Research Update

Over the past several years, HIV counseling and testing practice has evolved. Recently, the U.S. Centers for Disease Control and Prevention (CDC) has taken four actions that affect HIV prevention and the prevention counseling component of HIV counseling and testing: highlighting the importance of counseling and testing to raise awareness of HIV in underserved communities of color; prioritizing prevention interventions for people with HIV and identifying HIV testing as a key diagnostic approach; and embracing rapid HIV testing and its accompanying “single-session” counseling as a way to make testing more accessible. Finally, it has undertaken a seminal, ongoing study of HIV counseling: Project RESPECT.

While basic HIV counseling philosophy and tools have not changed in response to the CDC’s actions, the results of Project RESPECT have led to changes in the HIV counseling protocol. The Research Section of this issue of HIV Counselor PERSPECTIVES reviews the evolution and evaluation of the counseling and testing protocol, the changes it has undergone in response to Project RESPECT, and the application of RESPECT in California to both single-session and standard (two-session) counseling. It also examines another counseling innovation—the self-justification model—that, like the RESPECT model, has been tested in randomized trials. Lastly, it reports on critiques of HIV test counseling and its implementation.

Evolution of Guidelines

In 1985, the San Francisco Department of Public Health and the AIDS Health Project of the University of California at San Francisco developed the first protocols for HIV testing and results disclosure in the world. In this initial version of the protocol, the pre-test session focused mostly on education about the rapidly changing knowledge base about HIV disease, while counseling and behavior change planning were concentrated in the results disclosure session. However, even these first guidelines prioritized activities that eventually came to be known as client-centered counseling: individualizing sessions and focusing on the meaning of the test and the result for each client.

In 1986, the CDC adapted the AHP protocol and released the first national HIV counseling and testing guidelines, which were updated in 1987, 1993–1994, and 2001. These documents focused primarily on standards of care, including confidentiality and voluntary versus mandatory testing. The 1993–1994 CDC standards, which became the basis for HIV counseling and testing for the decade that followed, promoted individualized, neutral counseling and a focus on the client’s, not the counselor’s, goals for risk reduction.
The 1993–1994 CDC guidelines recommended a two-session, interactive, client-centered protocol.\(^2\) The first session focused on risk assessment, information about the test, informed consent to test, and blood or oral tissue sample collection from clients who chose to test. The second session, one or two weeks later, focused on disclosure of the test results, and for HIV-negative clients, discussion of risk reduction and provision of referrals. For HIV-positive clients, the session focused on helping the individual adjust to the news of the result, offering appropriate referrals, especially about initiating medical care, and, depending on the client, discussing disclosure to partners and risk reduction for partners.

The most current CDC guidelines, published in 2001, differ from and echo the 1994 report. They are also the first to be based on the results of a large clinical trial of counseling and testing methods: the RESPECT study.\(^2\) The 2001 guidelines advise counselors to use explicit language to describe test outcomes and to tightly focus sessions on the client’s recent risk incidents instead of broader behavioral factors that might affect the client’s risk. The guidelines also suggest that counselors motivate further change by affirming risk reduction steps clients have already taken. Although HIV education remains an important part of the session, the guidelines advise counselors to clarify specific, not general, misconceptions, for example, talking about the specific sexual risks that a client might actually encounter rather than all the possible ways a client might contract HIV. This increases the likelihood that counselor and client will be able to identify concrete actions a client can take to reduce risk and the skills necessary to do so.

The 2001 guidelines also stress the need for flexible implementation of the protocol in order to respond to differences in client base and available resources. They recommend, for the first time, the controversial step of possibly performing HIV testing without prevention counseling and referral, especially in areas with a low prevalence of HIV and for clients who have few or no HIV-related risk factors. These revisions, which are not being implemented broadly, reflect the dramatic changes in the epidemic achieved by HIV treatment advances.

Early diagnosis and knowledge of HIV infection have also become central components of controlling HIV transmission.\(^2\) Research indicates that, after learning they are infected, many people with HIV decrease sexual or injection behaviors that may lead to HIV transmission. Moreover, evidence suggests that medical treatments that decrease HIV viral load may also reduce risk of transmission to others.

