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PREVENTION WITH PEOPLE WITH HIV

Over the last few years, prevention interventions aimed at people with HIV have become central to stemming the spread of the epidemic. This shift offers both opportunities and challenges to HIV counselors. This issue of PERSPECTIVES reviews the research on prevention with people with HIV, focusing in particular on motivators for reducing risk in people who already have HIV and on the social forces that may undermine risk reduction. It also discusses how to help clients understand the ways in which having HIV changes the challenge of protecting themselves as well as others.

Research Update

Many of the estimated 850,000 to 900,000 people living with HIV in the United States are living longer, healthier lives thanks to successful HIV antiviral treatment. Improved quality of life has led to many outcomes, including enhanced emotional health, heightened capacity to participate in pursuits such as work or school, and increased sexual activity. While the majority of sexually active HIV-positive people express and fulfill a responsibility to protect others from HIV transmission, some are unable to achieve these goals and a smaller number may be consciously engaging in unprotected sex.

Some studies have found that as many as 60 percent of samples of people with HIV who know of their serostatus may be engaging in sexual behaviors that can transmit HIV. Some are unable to achieve these goals and a smaller number may be consciously engaging in unprotected sex.

In response, over the past decade, HIV prevention approaches have shifted from an almost exclusive focus on HIV-negative people and how they might protect others from HIV transmission, some are unable to achieve these goals and a smaller number may be consciously engaging in unprotected sex. An analysis of the sexual habits of 322 HIV-positive men who have sex with men found that 36 percent had unsafe receptive anal sex with an HIV-negative or HIV status-unknown partner. Further, 31 percent engaged in unsafe insertive anal sex, the most risky behavior for their receptive partners.

A study of 112 HIV-positive men who have sex with men who are HIV-positive found that 84 percent had engaged in intentionally unprotected sex: 49 percent only with other HIV-positive men, 49 percent with HIV-positive and HIV-negative men, and the other 2 percent only with HIV-negative men.

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Altruism as Motivator

There is both a desire and an attempt by the majority of people engaged in unsafe insertive anal sex, the most risky behavior for their receptive partners. A study of 112 HIV-positive men who have sex with men seeking other men through internet sites found that 84 percent had engaged in intentionally unprotected sex: 49 percent only with other HIV-positive men, 49 percent with HIV-positive and HIV-negative men, and the other 2 percent only with HIV-negative men.

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with HIV to decrease participation in behaviors that may transmit HIV and other STDs. Studies indicate that HIV-positive people feel a responsibility to protect others. For example, a study of 250 HIV-positive men who have sex with men in New York City and San Francisco found that 66 percent of participants identified a “self-perceived responsibility” to protect their sexual partners. The other third of the sample located responsibility either with their partners alone or as shared by themselves and their partners. The majority of the HIV-positive participants were motivated to protect their partners and themselves by “altruism,” “self-standard,” defined by ethical, moral, and religious beliefs, and “self-interest,” including avoiding feelings of guilt.

Health Risk as a Motivator

Before the institutionalization of “prevention with positives,” the primary HIV prevention message was that HIV-negative people needed to take responsibility for protecting themselves. But, to facilitate the role HIV-positive people might play in HIV prevention, the message must extend beyond the risk of contracting HIV.

While many messages for people with HIV focus on the responsibility to protect their partners, some have focused on the fact that the behaviors that may transmit HIV to others may also pose health risks for people already infected. In particular, certain sexual behaviors can lead to co-infection with other STDs, such as gonorrhea and chlamydia, and to the possibility of HIV superinfection. In addition, injection drug behaviors can lead to co-infection with hepatitis C.

People with HIV infection may experience more serious STD and hepatitis C manifestations, greater pain associated with STDs, and more difficulty treating STDs and hepatitis C. Once a person with HIV is co-infected, STD infection can increase the risk of transmitting HIV to a partner for several reasons. These include: increased shedding of HIV in the genital tract (caused by STDs such as gonorrhea and chlamydia), increased HIV viral load, and conditions such as sores, lesions, or tears, which increase the odds of HIV transmission (caused by STDs such as genital warts, herpes, and syphilis). STD treatment can reduce the infectiousness of a co-infected person by decreasing viral load and HIV shedding.

