HIV risk reduction counseling is usually performed in HIV test counseling, prevention case management, and health education settings by trained counselors who are usually not licensed mental health providers. HIV test counseling protocols for risk reduction counseling, including U.S. Centers for Disease Control's current RESPECT Model, focus on integrating HIV information with client-centered counseling.

Information is particularly useful as a tool for educating clients about level of HIV-related risk and for discussing options to lower risk. Client-centered counseling—counseling that is tailored to a person's individual needs—helps clients think more deeply about their relationship to HIV-related risk, including the psychological or social issues that underlie their behaviors. As part of this process, a counselor helps clients identify not only barriers, but also goals and strengths. The result is a risk reduction “conversation” that seeks either to shift a client's perception of risk or change his or her behavior to reduce risk by negotiating a realistic risk reduction step.1,2

This article reviews some of the barriers to implementing and maintaining client-centered counseling throughout a counseling session. It highlights specific intervention skills that can facilitate an effective client-centered, risk reduction conversation. The skills and specific interventions mentioned in this article are based primarily on observations and evaluations of HIV test counselors throughout California.

Barriers to the Risk Reduction Conversation

Counselors who effectively integrate information with client-centered counseling demonstrate an ability to follow a client's lead, exploring the client's desires and limits and the risk reduction options that are consistent with these. A risk reduction conversation becomes ineffective when a counselor stops listening to the needs a client expresses or fails to explore the relationship between a client's emotional state and the client's actions. Instead, the counselor may opt for a conventional (or generic) risk reduction message that may not have any relationship to what the client is willing or able to do.

In addition, limited research suggests that in some counseling settings, particularly HIV test counseling, data collection may inadvertently take precedence over client-centered counseling. According to a UCSF Center for AIDS Prevention Studies investigation, when data collection dominates, “the session becomes a highly depersonalized, bureaucratic interaction that reduces the counseling relationship to the exchange of personal data for a ‘free’ test.”3 In these cases, the counselor may tailor the session to the needs of the form rather than to the needs of the client and risk reduction may be based on the categories the form uses rather than the individual life of the client.4

There are a number of strategies that can help counselors transition from an information-based, more directive approach to counseling to a client-centered interaction that can help a client negotiate a risk reduction step. These strategies include: the value of asking open-ended questions rather than being directive, the appropriate use of validation, the logical sequence of the session, the process of “meeting a client where he or she is,” and the implementation of constructive confrontation to address barriers to change.

Asking versus Directing

Telling a client what to do is not considered client-centered counseling. The essence of client-centered counseling is
**Editorial: Accentuate the Positive?**

Robert Marks, Editor

How powerful is positive thinking and what can it achieve? Can it facilitate healthy behavior change or support the denial of risk? Can it undermine HIV prevention messages or mitigate the sense of crisis that might encourage a fatalistic attitude?

This issue of FOCUS begins to look at some of these questions in two very specific contexts. Jaklyn Brookman, who has spent the last few years evaluating HIV test counselors throughout California, offers her observations about what comprises an "artful intervention." She asks what is the appropriate balance between validating a client’s efforts and attitudes, and constructively confronting his or her HIV transmission-related behaviors.

David Huebner revisits a question that has engaged the HIV prevention community since the dramatic advances of triple combination treatment in the mid-1990s. At that time, researchers wondered whether the promise of improved health proffered by the new treatments was stimulating "treatment optimism" in groups that had been hardest hit by the HIV epidemic. Some early studies found such evidence, for example, that this optimism was associated with higher rates of unprotected anal sex.

More recently, studies seem to suggest that while treatment optimism exists, its effect on behavior seems to be much less dramatic than feared. Further, as Huebner points out, treatment optimism is justified—the consequences of HIV for many people today are less severe than they once were—and few people inflate this reality to mean that HIV has been eliminated or is curable.

Both Brookman and Huebner, each in a different context, question the value and efficacy of supporting what are essentially “false” messages. In counseling, complete validation of a client’s behaviors may be misinterpreted by the client to mean that these activities are completely risk-free. This may not only lead to a missed prevention opportunity, it may undermine the counselor’s credibility.

Likewise, prevention messages that negate the underlying reality of the current epidemic—HIV is less dangerous in communities where treatment is accessible—inadvertently encourage society to dismiss all health messages. Hearing the boy cry wolf for the third time at the arrival of a lamb might lead a town to ignore the approach of a wolf pack.

