HIV prevention efforts for injection drug users are often limited to outreach and pre- and post-test counseling, interventions that do not address the chronic aspects of HIV risk. As counselors have increased their emphasis on the maintenance of risk reduction behaviors, however, they are integrating into prevention programs interventions traditionally associated with psychotherapy. This article discusses general principles of psychotherapy that can be usefully applied, depending on the type of counseling and setting, to HIV risk reduction counseling. These principles relate to the "process," or patterns of client-counselor interaction, rather than the "content," or informational components of the interaction.

In a review of the literature, David Orlinsky and Kenneth Howard describe three therapeutic process elements, which form the basis of the conclusions of this article: the therapeutic bond, the relationship formed between patient and therapist; the therapeutic contract, the agreement that defines the purpose and format of the enterprise; and therapeutic interventions, the techniques of the professional.

Therapeutic Bond

In order to ensure that clients feel safe enough to reveal their concerns, the first task of treatment is to create an alliance in which a client feels the therapist is "on his or her side" and can be trusted. The importance of this alliance cannot be overstated. A cardinal characteristic of the therapeutic bond is strong role investment, where both client and counselor are committed to working together and investing energy in the process. The therapist must also give credibility to the effort, which involves believing that positive outcomes are possible and conveying this belief to the client.

Effective bonding is marked by mutual comfort and trust, and patient spontaneity: both parties feel rapport and that they understand each other. Recent evidence suggests that mental health counseling works, at least in part, when clients adopt the affirming and empathic qualities of their counselors. Therefore, any ambivalence toward clients on the part of counselors may interfere with the development of the bond and subsequent risk reduction.

A current issue in counseling is how much demographic similarity—for example, by race or substance abuse history—is needed to establish an effective bond. Counselors should avoid assuming that demographic matching implies a sameness or bond that, in fact, may not exist. Discussing differences and similarities explicitly with clients, rather than relying on matching, often resolves concerns and actively builds trust and mutual respect for each person's autonomy.

The counselor's investment in the counseling relationship should not be all-consuming. Empathy rests on the perception that client demands can be limited before they become overwhelming, and counselors who exceed these limits often face burnout. For example, it is reasonable for a counselor to freely invest a large percentage of on-the-job time with a client and to be truly concerned about that client's marital problem. Should the counselor begin to regularly allow client demands to disrupt his or her
Editorial: Back to the Basics
Robert Marks, Editor

The grassroots response to AIDS has been appropriately enshrined as a model for dealing with health emergencies. Central to this response has been the development of a clear and simple message: Don’t do these activities, and, if you must, do them safely to protect yourself and others.

Thousands of “risk reduction counselors” have been mobilized to spread the gospel of safer sex. Transforming these volunteers into experts has required training that has focused more often on the science of HIV transmission and treatment than on counseling techniques. Reliance on volunteer support has also meant that any training has had to conform itself to the limitations of volunteer commitment and time.

While this approach has worked, risk reduction will never be as easy as just saying “No.” The triumph of HIV prevention, exemplified by decreasing infection rates in urban gay communities, is threatened. Populations of younger gay men and gay men who have trouble integrating safer sex into their lives remain at risk, and their numbers are growing. Among injection drug users, needle exchange programs and bleach distribution efforts have led to reduced needle-sharing and even to increased demand for drug treatment, yet continuing sexual transmission may constitute the greatest risk of HIV infection in the United States today.

Sophisticated Techniques
These challenges demarcate the current limits of the HIV prevention model. To transcend these limits, program planners must reach beyond basic risk reduction counseling methods to deal with nuances of resistance to safer sex, the hardened conglomerate of beliefs and feelings about sex, drug use, death, health care, and ourselves. One-shot informational counseling may continue to work for some, but to reach those at greatest risk, it is necessary to apply sophisticated techniques and ongoing counseling.

Cost-efficient risk reduction counseling can never emerge as full-fledged psychotherapy. Effective risk reduction, however, must begin to employ psychotherapeutic techniques to establish the counselor-client relationships necessary to deal with these complex issues. In this month’s FOCUS, William Grace, Sander Genser, and Ro Nemeth Coslett suggest a hybrid approach that does not require dramatic changes, but may improve basic short-term risk reduction counseling.

