the health professional lines were motivational.
ÁLVARO	There was a thirty-one days break. Initially, the dialogue also acquired a "checklist" connotation, in which the health professional checked points from the previous encounters, especially if Álvaro was developing practices which favoured adherence, named by her as "agreement made between them" during the meetings. His answers were almost always short and/or generic, as for when Vera asked if he had been taking the 10 a.m. and 10 p.m. medication, and he just replied <i>"Yes."</i> Nevertheless, on the positive side, the health professional progressively made a more open/dialogical approach to the conversation, with more reflexive and evaluative questions about the experience of encounters, changes achieved and to be practiced, and what type of support he needed. Álvaro expressed himself a little more, but warned that he was very sleepy, what made expressing himself more difficult.
DEISE	The conversation with Deise was also more dialogical, although with the repetition of questions over what she needed to maintain long term adherence. Some generic expressions from the script, such as <i>"solutions found to maintain adherence,"</i> were not pertinent to the course of the conversations, as what they had talked about had no meaning of "solutions" (the terms and meanings were different). Deise seemed to demand an additional encounter, similar to the second and third ones, focused on the work with scenes. The last encounter, number 4, which was a process evaluation, was premature in her case.
	Repercussions of intervention for the person
WITH EVERYONE	In spite of frailties encountered in the group of dimensions and intervention components, the narratives about "whether the intervention had helped, and in which sense," or "how I was before, how I am today," suggested good repercussions towards adherence, improvement of self-care, emotional well-being, among other more specific improvements to the reality of each one of the participants.
CIRO	Encouraged to <i>"own the medications</i> (to know each one by their names)" and <i>"accept the possibility of them in your life,"</i> Ciro expressed positive feelings towards the medications and a better acceptance of the treatment: <i>"[...] You have to accept it, right? It's part of my life. It is like a partner."</i> Reminding us he is a calm person in relation to the diagnoses, he did not complain of side effects and believed he followed the treatment <i>"correctly."</i> Maybe that is why there were less statements from his side suggesting changes. The encounters were meaningful, a positive experience, and his narratives suggested motivation, awareness and engagement to the treatment. He had empathic and affectionate exchanges with Vera.
AMARO	He related feeling more secure and conscious of the importance of not <i>"becoming uncovered,"</i> referring to being late in taking his medications; <i>"more adapted"</i> to the treatment; from uncomfortable, he changed to mean it as <i>"a question of adapting to the routine,"</i> changing it into <i>"habit."</i> He valued the opportunity to talk and receive information, and he stated that it also had repercussion in his treatment of high-blood-pressure. Furthermore, he recognized he had changed, because previously he <i>"did not take anything seriously,"</i> compared with the present in which he has the intention of maintaining adherence. He also said: <i>"I have learnt to express myself a little better regarding my problem [...] I feel more at home to talk, do you get it?"</i> (I know). <i>"To have a dialogue and talk about HIV."</i> From a psychological point of view and the description itself, the change happened in stopping seeing himself as a victim: <i>"[...] I stopped feeling sorry for myself. I felt as a world's victim. I am not! [...] I have been thinking on this point of view, do you understand? (...) I think I am psychologically fine."</i> The meetings helped, in his words, as a <i>"self-affirmation of myself."</i> He emphasized that the health professional was not imposing: <i>"[...] No. [You did not say it] ' - You are going to have to do it this way, this and that way.' No. You gave me an option [...] I am not so passive as I used to be."</i>

<p>ÁLVARO</p>	<p>Álvaro is the patient with the most complex situation, of a synergy of aspects which amplified his vulnerability to becoming ill, highlighting the emotional (anguish in relation to his boyfriend) and citizenship nature (socio-economic difficulties, aggression by his family, housing instability). Considering, above all, his more laconic, slow profile, and that he was the least verbally aggressive, the repercussion narratives were few. He understood that he benefited through the intervention objective - <i>"start to take the medication at the right date and at the right time every day"</i> -, as he was <i>"absent-minded"</i> and now he was <i>"more aware,"</i> taking the 10 a.m. and 10 p.m. doses, what suggests the production of discipline and attention meanings regarding the prescribed timings. One interesting aspect is that Álvaro, in the evaluative dialogue, was more explicit in assuming (this was the meaning) how much, in the past, he did not follow the treatment correctly. He associated the positive change to the participation in the research, mentioning that the MEMS had helped him and adding that he would like to always have <i>"this cap,"</i> as it <i>"monitors us,"</i> <i>"we are more aware [...]</i> <i>to take the medication at the right time."</i> For him, the encounters were enough because they helped him produce a sense of need towards more implication from his part: <i>"[...] That is it, knowing at least the time that I have to take. That is it, I start to worry about setting an alarm, a reminder on the fridge [...]."</i> In his own words, the intervention helped him <i>"(...) to be ashamed, to take the medication at the right time, more continuously than I had been taking it."</i> Moreover, he said that the encounters had helped him <i>"looking for other solutions to the problems,"</i> rather than <i>"blowing up,"</i> suggesting repercussions that went beyond the treatment, in the sense of appreciating his own capacity of pondering over everyday situations that require making decisions in a more calm and less tense way.</p>
<p>DEISE</p>	<p>The repercussions suggest that although it had been produced a better understanding of herself and of the circumstances in which the adherence failures happened, these were still happening at the end of the activity (according to reports of the last days). The use of an alarm clock and a cellphone alarm, both encouraged, did not show to be systematic and enough to avoid the failures, and meanings of severity, frequency or problems regarding non-adherence were not produced. In her understanding they occurred occasionally, although she related, during the period of encounters, at least three occasions in which the dosage was abolished. Her statements did not suggest an intention of adopting new ways of taking the medication. Rather, they showed there were reflections on how she feels today and how she used to feel, and the implications over the treatment. She highlighted the learnings with the intervention: <i>"(We) learn a lot, don't we?"</i> In her evaluation, she was <i>"feeling a little down... I didn't even remember to take the medication,"</i> <i>"so, [the intervention] helped me,"</i> <i>"It was after this research that I took this decision [to change, to look after herself]."</i> She interpreted the encounters as a positive <i>"nudge,"</i> as they gave her an incentive to <i>"not forget to live, not forget of herself."</i> The most evident repercussion in Deise's movement was towards an emotional well-being for having been welcomed in what she needed to talk (she really valued <i>"being able to talk, to open up"</i>). From saddened and tired, she went on to live new sensations such as tranquility, self-confidence and security, besides understanding with more clarity the implications of her previous state as depressive on how to follow up her treatment. The production of well-being was also associated to the decision of effecting a very important change, during the intervention period: resign from her job, which was a difficult but necessary and freeing decision, according to her.</p>