In each of these cases, adherence to the basic tenet of client-centered counseling protects both the individual and the therapist, the community and the public health planner. Providers who respect the principles of personal autonomy and capacity, and who respond to those qualities with honesty, are in a good position to help. They can join with individuals to define healthy behaviors, support personal goals and desires, and help clients and communities achieve these goals.

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**References**


**Validation**

Having a conversation about risk reduction with a client involves not only a non-judgmental approach but also considerable empathy on the part of the counselor. The client needs to trust the counselor.

Validation is a particularly useful tool to maintain trust and to support behavior changes that a client has made or has attempted to make in the past. Counselor statements such as, "It sounds like you have made some strides in lowering your risk for HIV. That shows strength on your part,” represent an appropriate use of validation. Such statements may be particularly important for clients to hear, since some clients may feel embarrassed or inadequate discussing the details of their sexual and needle-sharing history.

Validation also feels good to counselors. Consequently, counselors like to validate their clients. Validation enables the counselor to play a supportive role focusing on the client’s strengths and life-affirming actions.
Yet many counseling sessions grind to a halt after the counselor appropriately validates his or her client’s strengths, stopping short of helping the client negotiate a risk reduction step when it is fitting. This may be because some counselors have difficulty knowing where to go next and how to get there or are afraid of being seen as judgmental if they raise current sexual or needle-sharing behaviors.

Validation, while a crucial part of the counseling process, is usually not, in and of itself, an intervention. When using validation as part of the risk reduction conversation, the actual intervention usually occurs when the counselor says, “I appreciate learning all the information about yourself you have shared. I wonder if we can discuss what you might be willing to do to lower your risk for HIV. Are you ready to have that conversation?”

It may help if counselors recognize that validation does not need to be abandoned during the intervention portion of the conversation. It is fine to validate a client’s courage when discussing the difficulties he or she may face, but that does not mean the conversation should end at the first sign of a client’s discomfort. A counselor’s role and responsibility, then, is to weave gentle exploration of a client’s difficulty discussing a risk reduction step with validation in order to help the client stay focused on identifying a meaningful risk reduction step.

Constructive Confrontation and Exploration

The word “confrontation” may initially send a chill up a counselor’s spine. Constructive confrontation, however, may be a particularly effective tool for clients whose words and actions seem to contradict each other.

A client’s statement, “Yes, I would like to lower my risk for HIV, but I don’t think I can make any changes in my behavior” is an example of contradiction that needs to be identified and explored. The sequence of a counselor’s response to this statement might be, “I hear you saying that you don’t want to get infected with HIV. I also hear you saying that you can’t make any changes in your behavior to lower your risk. What do you make of these two very different desires?” This response states in a neutral way the dilemma that the client is posing and offers the client a prime opportunity to reflect upon this incongruence.

If the client is willing, the counselor can continue in this non-judgmental way to support the client in exploring barriers to behavior change. This type of intervention helps the client to think more deeply about his or her dilemma and, in the best case scenario, may lead a client to identify a risk reduction step that he or she may be willing to take. Having said this, there are clients who express resistance to exploring contradictions. A client’s resistance is an important sign for the counselor. The message to the counselor is to back off and acknowledge the client’s right not to go further; the counselor’s responsibility then is to leave the door open for the client to explore his or her risk when ready.

Meeting Clients Where They Are

HIV counselors are taught to “meet the client where he or she is.” This phrase is particularly important because it says that a counselor needs to pay careful attention to the context of each client’s life and discuss risk reduction options that are appropriate to that client’s circumstances.

Sometimes this means counseling a client with considerable constraints in his or her life, everything from poverty and discrimination based on race, ethnicity, or sexual orientation to domestic violence, substance use, or depression. Approaching these issues requires counselors to think broadly and creatively about risk reduction options that can function within these constraints.

Consider the case of a female client who is in a violent relationship with a male partner who is at risk for HIV. Rather than assuming that there are no options for this client, short of leaving her partner, it is important for counselors to explore not only the client’s level of risk, but also the possible ways she can lower it.
her risk without inviting more violence into the relationship. Presenting lower risk options to the client allows her to think about how her partner will react. For example, if a client were to say that protected vaginal intercourse is not an option, it would be important to inquire if unprotected oral sex is something that is an option. It is crucial to follow a suggestion with the question: “How do you think your partner will respond to that?” If the client were to imagine that an option would put her at risk of violence, then the counselor should abandon the option.