Finally, new antibody testing technologies have influenced HIV counseling. Before 1994, drawing blood with a syringe was the only option for collecting a test sample. Since that time, new tests of oral fluid or tissue, urine, and blood from a finger puncture constitute less invasive sample collection, making testing a more attractive and available option. Rapid HIV testing has also made it possible for test sites to provide same-day HIV-negative and “preliminary positive” results, eliminating the potential that clients may not return for results.\(^2\) This is particularly important, because in 2003, more than 600 people who tested HIV-positive at state-funded test sites in California did not return for their results.\(^6\) In response to the development of the rapid HIV test, the CDC’s RESPECT team adapted the RESPECT protocol to single-session counseling.

While the CDC has guided the evolution of test counseling on a national level, state, county, and individual agency implementation varies. Some programs have leaned more toward a psychological approach; others have emphasized a health education approach.\(^6\) For example, the state of California has adapted the RESPECT protocol using its own client-centered counseling approach, which includes focusing on stage-appropriate interventions as identified by the Stages of Change model.\(^3\) The result is new protocols for both single-session counseling and two-session counseling.

### Evaluation of HIV Test Counseling

Surprisingly, while HIV counseling and testing protocols have been shaped by well-accepted behavior change theories and by health education and medical practices, there has been little standardized and controlled evaluation of HIV test counseling, itself. In 1999, researchers conducted a meta-analysis of 27 studies of testing and counseling published between 1985 and 1997 in North America, Europe, and Africa, involving almost 20,000 participants.\(^5\) Unfortunately, most of the studies included in the analysis did not specify their counseling approach, including the length of sessions or whether counseling followed CDC guidelines. This made it impossible for the meta-analysis to identify which counseling approaches are most effective.

The meta-analysis did find that HIV counseling and testing was effective in reducing sexual risk behavior both among clients in relationships in which one partner is HIV-positive and...
the other partner is HIV-negative, and among clients who tested HIV-positive. The data on couples came from three studies, involving about 300 participants from various counseling and testing sites. The analysis showed that counseling and testing had a “large” effect on reducing the couples’ risk behavior. The data for the HIV-positive clients came from five studies with about 400 participants, and showed that counseling and testing had a “medium” effect on reducing their risk behavior. However, based on data from nine studies with more than 1,000 participants, the meta-analysis also found that risk reduction among HIV-negative study participants was not significantly higher than among untested participants.

Two recent studies—the RESPECT study and the self-justification study (a model tested among gay male repeat testers)—have involved more rigorous analyses of their counseling processes, and have looked especially at risk reduction outcomes. These studies demonstrate techniques that can be applied in the field.

The RESPECT Model

From 1993 to 1996, Project RESPECT researchers conducted a multi-city, randomized, controlled trial that compared the CDC protocol with other types of test counseling. The study recruited 5,758 participants from inner-city, publicly funded, sexually transmitted disease clinics in five U.S. cities. All of the participants were heterosexual, HIV-negative men or women. The median age of the sample was 25 years old; and 59 percent of participants were Black, 19 percent were White, 16 percent were Hispanic, 16 percent were of other races.

RESPECT compared three types of interventions: enhanced counseling, consisting of four twenty-minute sessions; brief counseling, consisting of two 20-minute sessions modeled after CDC guidelines; and an informational approach, consisting of two short (5-minute) sessions on HIV prevention. The study’s key outcome measures were incidence of new STD infections over the course of the study period (as determined by laboratory tests), and self-reported condom use. Since only 10 percent of participants reported having anal sex in the last three months at the initial interview, the researchers defined risk reduction as using condoms during penetrative vaginal sex. To enable measuring these outcomes, all counseling and testing was confidential, not anonymous.

The two-session (“brief”) approach led counselors and clients through a process of negotiating a realistic and achievable risk-reduction step, unlike earlier CDC models, which emphasized long-term risk reduction and the identification of “one or two behavioral changes.” Although this approach was in essence client-centered, it differed from traditional client-centered counseling by using “prompts,” which outlined step-by-step the order of the session, and by suggesting timeframes for parts of the session to structure counseling interactions.