Chart 9. Objective evaluation of the development of dimensions and components

<p>Scale of development standards: Sufficiently (S), Moderately (M), Insufficiently (I), Not Applicable (NA), No Information (NI). Ciro (CI), Amaro (AM), Álvaro (AL), and Deise (DE). One to four crosses (+, ++, +++, +++++): predominance degree of each approach.</p> <p>Dimensions/Components</p>	Cases			
	CI	AM	AL	DE
<p>Dimension A: General Principles (theoretical, methodological and ethical principles) – transversal to the 4 encounters</p>				
<p>Production of Care in a dialogic communicational interaction</p>	M	M	M	S
<p>Horizontalized pattern of interaction</p>	S	S	S	S
<p>Enhancement of the patient's practical knowledge</p>	S	S	S	S
<p>Focus on the patient's daily experiences/ treatment contextualization</p>	S	S	S	S

Solidary environment and support in seeking solutions/ Involvement of the health professional with the patient	S	S	S	S
Dimension B: Transversal approaches to the 4 encounters				
Educational: instructions, explanations and technical information; focusing on doubts related to medications, side effects in general, medication intake time, learning and memorizing nomenclatures, etc. Predominance of professional guiding, informing, explaining, and teaching.	+++	++	+++	++
Cognitive-behavioral: suggestions and incentives for adopting strategies, such as reminders, alarms, medication assisted by third parties, etc.; a more prescriptive approach, with suggestions (of using alarm clocks, reminders, someone to help; of changing the medication intake schedule), and talks with the connotation of "training" the memory (remembering the schedule to take the medication). Professional predominance "giving hints," suggesting, stimulating behaviors and cognitive processes.	++ ++	++ +++	++	++
Psychosocial constructionist: 1) welcome (listening and responsiveness to the narratives and emotions related to living with HIV and broader issues: socioeconomic, family, relationship, and labor issues); 2) constructionist psychosocial approach (taking emotions, actions and beliefs [individual plan] as expressions intersubjectively constructed according to historically and social-culturally referenced and contextualized interactions [programmatic and social plans]). Predominance of dialogical conversations, open to plenty of critical, problematizing and comprehensive possibilities; analysis towards extrapolating the cognitive-behavioral level.	+	++	+++	+++
Dimension C: Development of the 1st encounter in relation to the script				
Analyzed components Produced meanings on the research participation and use of MEMS Conversation about the detectable viral load as a justification to the invitation for intervention Mutual presentation Free Dialogue and Listening Methodology of the presentation narratives and on the experiences with the treatment Closing and shared registration.	M	M	M	M
Dimension C: Development of the 2nd and 3rd encounters in relation to the script				
Concurrently analyzed dimension: Methodology management of the scenes and implications				
Development of the 2nd encounter	M	M	I	M
Development of the 3rd encounter	M	M	M	M
Dimension D: Management of the scenes methodology and implications				
Were there attempts and effort from the health professional to apply it in the encounters?	M	S	I	M
Did the use predominate in the opportune moments to apply it?	M	M	I	M
While applying it, did adequacy prevail in most part of the initiatives to "mobilize" scenes?	I	M	NA	M
Were meanings produced on the difficulties in using medications on the outcomes of storylines of each mobilized scene?	NA	M	M	M
In addition to the difficulties, are there narratives of the patient about actions or intentions to develop them towards self-care, improving adherence?	NA	S	S	S
Dimension C: Development of the 4th encounter in relation to the script				
Analyzed component: if occurred an evaluative conversation of encounters and on the adherence sustainability on long term Dimension concurrently analyzed: Intervention repercussions to the person	M	M	M	M
Dimension E: Intervention impacts on the person				
Was there a broader recognition and understanding from the patient regarding his/her own treatment, conditions, barriers, failures, and opportunities?	M	M	M	S
Passivity movement to engagement, proactivity and autonomy.	NA	S	S	S

Uncertainty to certainty movement.	NA	M	S	S
Movement from restriction in sociability to increasing sociability (friends, work, healthcare).	NI	NI	I	NI
Movement from dissatisfaction to satisfaction in the social and affective relationships.	NA	NI	NI	NI
Movement from worse to better coexistence with the treatment.	S	NA	M	S
Movement from misinformation/ ignorance/ misconceptions about the medications to a greater knowledge of the subjects.	S	S	M	NI
Movement towards adopting new strategies/ "ways" to use medications.	S	S	M	M
Movement of changing from negative to more favorable meanings towards the medication and treatment.	S	M	NA	NI
Movement of change in relation to the service. From little use and lack of knowledge of the service offered to an interest in making a better use of available resources in the service.	NI	I	I	S

Discussion

In the group of cases, the intervention was "moderately" developed. **The intended inflection intended saw "deconstruction" of the more traditional model of approach concerning adherence problems. It was preliminary, more "essay-like",** not operating in the four cases. Variations in the process implied better development either of some components or from one dimension to another. The implementation with Deise ("the last ones"), closest to the original bases, suggests a progressive improvement in relation to Ciro and Amaro ("the first ones").

It is worth highlighting two implementation fragilities which are common to the cases: 1) as a whole, the *dialogical conversations* were not predominant, although there have been some encounters, or moments, more dialogical than others; 2) developing *dialogical dialogues* in all encounters was difficult, especially sustained in the original theoretical-methodological references: *V&HR framework and scenes methodology*.

Motivate and train or dialogue?