While the contribution of lay counseling has been critical to stem the spread of HIV, the lack of fundamental counseling skills endangers the success of these efforts. For both lay and trained counselors, articles like Psychotherapeutic Principles and AIDS Counseling for Drug Users are essential to construct and maintain the conceptual framework needed to achieve risk reduction.

While this approach has worked, risk reduction will never be as easy as just saying “No.” The triumph of HIV prevention, exemplified by decreasing infection rates in urban gay communities, is threatened. Populations of younger gay men and gay men who have trouble integrating safer sex into their lives remain at risk, and their numbers are growing. Among injection drug users, needle exchange programs and bleach distribution efforts have led to reduced needle-sharing and even to increased demand for drug treatment, yet continuing sexual transmission may constitute the greatest risk of HIV infection in the United States today.

Therapeutic Contract
The therapeutic contract is the agreement that defines the therapeutic task and approach to working together. It may be written but is usually informal, and it should address several components. Some components of the contract will require straightforward discussion during the first meeting, and others will develop over time. The first contract issue is the size and composition of the counseling unit; that is, will it be individual or group counseling and, if group counseling is chosen, what type of group format will be used? Some evidence suggests that if a group format is used, female sexual partners of injection drug users participate more actively in same-sex rather than mixed groups.

Studies find psychotherapy outcomes are equally successful for both individual and group counseling, as long as patients remain in the agreed upon format. In deciding upon the format for HIV counseling, counselor and client should balance the opportunity for individualized assessment and discussion with the benefits and risks of peer influence and learning from others in a group. Groups may also enhance accessibility of patients to counseling (more people may be seen during a unit of time) or disrupt accessibility (clients may have to wait until group is formed). It is important to note that the psychotherapy literature is unusually consistent in finding that waiting lists decrease attendance and are detrimental to outcome. This implies that when a client is available, risk reduction interven-
Offering advice does not appear to improve therapy. This is consistent with the general stance that counselors should support client independence.

References


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Oftentimes should be provided without delay.

The next element of the contract is the schedule: when and how often client and counselor meet. Orlinsky and Howard conclude that there is no significant difference in psychotherapy outcome between once-a-week and more or less frequent schedules. The critical issues for scheduling follow-up appointments may be the client’s preference and the counselor’s assessment of urgency. In addition, the contract must address how long counseling is to last.

Time-limited therapy, where starting and ending dates are specified at the outset, seems to encourage people to stay longer and engage in treatment better than therapy with an indeterminate end date.

Studies of contract-making strongly support explicitly telling clients what is to occur and what is expected of them. Such instruction extends to basic parameters, for example, the amount of talking—versus listening or structured exercises—the client expects of the therapist, and the degree of reliance on the therapist to direct sessions. Preparation of the client is likely to be equally crucial in HIV-related counseling, where there are innumerable opportunities for misconception. Many fears can be allayed by providing basic information on procedures that may seem routine to the counselor. This is especially true with injection drug users, who may tend to perceive rejection when it is not present.

Ultimately, interventions that stray from the client’s perception of those allowed by the contract are likely to fail. For example, discussing sexual activities with a client who thinks he is to receive only information on needle cleaning may arouse resistance.

Therapeutic Interventions

Studies conclude that clients who actively participate by talking have better psychotherapy outcomes than those who say little. Data on the effect of counselors’ talking on outcome, however, are equivocal. In HIV counseling, then, it is probably wise for the counselor to explain the need for client involvement and then to give information in small doses, elicit responses, stimulate verbalization, and listen. Similarly, better therapy outcomes are obtained by therapists who encourage client independence and collaboration with the therapist than counselors who attempt to direct clients. Because the HIV counselor will have specific factual knowledge to impart and goals to accomplish, special care is needed to avoid appearing controlling and authoritarian.