The Logical Sequence of Counseling

There should be an inherent logic to the way a counseling session unfolds, and counselors should strive to ensure that their comments, questions, and suggestions are logically related to what the client is saying. This is often referred to as following a client’s lead.

At a recent HIV test counselor training in California, a participant playing the role of client in a practice session said that she had stopped having sex with her male partner because she had heard rumors that her partner was having sex with men. The participant playing the role of counselor immediately asked the client if she would consider introducing condoms into the relationship.

Thinking logically about this hypothetical situation means asking, “What is the next logical step for a client to take in this situation?” Would it make more sense for her to ask her partner to use a condom or for her to discuss with her partner her concerns about his rumored behavior? If this client has never used a condom in her relationship, does it make sense that she would present this idea with no explanation? As a counselor, it is important to think both, “How realistic is this option?” and “Does it make sense?” prior to asking a question or making a suggestion. This type of reflection can support a thoughtful exploration that can truly be helpful to the client in making decisions about a logical next step.

Creating the Artful Intervention

A risk reduction conversation, when done well, requires empathy, careful listening and creativity. An HIV test counselor who counsels sex workers recently described a client who generally engaged in safer sex with customers. This client also wanted to maintain a safe relationship with his primary partner but was unsure about how to accomplish this. The counselor initiated a conversation by saying, “I wonder if using condoms with your partner feels too much like your work; is that part of your dilemma?” This insight led to a more in-depth discussion of how the client might maintain safety with his partner while not replicating the type of sex he was having with his customers.

This anecdote is a wonderful example of an astute counselor first empathically tuning into his client’s angst about protecting his primary partner and then collaborating creatively with the client on how best to maintain the eroticism in his primary relationship. This creative collaboration requires not only the willingness to think beyond the usual, but also an understanding of the broad menu of harm reduction options for behaviors such as unprotected anal and vaginal sex and needle sharing.

Maintaining a client-centered approach can help clients feel seen and heard in a way that best serves the client’s needs. Appropriately using tools such as validation, a neutral stance, following a client’s lead, and constructive confrontation can move counseling from an information-based exchange to a meaningful conversation that can truly help a client identify and negotiate a viable risk reduction step.

Clearinghouse: Prevention Counseling

References


In fact, people may be more realistic than optimistic, recognizing both advances in treatment and continued HIV risk.

References

What Do We Know about Optimism?

In 2001, FOCUS published a review of the first generation of treatment optimism research among men who have sex with men. That review suggested that as of 2001, treatment optimism was not widespread in any country. Furthermore, although treatment optimism was associated with risk behavior in several cross-sectional studies, stronger longitudinal evidence of a cause-and-effect association was lacking. Finally, even if a causal relationship did exist, the effects of treatment optimism were modest and could not completely explain increases in unprotected sex occurring at that time.

In the four years since that FOCUS article, a number of important studies have been published. In 2004, the Journal of the American Medical Association published a meta-analysis of research conducted between 1996 and 2003. The combined results of 18 different cross-sectional studies indicated that overall, individuals with certain optimistic beliefs about antiviral treatment had between 1.5 and 2 times the odds of reporting unprotected sex.

Given that all the studies reviewed were cross-sectional, it was impossible to determine whether optimism really causes subsequent risk behavior. A reasonable alternative explanation would be that people who engage in risk behavior later become more optimistic as a way of alleviating concern they feel: “If I got infected last night, it’s okay; the new drugs will keep me alive.”

Over the past two years, researchers have published three longitudinal studies that suggest the causal relationship between optimism and behavior is indeed complex.

In one two-year study of 146 young men who have sex with men in Amsterdam, researchers found that treatment optimism was associated with increases in unprotected receptive anal sex, but not with increases in unprotected insertive anal sex.


See also references cited in articles in this issue.
Given the state of HIV treatment, a more accurate interpretation of existing data is that people are actually more “realistic” than “optimistic,” recognizing both the real advances in treatment and the continued dangers of becoming HIV-infected. Only a tiny minority of people agree with survey items that reflect true, unrealistic optimism; for example, the assertion that HIV has been cured. Thus, HIV prevention messages lose credibility when they try to convince people to be as afraid of HIV as they once were.