In a more immediate apprehension, the identified conversational difficulties are rooted in the interaction themselves, regarding the social interactions of "physician/health professional" and "patient", in which, historically, "the final word" belongs to the former. The latter tells "what the problem is," listens to diagnoses and prescriptions, "assimilates them" and behaves according to what is recommended - asking for clarification, at the most. It is uncommon the understanding that patients and health professionals always need to have a dialogue, especially beyond biomedical aspects. In fact, more common is exactly the absence of time in the consultations, making it even more difficult to extend the dialogue. How to expect, then, that in this intervention, conducted in the health service environment, the

patients would talk spontaneously? Additionally, how to expect that the patients would talk “about life, not only about medications”? They commented that this was uncommon in the medical consultations.

Despite these general difficulties, the implementation was close to the general principles, besides having repercussions in the self-care and well-being, according to the participants. It can be highlighted the “permission”, inter-subjectively built for the emergence of narratives about problems, failures, difficulties and mistakes in the treatment, produced in the conversation, in the four cases. If the health professional were normative, possibly the fear of reprehension would make it impossible to assume them - as it normally occurs in medical consultations, according to the patients.

Thus, the intended inflection was partially processed. In some measure, it was jeopardized by the loss of dialogism in key moments/subjects, changed for the more directive communicational style, the “checklist”, or by the “excessively motivational” bias. For example, in Álvaro’s case, although Vera was open to the dialogue, she slipped back to instructions and incentives by facing a more laconic interlocutor.

Generally, the conversations mixed characteristics of cognitive-behavioral guidance (change beliefs, train, motivate, increase sense of auto-efficiency) with characteristics closer to social constructionist perspectives.

The conversations tended to a “more constructionist” dialogic when, for example, the health professional made open questions, demonstrating the intention of better understanding; when she commented on what the person felt or did, not as “intrinsic” or “permanent” characteristics, but understanding them as conditioned to the interpersonal situation and context; when she recognized that there were “many ways of following the treatment,” or “many possible solutions;” or when she mentioned that, together, they would “find the solution which would make more sense to the person.” Engagements in this manner suggest that there has been some degree of “dynamics in the communication processes and [of] centrality of other-me interaction in the production of meanings” (Guañaes, 2006, p.30).

On the other hand, the more monological the conversation, the more predominated the closed questions (“are you doing it correctly?”), which investigated the frequency of practices, or which had “enclosed” expectations of answers; or, still, repetitive technical explanations, incentives, tips and instructions in the imperative (“you have to do this!”) which interrupted the continuity in the patient’s speech. It was thus produced a communicational dynamics which restricted the *new voices*, that is, of clarifying meanings according to other comprehensive perspectives, broader than those at individual level.

As for the rest, the general theme of the dialogue – the treatment of an incurable disease, whose risk of death by treatment failure is well-known – may have ‘incited’ these more monological engagements: “insisting on doing the right thing,” “repeating as many times as necessary,” “checking if the prescription is being followed,” and always “in the name of the person’s well-being.”

Additionally, the conversations took place in the research context, institutionally validated. Possibly, the symbolism of science as a controlled and patterned activity was present, inter-subjectively, in the care interactions, implying some loss of naturalism and spontaneity, and the sharing of a certain kind

of “pressure”: the health professionals “executed well” the expected; and the patients “enjoyed the opportunity of the research from USP.”

Therefore, the communicational difficulties identified are partially sustained in theoretical-conceptual and historical-cultural issues which extrapolate the “here and now” of the encounters. Deepening them would require more space for dialoguing with other productions which discuss: verbal interactions and dialogism in health practices (Corrêa, Ribeiro, 2012); social meaning of AIDS, living with HIV, being a health professional in the AIDS service in Brazil; “prescriptive and normative” tradition “of guiding and motivating”, “embodied” in the professional practices in health; or yet, about the psychological trends predominating in the professional education of psychologists and in health courses. These, still, are poorly inured to the more contemporary referential, such as the social and hermeneutic constructionism which emphasizes care as dialogical interaction.

Lastly, but of no less importance, there are the implications related to the patients’ own situations, which are being investigated in a different work for deserving further analysis. Individual situations involving complex social dimensions are of a difficult mitigation for the healthcare level. Thus, they challenge the “how to talk” about some many serious, synergistic and multi-dimensional aspects.

Dialoguing in *the Vulnerability and Human Rights Framework* is a challenge

In many moments, the conversations overvalue the “memory problems” and the “practical solutions,” such as “remembering to take the medication” when packing for travelling (Ciro); and “forgetting to buy the pill box” (Amaro).

Incentives and strategies to facilitate the medication intake are not problematic conversational resources themselves. Nevertheless, as they overlap decoding by the dialogue on psychosocial and symbolic “barriers” – which interact in the production of failures (meanings which they acquire in each scene, the act or taking the dosage or not) –, such incentives may be innocuous. That happens due to the health professional rhetoric does not connect to the action meanings which the patient is narrating. For example, *Ciro* explained that not taking the medications on his trips was a decision related to not having to give explanations to his friends on the type of treatment he was undergoing, rather than occurring because he had forgotten to take the medication with him while traveling. With respect to *Amaro*, the dialogues about the many meanings between taking the medications at home or at work were incipient. The co-understanding was that he did not use the pill box because he had forgotten to buy it. On his turn, irrational meanings – insecurity, fear of exposing himself and suffering discrimination – were not explored. What is the meaning of avoiding the use of the utensil at work? Would the identity of the worker be threatened for being recognized as someone who “takes medication every day”? What would his colleagues “suspect of”?

These examples suggest that, besides being scarcely used in the health area and more challenging, **the *dialogical conversations* had one added difficulty: developing them according to the *Vulnerability and Human Rights Framework* and the *methodology of scenes*.**

In conversations with patients, it was difficult **approaching to individual aspects of vulnerability to illness for lack of adherence to the treatment, while inter-subjectively produced personal experiences, in different contexts.** In other words, the beliefs, the behaviors, the degrees of motivation, self-sufficiency and information were not sufficiently worked on in terms of their situational meanings. Hence, individual components of vulnerability were not approached enough as inextricably integrated to the programmatic and socio-cultural components (Paiva, 2012a). That converged for the prevalence of an approach closer to the behavioral and cognitive trends, rather than to the psychosocial-constructionist trends.

The methodological resource of scenes, more innovative to help the dialogue supported by adopted references, was present, but not without considerable management difficulties. As the most important aspect, its incorporation was partially discordant of these references, mainly used as a “training” resource for cognitive-behavioral learning than for extending the dialogue.