These findings imply that HIV counselors should be reluctant to supply answers to the complex situations clients face, but should help clients develop their own solutions. Success also requires counselors to consider personal biases and how these may be injected into discussions. For example, a counselor’s desire to control anxiety in the face of the epidemic may prompt him or her to provide an excess of medical data or to be angry at a client who continues to engage in unsafe behaviors.

While counselors must guard against exerting too much specific control, they must, at the same time, clearly encourage client involvement in recognizing and implementing risk reduction. When appropriate, counselors should explore client resistance to making firm commitments to risk reduction. In various types of substance abuse, commitment to drug use abstinence has been shown to be a strong predictor of treatment success. It seems likely, then, that obtaining a commitment to risk reduction would be a strong predictor of adherence to low-risk behaviors.

Some interventions are seen as basic to most therapeutic endeavors. Among these are attempts to focus on the client’s emotional state, to explore behaviors, to restate themes, and to provide emotional support. Surprisingly, Orlinsky and Howard conclude that psychotherapy outcome studies suggest that none of these is a particularly potent force in behavior change, but each is “occasionally helpful” to “often helpful” without much risk of negative impact. This conclusion may be partially due to the universality of these elements in psychotherapy, so it is difficult to identify the independent contribution of each. Studies of factors associated with HIV risk reduction among injection drug users do conclude that counselor support is important in initiating and maintaining change. In medical settings where risk reduction counseling may occur, use of these therapeutic actions may be relatively uncommon, so their effects may be more obvious.
Certainly, HIV counselors should use these basic interventions. Where levels of anxiety and fear are likely to be high, a focus on feelings can build rapport and increase comfort. Emotional expression is important, but it is equally important to avoid limiting the interaction to a “ventilation of feelings.” Rather, clients must be steered toward discussing behavior patterns and the determinants of risk behavior in their lives, and toward acknowledging responsibility for their lives and the consequences of their actions. The vigor with which the counselor pursues the issues of responsibility may be moderated by the degree to which this might overwhelm the client, but self-exploration and acceptance of responsibility are hallmarks of effective counseling.

Confrontation, a powerful technique, is defined as the exploration of a client's experience through the counselor's articulation of a different perception of that experience. More akin to candor than to conflict, confrontation requires skill to apply without engendering antagonism, and it may be particularly useful in clarifying resistance to changing behaviors. For example, a client who states he can easily discuss sexual risk reduction with his partners may be confronted by a counselor who says, “That surprises me a little, because I felt like there was a little discomfort when you and I were talking about sex.” Notice that even this mild confrontation could be perceived as a threat if a strong therapeutic bond is not present. Since confrontation is difficult to use effectively, it should be learned through supervision with someone skilled in the technique.

It does not appear, from the research available, that offering advice affects outcomes in psychotherapy, and this conclusion is consistent with the general stance of supporting independence. HIV counselors should give advice sparingly, if at all, and maintain a clear distinction between informing and directing. Advice may be appropriate only for those who are truly unable through lack of intellectual or psychological resources to generate ideas and solutions on their own.

Counselor self-disclosure about personal experiences that exemplify effective actions is a type of advice that is not generally useful in psychotherapy. Counselors tempted to disclose during HIV counseling should consider their motives, since this technique more often helps providers work through their issues than it helps the clients approach theirs.

Conclusion
Psychotherapy cannot be simply imported as a method for risk reduction, but lessons learned from psychotherapy research can guide risk reduction. The most important lesson is to never underestimate the importance of the therapeutic alliance. Unimpeded access to services and a mutual understanding of the task are essential steps toward building that alliance. The bond between client and counselor provides only a basic foundation upon which to communicate explicit education and to explore risk reduction issues. Counselors must encourage client independence, perceived self- and behavioral efficacy, self-examination, assumption of responsibility for actions, and commitment to behavior change.

**Clearinghouse: Counseling Drug Users**

**References**


For most HIV providers the lives of injection drug users are foreign at best and stigmatized at worst. This response is based both on the covert nature of drug use and on societal prejudices about drug users. A glimpse into the daily life of a “street addict” challenges these presumptions and can inform the work of educators, counselors, and clinicians.