Even if we could recreate the fear and horror of the 1980s and early 1990s, would that really be a wise public health decision? Abundant research has demonstrated that the stress of those times exacted a considerable toll on mental health. If new HIV treatments have had some small disinhibiting effect on behavior, many would argue that the cost is more than compensated for by the relief of no longer living in those extreme circumstances.

**Conclusions**

Treatment optimism is appealing because it suggests a familiar, simple intervention: educate people about the risks of HIV. Even if we had strong data that people were once again unaware of the risks of HIV, 20 years of HIV prevention experience tells us that education is insufficient to change behavior.

Overemphasizing treatment optimism also detracts attention from other causes of risk behavior, both those that we have long known are important, for example, social norms, and those that we are just beginning to understand, such as methamphetamine use, the internet, sexual abuse, and the effects of discrimination. Interventions designed to address these risk factors are complex and challenging to implement. However, they are perhaps less daunting when compared to the alternative: waging a battle against the inevitable progression of time and medical science, and the understandable, justifiable hope and optimism that accompany them.


**Authors**

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same data, other researchers calculated that only 10 percent of the increase in unprotected sex observed in that study could be explained by treatment optimism.4 The remaining 90 percent was due to other factors.

Another study of 538 young men who have sex with men from the southwestern United States examined unprotected anal sex with casual partners and treatment optimism at two time points, one year apart.5 Treatment optimism at the first measurement point did not predict unprotected anal intercourse one year later. However, the reverse was true: sexual risk behavior at time one did predict treatment optimism a year later. Thus, this study found no evidence that treatment optimism causes risk, but did conclude that risk behavior might lead some men to feel more optimistic.

Finally, earlier this year, Dutch researchers found that among 151 HIV-negative men who have sex with men certain optimistic beliefs were associated with a subsequent sexually transmitted disease or HIV diagnosis over a three year period.6 These data were the first to link treatment optimism longitudinally to actual biological outcomes, providing support for the idea that treatment optimism can lead to the spread of disease.

This somewhat conflicting body of research suggests several conclusions. First, treatment optimism and risk behavior are somehow linked. While optimism might cause risk behavior, data indicate that risk behavior is just as likely to lead to optimism. Both are probably true. More importantly, no study has found that treatment optimism is widespread in any community. Furthermore, when effects of treatment optimism do exist, they are not great enough to adequately explain recent increases observed in the incidence of risk behaviors, HIV, or sexually transmitted diseases.

**Why Optimism Will Prevail**

The primary problem with the emphasis on treatment optimism is that combating optimism requires pitting HIV prevention messages against the reality of improving HIV treatments. The truth is that HIV is a less deadly disease than it used to be. In the developed world, people with HIV who have access to treatments are living longer, healthier lives. HIV infection is still serious, and medication regimens have side effects and fail for some people. But if pushed, virtually any person working with HIV would admit that he or she would rather be infected with HIV today than 20 years ago.

Given the state of HIV treatment, a more
The Role of Rapport in Test Counseling

Good rapport with clinic staff is a critical factor in having a positive experience with risk reduction counseling sessions, according to qualitative interviews with participants of an HIV vaccine trial. Despite discomfort regarding “risky” sexual behavior, no participants reported having withheld information during counseling.

Researchers interviewed a sub-group of 35 vaccine trial participants 18 to 24 months into their trial participation. This sample was 69 percent White and 14 percent Hispanic, and had a median age of 35. Within the prior 12 months, all participants had had anal sex with a male partner and none had been in a continuous monogamous sexual relationship of more than 12 months duration with an HIV-negative partner.

Most respondents reported that having good rapport with a test counselor was key to feeling comfortable discussing their sexual behavior, and that rapport increases their willingness to disclose sexual behavior details. Sincerity and a non-judgmental attitude toward clients were critical to establishing good rapport.

The most common source of discomfort during the counseling session was the disclosure of risk-related or unconventional sexual behavior. Despite this discomfort, no participant reported having withheld information or given false information.

Forty-six percent of participants reported that the sessions provided them with increased knowledge of HIV transmission, most commonly in terms of the degree of risk associated with specific behaviors. Yet, 29 percent characterized some information, for example, about routes of transmission, as the “same old messages.”