The conversations did not extend the *decoding* of each person’s scenes until the comprehension of programmatic and social scenarios involved. Most of the times, they extrapolated a little the cognitive-behavioral level – regarding what “the person thought and did in each scene,” and what could be learnt, memorized or remembered. The simplified handling of the exploration and decoding of meanings in the scenes/scenarios implied a loss to the psychosocial-constructionist approach of intervention. A clear indicative is that the AIDS stigma has not been decoded and problematized in its expression at a personal level: “*the fear of prejudice*” which reverberated in not taking medications in certain social situations – trips with friends (Ciro); at work (Amaro); or even at home (Deise hid the bottles when her son had friends over). Psychosocial experiences were reduced, in conversation terms, to an “already overcome” belief, which did not correspond to the meanings of Amaro’s narrative or to one “denial/resistance” – meaning suggested when Deise was asked: “**Haven’t you ever accepted the diagnostics, ever accepted the fact that you are seropositive?**” “No. No. [...]” “**In fact, it is how much prejudice you have, right? [...]**”

As the psychosocial constructionist emphasis was anchored on the *dialogical conversations* and on the *V&HR Framework*, this became less prominent, especially with Ciro and Amaro. There was a better welcoming with Deise and Álvaro while a necessary process to the inflection towards this approach, but that does not configure it in itself. Furthermore, the conversation was more dialogical with Deise, as she engaged in the conversations, and Vera was also responsive concerning other issues of Deise, such as anger and non-acceptance of her seropositivity, her “tiredness over work,” “her depression,” and her plans after resigning.

The scene methodology went also better with Deise, in contrast to what happened with Álvaro, who practically did not use it. Even so, the disposition to dialogue with Álvaro seemed better if compared

to Amaro and Ciro, and Vera's positioning tended to extrapolate, a little more, the cognitive-behavioral level, characterizing a direction towards a psychosocial approach and an implementation similar to counseling. The dialogue thematic limits were extended and Vera made an effort to help Álvaro to "insert" the treatment in the problems experienced, although he did not seem mobilized enough, as if the treatment was secondary to his concerns. Favorably, she used metaphorical resources - his life as a "cake"; the problems/issues as "slices of cake" -, proposing that he reflected on how they impacted the treatment. Asked about what could be done, he answered: "look after myself." He was encouraged to be more independent and have more initiative in his decisions and attitudes in situations that afflicted him and harmed self-care - for example, to be sad, "listless" and "dependent" on his boyfriend. So, a movement was produced. Alvaro intended to have "*a serious conversation*" with his boyfriend. In his project of happiness, inextricably linked to the search for health, his relationship with his boyfriend was very important.

Even facing obstacles, the effort to apply the scene methodology contributed to enhance the exploratory dialogue about their experiences, instead of checking habitual practices or, rashly, indiscriminately giving out prescriptions and guidance. In most part of the conversation, it was accessed the "how I live with HIV" and "how I follow the treatment," rather than "what I have to say." With Ciro, the situation was very illustrative: in many moments there was a doubt if "he needed intervention," because he assured he followed the treatment "to the letter," denying any difficulties. Initially, it was considered that the dynamic of "doing an interview" had influenced his behavior as a "good patient." Notwithstanding, his clinical data accessed at the end of the analysis suggested that the viral replication was kept relatively low, although constant, both a year before and a year after the trial. On the other hand, contrary to the "expected," his adherence was above 95% before, during and after intervention.

Clinically, Ciro's case seems compatible with the long time having the illness, despite deserving medical evaluation over the possibility of failure. Álvaro's and Deise's exams – pre- and post-intervention – show a typical pattern of insufficient adherence, which, evidently, would demand an accurate investigation of adherence and, if necessary, genotyping. In these three cases, the possible individual benefits of intervention did not reach high technical success in the clinical-laboratorial situation. Had the research protocol not demanded the isolation of intervention in the work, the situation would have probably been different. Vera would have known the lab data and, at least, would have talked with the responsible physicians, as she would be provided with further knowledge about the adherence situation of each one. In Amaro's case, the intervention, from the clinical-laboratorial point of view, may have only helped or encouraged him to keep his adaptation process from the beginning of the treatment, which, although easier from the clinical point of view, is a period considered classically difficult and crucial for adherence.

Conclusion

This work illustrated how modalities of individual interventions concerning adherence care may be structured and protocolled to facilitate its dissemination and incorporation to the Brazilian Unified Health System (SUS). For that, the modalities of care must be faithfully implemented to the theoretical-methodological references planned, which in this study did not occur fully. This was made more difficult, in part, by the general characteristics of a clinic trial and by the research context.

The trainings, supervisions and the intervention script were not sufficient to guarantee loyalty, or to fully promote the intended inflections in the direction of a dialogical communicational process, less “cognitive,” supported by the referential of the V&HR and the psychosocial dimension of Care. It remains a challenge to develop pedagogical and conversational resources that can help the “weaving” of psychic level with the interpersonal and the socio-cultural in the intelligibility of adherence problems.

The scripts, specifically, have such aim, but not without the risk of “adverse effects” – homogenizing or mechanizing the conversations, losing in dialogism. After all, are they reconciled interventions structured with social constructionist proposals, such as “developing a free conversational space”? (Anderson, Goolishian, 1998, p.37).

The protocols/scripts of this research are open and not very directive; it does not advocate models of questions or a sequence of subjects. They showed themselves to be very satisfactory, confirming Santos’ findings (2010), except when regarding the fourth encounter. The objectives were relevant; nevertheless, they were transformed into abstract or closed generic questions, which almost did not incorporate specificities talked about on previous encounters, thus harming the continuity of the dialogues.

The results, even though partial, suggest that they are compatible – social-constructionist perspectives and structured interventions – as long as the implementation is made more flexible, allowing for innovations in the process that retro-feeds the protocol/script, including in differentiated versions, sensitive to the diversity of the users’ profile, health professionals and places of implementation. Its use should not restrict the dialogues; quite the opposite, it should extend them, even beyond individual assistance – in the interlocutory interaction between the health professional conducting it and the multi-professional team. For the complete/integral *Care*, it is essential that non-medical health professionals, conducting communicational interventions on adherence, act in a team and, above all, in coordination with the medical professionals, incorporating to the dialogues with the patients their clinical-laboratorial data regularly monitored.