Street addicts, unlike more mainstream, functional drug users, often resort to theft because they have few other options for obtaining money to buy drugs and because the powerful dictatorship of addiction demands that users compromise their values in its service. Coming out of youth, poverty, and fragmented lives, street addicts often lack education and have few marketable job skills that offer alternatives to theft. Once addicted, a combination of the cost of drugs and unremitting drug craving keeps them poor and unable to compete in the job market. Even with the will to fight addiction, the social network on the street offers little support for this difficult process, and government priorities offer little hope of getting drug treatment.

The following portrait represents a “typical” day in the life of Laura, a heroin-using drug injector living in a city in the United States. Laura is a 32-year-old Black single mother. After years of suffering incest, she ran away from home when she was 16. Soon she was selling her body to get money for food and shelter, and she continued to live on the streets for two years before becoming pregnant and then marrying. Now divorced and with three children, Laura is an unemployed high school drop-out living in what appears to be a unbreakable cycle of crime, sex, and drug addiction. While not all drug users fit Laura’s profile, many share her fear, hopelessness, and frustration.

Hustling

Laura awakens with a start to face another day in the streets and immediately checks the clock. Time is critical to the addict. If it is too early the dealers won’t be out yet, and the mall will not open before Laura goes into withdrawal, becoming too sick to “get a good hustle going” (steal merchandise to sell so she can buy drugs). Today Laura is relieved. It’s only noon.

Laura’s work team consists of three people: two shoplifters—Laura and Mary—and the driver—John—who is available to make a quick getaway. First the team visits the mall, stealing just enough to buy drugs to “take the sick off” (prevent withdrawal). Then they sell the goods, “cop” (purchase drugs), and “get off” (use the drugs). As Laura shoots her share of the drugs, she is already worrying about getting back to the stores to complete her

“Maybe I won’t ever have to wake up and face that jungle again. But, God, if I do wake up, please let it be by noonday.”


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Contacts
Joanna Rinaldi, UCSF AIDS Health Project, Box 0852, Suite 7E25, San Francisco, CA 94110, (415) 206-6178.

William C. Grace, PhD, National Institute Of Drug Abuse/Alcohol, Drug Abuse and Mental Health Administration, 5600 Fishers Lane, Room 11A-33, Rockville, MD 20857, (301) 443-1801.

Janet Johnson-Wise, MSW, HIV/STD Control Branch, Division of Epidemiology, Department of Environment, Health, and Natural Resources, 225 North McDowell Street, Room 5027, Raleigh, NC 27611, (919) 733-7301.

Mark Winiarski, PhD, Montefiore Medical Center Ambulatory Care Network, 111 East 210th Street, Bronx, NY 10467, (212) 920-6062.
hustling for the day.

John waits in the car ready to pick up Laura and Mary at the first sign of trouble. Today, the women return walking “all wide-legged”; they have scored big. In the car Laura and Mary raise their skirts and begin to pull merchandise from their girdles.

At this point, everybody is happy. They place the stolen clothing under the back seat of the car, drive cautiously away, and find a “fence” to buy the stolen goods.

Taking the Sick Off

After using drugs for more than 10 years, Laura knows all the “dope men” (dealers) in town, who has the best dope, and who will not “burn” them (give them drugs that they later discover to be baking powder or some other false substitute). Mary, a newcomer, wants to go back to the safety of her home to use the drugs. John and Laura, however, know that as soon as the drugs are in their possession, each will begin to experience pseudo-withdrawal symptoms, and the urgency to use the drugs will become overwhelming.

The team ends up in the “shooting gallery” (a place to rent drug-using equipment and inject drugs), a squalid building across the street from where Laura had purchased the dope. Each team member pays the “gallery boss” $2.00 for rental of the “hype” (the syringe) and the place.

Atop a grimy table lay about 15 or 20 syringes, several greasy jars and cups, a whole slew of bottle tops, and some bleach. John and Laura scurry about trying to clear off a small space where they can “cook” (liquefy powdered heroin or cocaine) the drugs and “fire up” (inject). They consider cleaning their needles, but there is not enough bleach, so they shoot up without using it.