Test Counseling Practices

A small qualitative study of HIV test providers identified a remarkably consistent set of practices, central to both HIV prevention education and relationship building and counseling.

Researchers interviewed five physicians and 12 HIV test counselors from five urban centers in Canada and a variety of different types of venues dealing with different types of populations. After transcribing the interviews, researchers thematically analyzed them and identified a set of best practices for HIV education and public health and a set of practices for counseling not necessarily related to HIV.

Test providers emphasized the following practices as important to relationship building in the counseling session: maintaining professional boundaries; ensuring a comfortable and safe environment; ensuring confidentiality; imparting a non-judgmental attitude toward clients; and building trust and rapport through the use of language, listening, and humor. Test providers also valued the importance of promoting client self-determination in the counseling session, and they highlighted the need to remain client centered rather than allow personal or professional values to influence the session. The goal of maintaining professional boundaries was frequently cited as the most challenging aspect of the test counseling encounter.

Most participants emphasized the importance of educating clients about HIV to support risk reduction. Almost all test providers also stressed the importance of individualizing the risk assessment. Some said they do this by asking clients why they have chosen to get tested and why they have chosen that particular day to get tested. All test providers said they
insist upon giving test results in person, and most also said they provide referrals to other services as appropriate.

Risk Reduction for Substance Users

According to a study comparing standard HIV counseling and testing to an enhanced intervention, both approaches resulted in significant reductions in risk behavior.

The Long Beach site of a multi-site study of the U.S. National Institute on Drug Abuse (NIDA) compared a two-session counseling and testing protocol with an enhanced intervention that, in Long Beach, included standard counseling and testing plus two group workshop sessions, one individual counseling session, two social events focused on HIV risk reduction, and a minimum of two follow-up outreach contacts.

Researchers recruited 1,362 subjects from two groups—injecting drug users and non-injection crack cocaine users—who had not participated in any substance abuse treatment programs in the prior 30 days. The average age of participants was 39, and 33 percent of respondents were female. The sample was 47 percent African American, 28 percent White, and 21 percent Hispanic. The majority of African American participants were crack cocaine users (61 percent), while White and Hispanic participants were more likely to be injection drug users.

Between baseline and follow-up interviews, participants in both groups reported a significant decrease in all 14 needle-related, drug-related, and sex-related risk behaviors. There were only two significant differences between the two groups. First, a smaller proportion of enhanced versus standard intervention participants reported having had sex in the prior 30 days. Second, among participants who reported sharing injection works at baseline, enhanced intervention participants were significantly more likely than standard intervention participants to report using their own works at the six-month follow-up.

A large national study found no significant differences in subsequent sexual risk behaviors between clients who receive rapid HIV testing and those who receive standard HIV testing, although men who received rapid testing had a higher incidence of subsequent sexually transmitted disease.

Researchers recruited HIV-negative clients seeking STD examinations at public STD clinics in Denver, Long Beach, and Newark. A total of 1,648 clients received a one-session rapid HIV test, and 1,649 clients received a standard two-session HIV test. Forty-six percent of participants in both the single-session and two-session groups were female. During the week between testing and disclosure, standard test participants had the opportunity to try an initial risk-reduction plan and discuss their efforts during the second session.

At both six- and twelve-month follow-up, men, but not women, in the rapid test group had a significantly higher incidence of STDs than men in the standard test group.

Sexual risk behaviors at each follow-up were similar among participants in both intervention groups. Risk behaviors for each follow-up interval included: two or more sex partners; any unprotected sex; any unprotected sex with a nonprimary partner; any unprotected sex while drunk or high; sex with a new partner on the day first met; and having had a one-time sexual partner.

**Next Issue**

HIV prevalence rates in U.S. prisons are significantly higher than those in the general populations and disproportionately higher among certain populations of inmates. Yet HIV prevention and care in many prisons falls below standards in many communities. In the September issue of *FOCUS*, Joshua Spaete and Josiah Rich, MD, MPH of Brown University review the literature on HIV in prisons and the ways in which prison culture and public policy exacerbates the problem and challenges for communities to which inmates return.

Also in the September issue, Jessica Barclay-Strobe and Robert Espinoza, MPH of Family Justice in New York review the psychosocial challenges for formerly incarcerated individuals returning to their communities and ways in which family case management can be applied to meet these challenges.
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