The evaluation of the three professionals points toward the need for the following changes regarding the future implementation of this intervention in the United Health System (SUS): the number of encounters and their duration must be flexible; and the trainings must improve the “*communication issue*” and the challenge of transiting between “a discussion more focused on adherence and the wider approach of issues brought by the patients about their daily lives” which are not directly related to the treatment (Santos, p. 53). Nevertheless, depending on the conceptions over adherence and the interventions referential, the defining criteria “that goes beyond” the script may vary enormously. The

analysis of what is “directly related” to adherence must not be based only on “classic” risk factors, otherwise many subjects will be left without being heard and answered to.

Concluding, the health professionals will have to continuously deal with the tension “not follow the script, stick to the script.” “Not following” means to accept the user’s invitation to have a dialogue about a given issue, “sticking to the script” with new elements which broaden the understanding of daily difficulties in following the treatment; and indicate convenient and possible changes. The potential of the dialogical communication to clarify the (always singular) connections between the “life issues” and the (non) adherence – associated to the therapeutic value of being listened to and welcomed – will contribute to the mitigation of vulnerability to illness, besides the suffering and violations of rights.

Collaborators

The first author completed the analysis and the writing of the first version of the paper. The second and third authors strongly contributed to the final version, in addition to the coordination of the original research, formulation and training in *the scene methodology*, respectively.

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Annex 1. Objectives and Structure of the protocol of psychosocial intervention for care in adherence

	Session 1	Sessions 2 e 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 chooses 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 role-playing;</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>

* Extracted from Basso et al. (2012)

Translated by Scheyla Riyadh Weyersbach

Erratum

In the paragraph "In the group of cases, the intervention was"

The implementation with Dirce...

The correct is

The implementation with Deise...

Instead:

Chart 7. Analysis of the conversations by dimensions and components. 1st Encounter