At the three-month follow-up, a slightly higher percentage of the enhanced group and brief counseling group participants reported no episodes of unprotected vaginal sex than informational session group participants, but this difference was not statistically significant. However, at the six-month follow-up, 30 percent fewer enhanced group and brief counseling group participants than informational session group participants had new STD infections; and, at the 12-month follow-up, this figure, while falling to 20 percent fewer new STD infections, remained high. Both of these outcomes were statistically significant.

These data are powerful. They prove that the RESPECT approach is effective in reducing risk, more effective than an informational model, and as effective as a more intense (four-session) counseling approaches. As a result, this is the model promoted by the CDC in their 2001 guidelines.

Self-Justification Model

The only other significant test counseling model that has been rigorously evaluated is the self-justification model, which focuses on “repeat testers,” people who test more than twice. Recent data has shown that men who have sex with men and who are repeat testers tend to have more unprotected sex. In response to this data, researchers from the University of California San Francisco AIDS Health Project and the San Francisco Department of Public Health designed a model aimed at gay and bisexual HIV-negative repeat testers.

This model is based on the work of Australian researcher Ron Gold. Gold sought a way to explain why people who knew the risks of contracting HIV continued to engage in those behaviors known to have the highest likelihood of transmitting the virus. He suggested that during the “heat of the moment” of sexual activity, such individuals convince themselves that their risk of infection is low. Gold later demonstrated that individuals could reduce future risk by examining their “self-justifications” in the “cold light of day” through an approach that involved the use of journal writing and a “sexual diary.”

The San Francisco researchers adapted Gold’s approach to HIV counseling by incorporating a focus on the identification and discussion of self-justifications into the standard two-session counseling model. This
“self-justification” session, conducted by a licensed mental health professional, occurred during an additional session between the standard risk assessment and results disclosure sessions. During this extra session, the counselor asked the client to think about a recent incident of unprotected anal sex and to complete a questionnaire of possible thoughts, beliefs, and attitudes that may have been in the client’s mind at the time the incident occurred. The goal was to identify and then discuss those specific thoughts, attitudes, or beliefs associated with the client’s decision to engage in that occurrence of high-risk sex.

Researchers randomly assigned clients to one of four groups. All groups received standard two-session counseling. The first group, a control, received standard counseling only. A second group also kept a 90-day sexual diary. A third group kept the diary and participated in an extra self-justification session. A fourth group received the self-justification session without the diary. Researchers recruited 241 men, ages 18–49, from anonymous HIV counseling and testing sites in San Francisco. Subjects had to have had at least one previous HIV-negative test at least six months prior and had to have had unprotected anal sex in the prior 12 months to be included. Ninety percent of the sample was White.

The study found that pairing standard counseling with either of two of the extra interventions—self-justification counseling alone or self-justification counseling plus diary keeping—resulted in significantly fewer client reports of unprotected anal sex. At the six-month follow-up, unprotected anal sex decreased by 45 percent in the self-justification-only group, compared with only a 14 percent decrease in the control group. At the 12-month follow-up, unprotected anal sex decreased by 40 percent from baseline in the self-justification-only group, compared with only 1 percent in the control group. When coupled with self-justification counseling, diary keeping also decreased risk, but not significantly.

The San Francisco researchers are undertaking a new investigation using the same intervention, this time with unlicensed but state-certified HIV antibody test counselors, in order to determine the feasibility of using paraprofessionals to implement the model.12 Until that investigation is complete, the study’s results—and the model’s value—are limited to licensed counselors.

**Quality Control**

While studies such as RESPECT demonstrate the value and efficacy of client-centered counseling, it is important to recognize that other perspectives are being articulated. For example, there have been some questions both about the need for test counseling and about the way the counseling protocols are carried out.5,13,14

In addition, and more significantly, the CDC and others have noted that some counselors at CDC-funded sites nationwide are not implementing the client-centered protocols.2,15-17 In its 2001 guidelines, the CDC notes that “client-centered” is often misinterpreted as meaning only “face-to-face,” and that counselors are not undertaking personalized risk assessments with clients;2 This is crucial, because improperly implemented counseling may be counterproductive.