Nighttime

After the need to avoid withdrawal has been satisfied, the team gets back to the mall. They continue hustling until they accumulate enough to cover the rest of the day and night. This time they simply fence the goods and split the money.

Now it’s everyone for themselves. Laura’s kids have been home alone since they got out of school at 3:00. John has to go see his parole officer. Mary has to clean the house before her mother returns. Laura buys more drugs. She knows to save at least $5.00 to buy hot dogs, bread, and pork ‘n’ beans for the kids. She questions the nutritional value of these foods, but knows that her habit won’t allow her to do anything else. The kids are glad to see Laura when she returns and are happy about the food she has managed to buy.

There have been many times that Laura has gotten so high that she hasn’t even remembered that the kids needed food. Times when Laura has had to have sex with guys so she could get some cocaine to mix with the heroin. On days like that, there was no money for food. Laura consoles herself with the thought that at least she has always come back to the children.

Throughout the evening Laura continues to get high, hour after hour until all the drugs are gone. At 2:00 AM, she sits on the side of the bed with tears in her eyes and wonders how long she can keep up this life. As she falls into a stupor, she thinks to herself, “Maybe it’ll be over this time, maybe I won’t ever have to wake up and face that jungle again. But, God, if I do wake up, please let it be by noonday.”

Conclusion

Laura wants to stop using drugs, but on the streets, she has little support for that decision. She is not qualified for most jobs, and, because of her addiction, would have trouble holding one. Through her neglect of family and friends, she has lost all the outside support that might have helped her both financially and psychologically to fight her addiction. She cannot get into drug treatment; there is a two-year waiting list.

It is easy for some of us to hold Laura completely responsible for her condition and as easy for others to excuse the results of her behavior: the most helpful approach lies somewhere in the middle. Laura must ultimately decide for herself whether she will fight her addiction, but others must respond by making drug education and treatment available to her and by fighting the societal conditions.
**In Review**

**Family Therapy**


Whether and how to include families in the therapeutic treatment of HIV-infected people is a central question for HIV-related counseling. *In the Midst of Winter* explores the dynamics of HIV-related therapy using a family systems model as opposed to an individual approach. The book is based on the work of the AIDS and Families Project of the Ackerman Institute in New York City. Gillian Walker, the project’s co-director is a respected family therapist.

The book’s most innovative contribution is found in its first section. Walker introduces the reader to the current thinking on the family therapy systems approach and its application to the psychological treatment of HIV-infected individuals and their families. Case studies and case transcripts, used effectively throughout *In the Midst of Winter*, help to illustrate points.

Later sections address living with HIV infection, preparing for death, the inner-city experience of HIV disease, and AIDS and larger systems such as the health care system or the community network. While Walker may be lauded for her ambitious attempt to bring all of this information together in one resource, the book suffers from this diversity. Topics such as safer sex, the stigma surrounding HIV disease, disclosure of infection, and death and bereavement have been covered, often more effectively, in other publications. A short chapter on pediatric AIDS, unusual in the literature, will be of interest to those working with children.

Although Walker generalizes the project’s experiences to all urban populations, *In the Midst of Winter* has a decidedly Northeastern slant. For example, many people with HIV disease in California are geographically distant from families who therefore cannot participate in ongoing therapy. The book might have benefitted from information on using family therapy techniques—such as communication through letters, telephone conversations, audio and video tapes—to deal with absent family members.

Currently, the majority of books written on the psychological treatment of HIV-infected persons are anthologies. This format can result in a choppy and disjointed approach. *In the Midst of Winter* flows from one chapter to another and maintains the focus of a single author throughout. Despite its limitations, *In the Midst of Winter* is a must for those who are interested in the impact of HIV disease on the family.

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**Recent Reports**

**Intervention and Risk Reduction**


Injection drug users showed sustained and dramatic declines in unsafe needle- and drug-using behavior following an educational intervention, according to a study of 402 injection drug users in Cleveland.