CASES	CIRO	AMARO	ALVARO	DEISE
Meanings produced in the intervention on presentation	Except for Ciro, there was a predominance of meanings favoring the positive understanding that the encounters would be for care and not for research: "care," "helping people handle with their medications," "let us think together," "an exchange." On the other hand, for Ciro, the predominant meanings were: "a research," "a kind of interview." The patient even added: "I already gave an interview once to VERA." With him, it was emphasized the use of MEMS, the counting of pills by the researchers and the Free and Clarified Consent Term (FCCT), without properly appreciating the specificity of the encounters as an activity of Care (the amount of encounters and their objectives, for example), although that was part of a more extensive research. That implied in a difficulty in producing, between the health professional and the patient, a dynamic of Care that was secondary to their interaction.	1st ENCOUNTER (the patients' talks are in <i>italic</i> and bold)		
Meanings about the research participation and the use of MEMS	Both cited the health professionals of the service with familiarity, as if they had answered the invitation of friendly people. Amaro gave altruistic justifications, agreeing with what the health professional had told him, "to help others," but he also said: "It is good, sometimes, to talk [...] it is good to talk with someone," suggesting the sense of need or personal relevance, the opposite of Ciro who basically came to answer a request. Ciro believed that he "had always taken [the pills] properly," although he had had "one or two failures" while traveling in the past. Questioned about expectations on the research, he wished to have a new vaccine: "for us to take less medication and get physically healthier." Although asked about MEMS, he does not comment on it. The use of an electronic device is not explored with Amaro. It emerges by chance in the second encounter, when he justified not using a pill box in his daily life to carry the medication from his house to work.	First, he says it was "out of curiosity," when the health professional questions him (negotiation of meaning) as if that was not enough. Then, a personal meaning is produced: "That I started to take, to take the medication properly." He recognizes his failure regarding the continued use of medications, especially after breaking up with his partner: "I did not take it with such regularity [...]. I had lost the will to live." He believes the research is already helping him, possibly referring to MEMS: "because it is helping me to take the medication more regularly." He refers to the electronic device as an aid resource to remind him of taking the medication at the right time, seeing that as a beneficial control.		Meanings were produced: "to keep a better eye on myself," "to improve our lives [...]. and to find other solutions." Deepening the dialogue about the experience of MEMS enabled the emergence of the scenes of medication intake at the workplace scenario, as Deise explained that it was not possible to take the bottles to work "because they would stay in my bag, [...] in some cabinet [...]. If someone wants to open the bag, he/she will open it [...]. [You] avoid that because of fear? Yes!"
Conversation about the detectable viral load as a justification to call for intervention	It was not developed in the first encounter, only in the second one. Amaro said that, being for almost six months under the antiretroviral therapy (ART), the doctor had told him that the results of his latest tests were better (also referring to CD4). He did not know the values, but he understood the function of each one. Ciro, on the other hand, had more difficulty regarding this matter. For him, it was incomprehensible the reason of this detectable viral load, as he believed to take the medication "properly." He said: "The doctor tells me off," and he thought that the "bad results" were because of his age (he is 71 years old).		Although it has not happened in the initial conversations that presented the intervention, it happened at the end of the first encounter with Alvaro and Deise. With him, amid the investigation on failures in taking the medication and explanations of the health professional about the relation between the increase of the viral load and the delay or suppressions of the doses, encouraging him to be more adherent. As for her, the approach at the end of the encounter was providential and, possibly, a consequence of the health professional's sensitivity in not lacking the issue about the viral load in the beginning, since Deise felt quite uncomfortable with the information of the Free and Clarified Consent Term (FCCT) about the possibility of filming and recording the intervention, besides being sensitive with her seropositive condition, as she felt it was unfair having a sexual infection caused by her husband.	
CASES	CIRO	AMARO	ALVARO	DEISE
Mutual presentation	The health professional almost did not introduce herself to the four patients. She positioned herself generally as the "psychologist in research," for she did not say anything about her, contradicting the principle of mutual recognition for the development of a dialogical communication. With Deise, at the end of the intervention, she stated that she would rather not mention that she was a psychologist in the service, thus going against protocol.			
Free conversation	It was well developed with the four patients, enabling the possibility of emerging both their past and current personal stories. The focus on the treatment routines allowed to see the everyday, the scenarios in which the treatment occurs, despite the frailties in specific conversations about the treatment regimen of each one, possibly hampered by the medication nomenclatures or due to the complexity of the treatment regimen (Ciro). The confusions and doubts came not only from the patients, but also from the health professional, incident with the four was exploring possible differences in the routine of current medication intake with MEMS, and previously without the electronic device.			
on narratives and to the experiences with the treatment		Amaro had a more inviting, exploratory talk, being more specific in his questions about the treatment. He could explain clearly about the circumstances of up to 3 hours delays in taking the medication. He stated that they happened quite rarely, and that meaning transformed along the dialogue: he recognized that the overtime work occurred more frequently; therefore, he delayed taking the 700 p.m. medication; and he also recognized that, sometimes, he slept without taking the last medication, that should be taken at 11:00 p.m. Thus, understanding the treatment regimen was impaired. He complains about side effects: "The <i>Evafen</i> mixes me a bit up. Then, I don't take it."		
Free conversation	CIRO	AMARO	ALVARO	DEISE
Listening to the presentation narratives and to the experiences with the treatment	There was an effort from the health professional to identify "issues, difficulties, problems" with the treatment. There was a predominance of questions such as "do you take [the medication] properly?" "you are taking [the medication] properly, aren't you?" Thus, the use of a directive non-dialogical style ("checklist") which did not favor meanings exploitation. Checking, timeless, generic questions invited very mildly the recollection and analysis of specific situations. Ciro faced difficulties to describe the regimen he replaced the nomenclature of each medication by its color). There was no association of the treatment with meanings of problem and difficulties (terms used by the health professional according to the script), but to other issues of his life, such as toothache, missing one of his sisters and lack of money. On expressing them, the health professional had investigated if they had the sense of experiences that jeopardized the treatment – which he denied. According to him, he had failures regarding the past treatment (on trips when he had decided not to take the medication with him not wanting to expose himself to his friends), and he believed he would act in a similar way in the future, i.e., he would only travel either alone or with friends who knew the diagnosis. Insecure, Vera found no means to problematize the claims that he had no problem with the treatment. She even commented on her doubt about the real need of Ciro to take part in the intervention, as if she were "thinking aloud."	<i>It gives me a bit of anxiety, do you understand? [...]. So, I avoid [taking it]. It makes me dizzy [...]. giving me a bad taste in the mouth [...]. That medication gives me the worst reactions. Apart from that, [...]. A relevant but unexpected aspect was the association that the patient made between his moods and his better or worse adherence (irritation, agitation, anxiety, "being on the verge," "hyperactive," "sometime who sometimes fights"); and that he has never liked taking medication. It was not exploited the possible implications of these descriptions of himself towards the treatment, or if they represented repercussions of living with HIV. Facing these colloquations, the focus was closed: "Then, our major objective is thinking about the medications, isn't it? [...]. what made impossible to continue the conversation"</i>	The dynamics of interaction with both were similar in a given aspect: the theme of the treatment turned secondary during a good part of the 1 st encounter and also in the following ones. They expressed themselves significantly about other issues beyond the treatment with a strong suffering. Deise, regarding her recent decision of resigning her job, the circumstances of the sexual infection she got from her husband, the embarrassment of having AIDS, and the "obstacle" in her sexual life that reventerated in dialogues about feeling herself depressed. Alvaro, on the other hand, recognized as problems in his life: the breaking up with his boyfriend and his effort to continue the relationship, the suspicion of being betrayed, the debts, the house built on a piece of land that was shared with his aggressive sister, and the violent brothers who discriminated him. The communicational dynamic that was produced was, therefore, characterized by the health professional's ability of listening, accepting and being emotionally supportive. By respecting the needs of Alvaro and Deise, she inserted properly the theme of the treatment and in possible circumstances. The psychosocial complexity of their lives had implications on the dialogue and on the intervention as a whole: the "tension" between restricting or expanding the focus of the conversations; the pertinence, or the lack of pertinence, of guiding them to a psychologist and a psychiatrist (if they desired that or agreed to it) and, in the case of Alvaro, the long interval of 60 days between the 1 st and the 2 nd encounters, resulting in their difficulties of remembering the previous talks. In spite of that, the health professional could value and reposition the theme of the treatment experience amid talks on other themes. It was possible to identify the circumstances of adherence problems and, although with not so much clearance, the treatment regimen.	
		Difficulty of prioritizing the treatment amid life problems (quarrels, affective relationship, housing). By trying to understand the whole "plot," Vera listed "the sister's prejudice" and asked: "Does that affect your life, in terms of treatment and of taking your medications?" Alvaro denied it and then the subject faded. However, it emerged again when he admitted his failure in taking the medications continuously after breaking up with his boyfriend and going into depression. Vera did not criticize him; rather, she explored the meaning of the statements "today, I take [the medication] regularly," "ninety-five percent of the time." Even though, the dialogue on the scenarios of the failures was secondary concerning the psychosocial problems. Taking medications seemed to be "the least" compared to the urgency of getting back together with his boyfriend, living together again in Alvaro's house. Speeding the night at the boyfriend's house implied in failures as he did not always take his medications with him) – an aspect which was not thoroughly examined.	Failures (delays and doses suppressions) occurred in the morning at work. When the production line stopped to the worker's coffee break, at 9:30, Deise took the dose regularly, at 10:00. However, when the work schedule was changed for 7:30, it led to the inconvenience of stopping to work for taking the medication, and the fast work pace made it difficult. In the evening, delays of up to 3 hours are meant as a consequence of fatigue: she falls asleep watching TV and she only takes the dose if she wakes up until 1:00 A.M. Sometimes, she does not take it. She makes "self-management" of the medication (suppression or postponement) according to commitments. So, she believes to avoid side effects – what will be detailed in the analysis of working with scenes.	