Two studies have examined specifically whether the test counseling is implemented in a client-centered way. A 1998 study, published in 2002, evaluated program adherence to CDC guidelines in the areas of counseling, administering test results, referral, and quality assurance.15 The researchers, associated with the CDC, interviewed 51 counselors chosen as representatives of their clinics in 10 randomly selected states (the specific states were not named in the study’s results).

Researchers noted three key findings in the counseling arena. Clients talked less than counselors did; only 22 percent of respondents reported that clients spoke more in post-test sessions with HIV-negative clients and only 31 percent of respondents reported that clients spoke more in post-test sessions with HIV-positive clients. Counselors discussed clients’ individual risks only 68 percent of the time. Finally, only 61 percent of respondents said they negotiated a risk plan with clients in more than half of their sessions.

The second study, which looked at test counseling sessions in the San Francisco Bay Area in 1996 and 2003, had similar findings.16,17 The conversational analysis of 70 test counseling sessions found that sessions were often shaped by counselors’ data-collection responsibilities, rather than client needs; characterized by limited interaction between counselor and client; and defined by a fixed, not tailored, sequence of topics. In addition, they often did not address risk reduction.

**Conclusion**

Despite the belief that client-centered HIV test counseling is an effective prevention tool, few studies have successfully measured the effects and efficacy of specific counseling methods. Yet, the results of two rigorous studies—the RESPECT study and the self-justification study—suggest that current client-centered counseling approaches, especially as recently revised, do have significant capacity to reduce risks in a sustained way. Notably, both models focus on a particular risk event and specific risk reduction steps. RESPECT has proven that the essence of the CDC approach works, particularly when it is structured in this way. The self-justification study is a good example of innovation in response to the challenges of a particular population.

Other studies suggest that protocols alone do not determine the quality of counseling. The counseling and testing process has other goals, for example, collecting data that is crucial to tracking the epidemic. Without the sensitive implementation of all these goals within a client-centered context, even the most rigorously tested approaches can be undermined.
Implications for Counseling

The advent of the new “rapid,” single-session HIV test has inspired a re-evaluation of counseling and testing protocols. The result is a shift in how a client-centered approach, the primary tool of counseling and testing, is applied to HIV prevention counseling—both in the new single-session counseling and in standard (two-session) counseling. Many of the general principles of client-centered counseling—exploring the context of risk behavior, individualizing counseling sessions, offering more than information about prevention, and recognizing the limited role of the counselor—are reemphasized in the evolving counseling guidelines.

Yet, two key changes in the counseling session—focusing on a specific risk incident and identifying a single step for behavior change—narrow the scope of counseling. This narrowing increases the likelihood that counselor and client will identify a key source of risk and an effective risk reduction strategy. For many counselors, these changes may require the development of new skills; for others, the approach may confirm practices they are already using with clients.

Individualizing Sessions

One of the key principles of client-centered counseling is to individualize the session to a client’s specific needs, risks, and questions. This principle is highlighted in newer approaches to counseling and testing. Counselors individualize sessions in several ways. First, they recognize that information alone does not change a person’s behavior. Second, they design interventions to fit the personal circumstances of the client. Third, they listen for and identify with the client the behaviors that put him or her at greatest risk for acquiring HIV.

While the focus is on identifying client concerns and building client motivation to change risk behaviors, there is still a role for “health education,” that is, for ensuring that clients have the correct information about risk behaviors. Counselors use health education to help a client understand what levels of risk might be personally acceptable for him or her. A counselor might say, “The activities that you say are comfortable for you put you at some risk of HIV infection, but you also say that you are concerned about getting HIV. I would like to understand how you balance these competing feelings. Can you tell me more?”

Identifying a Specific Risk Incident

Focusing on the most recent risk incident helps individualize counseling sessions by personalizing interventions toward behaviors that are most likely to put the client at risk. For example, a counselor might ask, “When was the last time you might have put yourself at risk for HIV? What was happening then?”

It is also important to remember that it will help the client most if the incident is not merely recent, but also reflects a behavior that is most likely to lead to HIV transmission. A good example of this distinction is a client who was the insertive partner during oral sex the night before the session but who had been the receptive partner during unprotected anal sex two weeks earlier. The most helpful counseling for this client would be to focus on the anal sex incident.