In a one-on-one intervention with a health educator, participants received basic information about HIV and its transmission and progression, and viewed part of a film produced by prisoners with AIDS. This session, which lasted up to an hour, included condom and needle-cleaning demonstrations. Subjects were given bleach, condoms, and literature, were told about antibody testing, and were encouraged to take advantage of anonymous testing. Nearly all participants were described as “street addicts,” and few were enrolled in treatment. Most participants were male, most were Black, and their median age was 36 years. Researchers paid subjects a nominal fee for participating.

Before the intervention, interviewers asked subjects to identify their drug-using behaviors during the previous two months. Subjects answered these questions again in follow-up interviews usually between three and five months after the intervention, but in some cases as long as one year later.

The number who reported sharing syringe equipment fell from 67 percent initially to 24 percent at follow-up; those cleaning their syringes with bleach increased from 34 percent to 62 percent.

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**Authors**

Gloria C. Horsley, RN, MS is a licensed clinical nurse specialist in private practice in San Francisco, a marriage and family therapy intern, and a volunteer therapist with the AIDS Health Project.
The number of subjects who injected drugs fell from 92 percent to 71 percent, and the percent injecting heroin fell from 75 percent to 50 percent. No significant differences were found between genders or among ethnic groups.

Rates of change did not vary between those who returned for follow-up interviews as little as three months after intervention and those who did not return until several months later. Those who returned sooner after intervention generally reported greater behavior change than those returning after longer periods. However, this finding was neither consistent nor significant for all behaviors, and does not suggest decay in behavior change over time.

Drug Use Treatment

AIDS is linked to drug use, which is linked to poverty, which is linked to community opposition to drug treatment, which is linked to the further spread of HIV. The most formidable barrier to breaking this chain lies not in the absence of interventions, but in the pervasive belief that available interventions will not work and are not worth the effort and the money. In response to this situation, the authors of this overview article on HIV disease and drug use suggest that policy makers should seek diverse methods to reach drug users and their sexual partners, must integrate AIDS education and treatment into existing drug treatment programs, and must develop innovative drug treatment programs that begin with drug education.

This review article provides brief entries on theories of addiction, addiction treatment, the epidemiology of drug use, and HIV education and risk reduction among drug users. It offers a useful overview of the range of drug treatments.

The most common treatment approaches for heroin addiction are detoxification and methadone maintenance. Acute detoxification, which often consists of an inpatient stay of up to 21 days, is a sudden withdrawal process from heroin. During detoxification, patients usually ingest only fluids; some may receive methadone, a synthetic narcotic that substitutes for heroin, to ease withdrawal symptoms.

Detoxification can lead to longer-term treatment, most often methadone maintenance. Methadone does not cure heroin addiction, but replaces heroin. Studies have found that continuous methadone use for more than a year is the most effective method of reducing heroin use. Unlike heroin, which is injected several times a day, methadone is taken by mouth once a day. The drug naltrexone is sometimes used in place of methadone. Successful naltrexone use usually leads to complete drug abstinence after six to 12 months. Naltrexone has few side effects and is administered once every 72 hours.

Other treatment approaches include sociotherapies, such as therapeutic-based residential communities. A person living in the residence has gone through detoxification, takes an active role in the residential community, and remains at the residence for several years. Psychotherapy may be useful in supplementing other interventions, but alone has little value in drug treatment. Acupuncture is also a useful addition: it reduces drug craving and attenuates prolonged withdrawal symptoms.

Next Month

While fears that AIDS would wreak havoc in the workplace have been unfounded, more subtle and unanticipated issues have emerged as businesses have grappled with the epidemic. Among these are homophobia, workplace safety, the rights of employees, the balance between fitness for duty and reasonable accommodation, the role of emotional support in the workplace, and grief management. In the February issue of FOCUS, Jude Sharp, PhD, Administrator of the Employee Assistance Program at Pacific Gas & Electric in San Francisco, describes ways in which employee assistance programs can handle these concerns.

One of the gravest concerns for corporations is the effect of AIDS dementia on employee functioning. Also in the February issue, James W. Dilley, MD, Executive Editor of FOCUS, Director of the AIDS Health Project, and Associate Clinical Professor of Psychiatry at the University of California San Francisco, reviews aspects of HIV-associated dementia, the complications they raise for employers, and ways employers can manage their concerns.
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