The correct is:

Chart 7. Analysis of the conversations by dimensions and components/1st Encounter

CASES	CIRO	AMARO	ÁLVARO	DEISE
1st ENCOUNTER (the patients' talks are in italic and bold)				
Meanings produced in the intervention presentation	Except for Cirol, there was a predominance of meanings favoring the positive understanding that the encounters would be for care and not for research: "care," "helping people handle with their medications," "let us do this together," "an exchange." On the other hand, for Cirol, the predominant meanings were: "a research," "a kind of interview." The patient even added: "I already gave an interview once to VERA." With him, it was emphasized the use of MEMS, the counting of pills by the researchers and the Free and Clarified Consent Term (FCCT), without properly appreciating the specificity of the encounters as an activity of Care (the amount of encounters and their objectives, for example), although that was part of a more extensive research. That implied in a difficulty in producing, between the health professional and the patient, a dynamic of Care that was secondary to their interaction.			
Meanings about the research participation and the use of MEMS	Both cited the health professionals of the service with familiarity, as if they had answered the invitation to friendly people. Amaro gave altruistic justifications, agreeing with what the health professional had told him, "to help others," but he also said: "It is good, sometimes, to talk [...] it is good to talk with someone," suggesting the sense of need or personal relevance, the opposite of Cirol who basically came to answer a request. Cirol believed that he "had always taken [the pills] properly," although he had had "one or two failures" while traveling in the past. Questioned about expectations on the research, he wished to have a new vaccine "for us to take less medication and get physically healthier." Although asked about MEMS, he does not make any comment on it. The use of an electronic device is not explored with Amaro. It emerges by chance in the second encounter, when he justified not using a pill box in his daily life to carry the medication from his house to work.	First, he says it was "out of curiosity," when the health professional questions him (negotiation of meaning) as if that was not enough. Then, a personal meaning is produced: "That I start to take, to take the medication properly." He recognizes his failure regarding the continued use of medications, especially after breaking up with his partner: "I did not take it with such regularity [...] I had lost the will to live." He believes the research is already helping him, possibly referring to MEMS: "Because it is helping me to take the medication more regularly." He refers to the electronic device as an aid resource to remind him of taking the medication at the right time, seeing that as a beneficial control.	Meanings were produced: "to keep a better eye on myself"; "to improve our lives [...] and to find other solutions." Deepening the dialogue about the experience of MEMS enabled the emergence of the scenes of medication intake at the workplace scenario, as Deise explained that it was not possible to take the bottles to work "because they would stay in my bag [...] in some cabinet [...] if someone wants to open the bag, he/she will open it [...] You avoid that because of fear? Yes!"	
Conversation about the detectable viral load as a justification to call for intervention	It was not developed in the first encounter, only in the second one. Amaro said that, being for almost six months under the antiretroviral therapy (ART), the doctor had told him that the results of his latest tests were better (also referring to CD4). He did not know the values, but he understood the function of each one. Cirol, on the other hand, had more difficulty regarding this matter. For him, it was incomprehensible the reason of this detectable viral load, as he believed to take the medication "properly." He said: "The doctor tells me off," and he thought that the "bad results" were because of his age (he is 71 years old).			
Mutual presentation	The health professional almost did not introduce herself to the four patients. She positioned herself generically as the "psychologist in research," or she did not say anything about her, contradicting the principle of mutual recognition for the development of a dialogical communication. With Deise, at the end of the intervention, she stated that she would rather not mention that she was a psychologist in the service, thus going against protocol.			
Free conversation	It was well developed with the four patients, enabling the possibility of emerging both their past and current personal stories. The focus on the treatment routines allowed to see the everyday, the scenarios in which the treatment occurs, despite the frailties in specific conversations about the treatment regimen of each one, possibly hampered by the medication nomenclatures or due to the complexity of the treatment regimen (Cirol). The confusions and doubts came not only from the patients, but also from the health professional. Incipient with the four was exploring possible differences in the routine of current medication intake with MEMS, and previously without the electronic device.			
Listening to the presentation narratives and to the experiences with the treatment	There was an effort from the health professional to identify "issues, difficulties, problems" with the treatment. There was a predominance of questions such as "do you take [the medication] properly?" "you are taking [the medication] properly, aren't you?" Thus, the use of a directive non-dialogical style ("checkboxes") which did not favor meanings exploitation. Checking, timeless, generic questions invited very mildly the recollection and analysis of specific situations.	Amaro had a more inviting, exploratory talk, being more specific in his questions about the treatment. He could explain clearly about the circumstances of up to 3 hours delays in taking the medication. He stated that they happened quite rarely, and that meaning was transformed along the dialogue: he recognized that the overtime work occurred more frequently; therefore, he delayed taking the 7:00 p.m. medication; and he also recognized that, sometimes, he slept without taking the last medication, that should be taken at 11:00 p.m. Then, understanding the treatment regimen was impaired. He complains about side effects: "The Estavren mixes me a bit up. Then, I don't take it."	The dynamics of interaction with both were similar in a given aspect: the theme of the treatment turned secondary during a good part of the 1 st encounter and also in the following ones. They expressed themselves significantly about other issues beyond the treatment with a strong suffering. Deise, regarding her recent decision of resigning her job, the circumstances of the sexual infection she got from her husband, the embarrassment of having AIDS, and the "obstacle" in her sexual life that reverberated in dialogues about feeling herself depressed. Alvaro, on the other hand, recognized as problems in his life: the breaking up with his boyfriend and his effort to continue the relationship, the suspicion of being betrayed, the debts, the house built on a piece of land that was shared with his aggressive sister, and the violent brothers who discriminated him. The communicational dynamic that was produced was, therefore, characterized by the health professional's ability of listening, accepting, and being emotionally supportive. By respecting the needs of Alvaro and Deise, she inserted properly the theme of the treatment and in possible circumstances. The psychosocial complexity of their lives had implications on the dialogue and on the intervention as a whole: the "tension" between restricting or expanding the focus of the conversations; the pertinence, or the lack of pertinence, of guiding them to a psychologist and a psychiatrist (if they desired that or agreed to it) and, in the case of Alvaro, the long interval of 60 days between the 1 st and the 2 nd encounters, resulting in their difficulties of remembering the previous talks. In spite of that, the health professional could value and reposition the theme of the treatment experience amid talks on other themes. It was possible to identify the circumstances of adherence problems and, although with not so much clearness, the treatment regimen.	