A Counselor’s Perspective

“The client is the expert on his or her own risks and readiness to change. As a counselor, I can help that client figure out where to start, and what obstacles he or she face when approaching the process of a change.”
For example, the counselor might say, “It sounds like during both of the times when you might have been exposed to HIV, you were high on cocaine, were out with new partners, and had had a tough week at work. Does using cocaine influence your decisions to have sex without a condom?”

It is helpful to note and affirm attempts clients have already made to protect themselves. A counselor might observe: “You said that sometimes with new partners, you do use a condom. Tell me about the last time that happened. How was it different than the other two times we talked about?” These questions paint a clearer picture of the circumstances in which the client might be successful in reducing risk and give the counselor a chance to affirm and build on the client’s existing risk reduction skills. They may also enable the client and counselor to explore potential obstacles to risk reduction. The counselor might ask, “Are there certain guys you feel less comfortable talking to about using condoms?”

The process of asking about a particular risk incident and its context relies on many of the same skills that counselors have always applied to assess the client’s risks. But, instead of attempting to reveal a complete picture of every risk, it focuses on one risk and understanding this behavior more fully.

After discussing context, counselors summarize the risk situations and patterns the client has shared: “It sounds like some weeks when you are really stressed out after work, you get high and go out to the bar. When you meet a guy, if he seems a lot younger than you, you don’t insist on using a condom, because you figure he’ll just find someone else. On the other hand, there have also been times you have used condoms with new partners and had a great time. At those times, you actually felt a lot less stressed because you didn’t worry about HIV afterwards.” These explorations and the focusing process help the counselor and client move toward the next phase of the counseling session: planning an achievable step.

Planning an Achievable Step

One of the goals of client-centered HIV counseling has always been to work with clients to develop a comprehensive risk reduction plan or goal. The evolving counseling approach, however, advocates negotiating a realistic, incremental step. This is particularly important in terms of single-session counseling, when counselors will not be able to follow up with clients in a future disclosure session. Because every significant behavior change is made up of a series of steps, helping a client identify the first step towards change could increase the likelihood of his or her following through.

Dividing long-term goals and plans into smaller incremental steps can reduce the likelihood that a client

A Counselor’s Perspective

“It’s important that the client leaves the session with something he or she can use in the moment—when he or she is negotiating sex or about to use drugs or whatever the behavior is.”

### References

Case Study

Tanya is a single, White, heterosexual woman in her thirties, who chooses to take a rapid HIV test. When her counselor, Nina, moves Tanya toward discussing a specific risk incident, Tanya shares that while she usually uses condoms with men she does not know well, she had unprotected vaginal sex about two months ago with a guy she had met at the club. “You don’t have to tell me,” Tanya says, “I know, ‘use a condom every time’.”

Counseling Intervention

Nina asks Tanya what she was feeling and thinking when she met the guy at the club, whether Tanya went to the club alone, and how much Tanya had to drink or use that night. “I had gone to the club by myself,” Tanya responds. “I think when I saw him I just felt like—I’ve been so good, everybody has to take a break sometimes. Plus, I was feeling pretty lonely and didn’t want to go home alone that night.”

After more discussion, Tanya realizes that she responds to feeling lonely by going to a bar. Further, if she meets an especially attractive man, she sometimes avoids bringing up the subject of safer sex.

Nina also acknowledges Tanya’s familiarity with safer sex guidelines. She asks: “What is it like to be here testing, feeling like you have “heard it all before,” the use-a-condom-every-time message?” Tanya smiles sheepishly and replies, “It’s been frustrating and, I guess, a little embarrassing. I am really good at making the decision to be safe and I do follow through most of the time. This is the first time that I really got it that when I am lonely, it all goes out the window. But, I don’t think hearing about condoms all over again is really going to help.”

Nina smiles and says, “It is so important—and great—that you recognize your risk and the ways you can protect yourself. At the same time, it’s true that for most folks that the message “use condoms” is just a starting point. You’re right that knowing that doesn’t magically make it happen for any of us.”