CASES	CIRO	AMARO	ÁLVARO	DEISE
Free conversation	Cirol faced difficulties to describe the regimen (he replaced the nomenclature of each medication by its color). There was no association of the treatment with meanings of problem and difficulties (terms used by the health professional according to the script), but to other issues of his life, such as toothache, missing one of his sisters and lack of money. On expressing them, the health professional had investigated if they had the sense of experiences that jeopardized the treatment – which he denied according to him, he had failures regarding the past treatment (on trips when he had decided not to take the medication with him not wanting to expose himself to his friends), and he believed he would act in a similar way in the future, i.e., he would only travel either alone or with friends who knew the diagnosis. Insecure, Vera found no means to problematize the claims that he had no problem with the treatment. She even commented on her doubt about the real need of Cirol to take part in the intervention, as if she were "thinking aloud."	<i>It gives me a bit of anxiety, do you understand? [...] So, I avoid taking it. It makes me dizzy [...], giving me a bad taste in the mouth [...]. That medication gives me the worst reactions. Apart from that, [...].</i> A relevant but unexplored aspect was the association that the patient made between his moods and his better or worse adherence (irritation, agitation, anxiety, "being on the verge," "hypersensitive," "someone who sometimes fights"); and that he has never liked taking medication. It was not explored the possible implications of these descriptions of himself towards the treatment, or if they represented repercussions of living with HIV. Facing these colloquations, the focus was closed: "Then, our major objective is thinking about the medications, isn't it," what made impossible to continue the conversation.	Difficulty of prioritizing the treatment amid life problems (quarrels, affective relationship, housing). By trying to understand the whole "plot," Vera listed "the sister's prejudice" and asked: "Does that affect your life, in terms of treatment and of taking your medications?" Alvaro denied it and then the subject faded. However, it emerged again when he admitted his failure in taking the medications continuously after breaking up with his boyfriend and going into depression. Vera did not criticize him; rather, she explored the meaning of the statements "today, I take [the medication] regularly," "ninety-five percent of the time," even though the dialogue on the scenarios of the failures was secondary concerning the psychosocial problems. Taking medications seemed to be "the least" compared to the urgency of getting back together with his boyfriend, living together again in Alvaro's house. Spending the night at the boyfriend's house implied in failures (as he did not always take his medications with him) – an aspect which was not thoroughly examined.	Failures (delays and doses suppressions) occurred in the morning at work. When the production line stopped at 9:30, Deise took the dose regularly, at 10:00. However, when the work schedule was changed for 7:30, it led to the inconvenience of stopping to work for taking the medication, and the fast work pace made it difficult. In the evening, delays of up to 3 hours are meant as a consequence of fatigue: she falls asleep watching TV and she only takes the dose if she wakes up until 1:00 A.M. Sometimes, she does not take it. She makes "self-management" of the medication (suppression or postponement) according to commitments. So, she believes to avoid side effects – what will be detailed in the analysis of working with scenes.
Listening to the presentation narratives and to the experiences with the treatment	There was an effort from the health professional to identify "issues, difficulties, problems" with the treatment. There was a predominance of questions such as "do you take [the medication] properly?" "you are taking [the medication] properly, aren't you?" Thus, the use of a directive non-dialogical style ("checkboxes") which did not favor meanings exploitation. Checking, timeless, generic questions invited very mildly the recollection and analysis of specific situations.	Amaro had a more inviting, exploratory talk, being more specific in his questions about the treatment. He could explain clearly about the circumstances of up to 3 hours delays in taking the medication. He stated that they happened quite rarely, and that meaning was transformed along the dialogue: he recognized that the overtime work occurred more frequently; therefore, he delayed taking the 7:00 p.m. medication; and he also recognized that, sometimes, he slept without taking the last medication, that should be taken at 11:00 p.m. Then, understanding the treatment regimen was impaired. He complains about side effects: "The Estavren mixes me a bit up. Then, I don't take it."	The dynamics of interaction with both were similar in a given aspect: the theme of the treatment turned secondary during a good part of the 1 st encounter and also in the following ones. They expressed themselves significantly about other issues beyond the treatment with a strong suffering. Deise, regarding her recent decision of resigning her job, the circumstances of the sexual infection she got from her husband, the embarrassment of having AIDS, and the "obstacle" in her sexual life that reverberated in dialogues about feeling herself depressed. Alvaro, on the other hand, recognized as problems in his life: the breaking up with his boyfriend and his effort to continue the relationship, the suspicion of being betrayed, the debts, the house built on a piece of land that was shared with his aggressive sister, and the violent brothers who discriminated him. The communicational dynamic that was produced was, therefore, characterized by the health professional's ability of listening, accepting, and being emotionally supportive. By respecting the needs of Alvaro and Deise, she inserted properly the theme of the treatment and in possible circumstances. The psychosocial complexity of their lives had implications on the dialogue and on the intervention as a whole: the "tension" between restricting or expanding the focus of the conversations; the pertinence, or the lack of pertinence, of guiding them to a psychologist and a psychiatrist (if they desired that or agreed to it) and, in the case of Alvaro, the long interval of 60 days between the 1 st and the 2 nd encounters, resulting in their difficulties of remembering the previous talks. In spite of that, the health professional could value and reposition the theme of the treatment experience amid talks on other themes. It was possible to identify the circumstances of adherence problems and, although with not so much clearness, the treatment regimen.	
Closing List the failures, problems or difficulties. Shared registering	In general, it was a flawed process to list jointly the issues, problems and difficulties identified in the conversation and written down as a shared register of the four patients. Whether due to low clarity/specificity (with Alvaro), or to start but not conclude it (with Amaro), or even for abandoning it (it seems to be forgotten with Deise and left aside with Cirol, for not making sense once he did not have any problem with the treatment), in order to illustrate that, the register with Amaro could be: "The delays taking the medication when he works overtime," what did not happen. When asked about what problems could be listed, Amaro did not identify them and, usually, he answered: "in my case, who's causing the problem is myself." Vera neither disagreed nor proposed new formulations, and that was harmful because it allowed self-blame. In a positive attitude, Amaro, at the end of the first encounter, had already mentioned possible solutions: "I can buy a little case" (pill box) to take the doses to work – what turned out to be an extremely difficult intention to be practiced (and then it was postponed) in the course of the encounters.			