Nina talks with Tanya about how she might handle the situation differently in the future, drawing on Tanya’s past successes, then asks, “What’s one small thing you could do to decrease your risk for HIV?” Tanya reflects that going to the bar alone when she feels lonely “sets me up” for unsafe sex. “Next time, I could go to the bar with a girlfriend. I could even tell her not to let me go home with anyone! And I can make sure I have condoms just in case I decide to have sex after all.”

Nina acknowledges that this sounds like a good idea, and asks Tanya if there are any potential problems with the plan. When Tanya says that she is worried about “laying down the law” with the guy, Nina and she role play a situation with an attractive man.

Nina congratulates Tanya on the work she has done in the session. Nina also acknowledges that the session can’t cover everything: “I know we haven’t had much time to talk about some other things that are going on for you. Sometimes it can help to talk more about things like feeling lonely. Can I offer you some counseling referrals in case you’d like to talk more?”

will feel overwhelmed. A client’s success in achieving this step may increase his or her motivation to attempt additional steps in the future. Finally, a single step is more likely than a whole plan to build on past successes and acknowledge past obstacles.

The Stages of Change—from precontemplation to maintenance—remain central in the evolving approach. Not only do clients differ significantly from one another in their readiness to change risk behaviors, but also a single client may be at different stages regarding different risk behaviors. To help locate an area for which the client is “ready for action,” a counselor might ask, “Given the concerns that you have shared with me today, what can you imagine yourself doing to reduce your risk for HIV? What’s one small, achievable step you could take to begin the process of changing the behavior that concerns you?”

The client in the example above, having identified work stress, cocaine use, going to the bar, having sex with younger guys, and fear of rejection as aspects of his “context” for unprotected sex, might come up with several options. He might think about alternatives such as: using another support for his work stress, staying home when high, reducing his cocaine use, selecting partners he feels more comfortable negotiating safer sex with, deciding he is only going to have oral sex or masturbate with younger guys, or developing a backup plan in case he is rejected sexually.

The step the client identifies is likely to be the one he or she is ready to take. To improve the client’s chances for success, counselors and clients can identify obstacles and brainstorm solutions. For example: “How would you go about making this step happen? What would you need to do first?”
Test Yourself

Review Questions

1. There have been rigorous studies of which two counseling and testing approaches: a) self-justification and the original CDC protocol; b) the original protocol and the RESPECT protocol; c) the RESPECT protocol and the self-justification approach; d) the Kinsey protocol and the self-justification study.

2. The CDC recommends all but the following in test counseling situations: a) individualized counseling sessions; b) counselors clearly asserting their opinions about a client’s risk-taking decisions; c) negotiating one small, achievable risk-reduction step; d) clear language when discussing risks and results.

3. True or False: Hundreds of HIV-positive clients in California do not return for their test results.

4. Research has found that HIV counseling and testing is effective in reducing sexual risk behavior in what sorts of clients: a) people who have tested HIV-negative; b) people who have tested HIV-positive; c) people who come in for counseling and then do not take the test; (d) all of the above.

5. True or false: It is ideal to focus on a client’s risk over the year prior to counseling in order to define the full range of a client’s behaviors.

6. Creating an achievable step to reduce risk reduction might be accomplished by: a) breaking down a comprehensive plan into all the steps it will take to achieve it and then organizing them for the client to follow; b) asking a client about a small action he or she could take to begin changing his or her behavior; c) ignoring any steps the client has already taken to reduce risk in order to focus on future efforts during the limited time of the counseling session; d) working with the client to figure out how he or she can stop all risky behaviors.

Discussion Questions

1. In what ways has client-centered counseling been more effective than education-only sessions?

2. What are the barriers to client-centered counseling and how can a counselor overcome them?

3. What parts of the counseling and testing protocol are easiest to implement, and which are most difficult?

4. In what ways does focusing on a specific risk incident or a single risk reduction step complicate or ease counseling?

5. How might a counselor help a client who identifies “always use condoms” as a goal to break this down into a more realistic, achievable steps?

6. How does knowing the context of a client’s risk behaviors help in creating behavior change?

Answers

1. c.
2. b.
3. True.
4. b.
5. False. It is better to focus on a client’s most recent risk incident, not on hypothetical risks, their whole history of risk, or even risks from the prior year.
6. b.
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