A person may also be co-infected with HIV itself, that is, he or she may be infected with two different strains of HIV. In this context, the term “co-infection” refers to two strains of HIV contracted at the same time during initial infection. If a person who already has HIV is then infected again at a later date with a second strain of HIV, he or she is said to have been “superinfected.” (In the research literature, this phenomenon is sometimes referred to as “reinfection,” but technically, reinfection implies that a person has overcome infection and then been infected again.)

Superinfection needs further study to determine its prevalence, which is currently unknown, and to confirm its health consequences. It appears that superinfection is rare, but recent case reports suggest that it may be more common than previously believed. Superinfection has been linked to significant health consequences, including elevated HIV viral load, reduced CD4+ cell count, and enhanced disease progression.

Further, the second strain may be resistant to one or more specific HIV antiviral drugs, including ones that the person has been successfully using. A recently published study of 31 HIV-positive subjects followed for up to seven years identified the first documented case of multi-drug resistant HIV superinfection. Such findings challenge the assumption that immune responses can protect against reinfection (superinfection). A review of the literature on this topic also supports this conclusion.

Public health officials suggest that, given the limited understanding of these phenomena, counselors should alert HIV-positive clients about the possibility of superinfection if they engage in behaviors that can transmit the virus with other HIV-positive individuals. Counselors should avoid overstating the risk, especially since the extent of this risk is unknown, but should seek to offer limited information.

Social Forces Undermine Risk Reduction

Despite both altruistic and health motivations to protect others and to protect themselves, people with HIV face complex barriers to effective decision making and risk reduction. These barriers help to explain the disparity between the desire and the ability to reduce risk and suggest prevention interventions.

According to the CDC, social challenges, including stigmatization, homelessness, mental illness, substance abuse, domestic violence, and economic stressors, “may adversely affect HIV-positive persons, decreasing their ability to obtain and adhere to proper medical care or to reduce their HIV risk behaviors.” Further, prevention interventions may be limited by the very social forces that had a role in a person’s initial infection: “The environmental factors that encourage sexual risk-taking remain largely unchanged for infected people and may foster unsafe sex after the seropositive diagnosis.”

Counselors should seek to avoid overstating the risk of superinfection, especially since its extent is unknown, but should seek to offer limited information about the phenomenon.
In his Sociocultural Model, psychologist Rafael Diaz identifies oppressive factors, including homophobia, family loyalty, sexual silence, poverty, racism, violence, and a history of sexual abuse that may impede an individual’s ability to reduce risk.20 These psychosocial forces may create difficulties for people with HIV, ranging from loneliness and social isolation, through lowered self-esteem, sexual discomfort and diminished perceptions of sexual control, to depression, hopelessness, anger, and powerlessness. Such challenges may undermine an HIV-positive person’s ability to embrace or negotiate safe behavior and make health-affirming choices. In response, prevention efforts must ultimately address these societal issues.

Self-Efficacy, Coping, and Change

The web of psychological challenges and complications HIV-positive people face can result in diminished self-efficacy.4,7,9,10 For HIV-positive people, the resulting loss of self-empowerment can lead to decreased sexual communication, which can result in less frequent condom use, poor or no sexual negotiation, and less frequent disclosure of serostatus to sexual partners.9 Low self-esteem and negative expectations, including the fear of being stigmatized for being HIV-positive, may undermine the ability to reduce risk.

For example, a person with HIV may be reluctant to ask a partner to use condoms or to disclose his or her HIV-positive status to a partner, fearing sexual or interpersonal rejection, or violence.24,7,8,11

“Negative mood states” such as depression and loneliness can also undermine risk reduction.10,11,21,22 Rates of depression are higher in the populations most affected by HIV than in the general population, and some studies have found higher rates among people with HIV compared to their HIV-negative counterparts (although these studies do not suggest that depression is caused by HIV).23 Depression may also compromise decision making regardless of a person’s HIV serostatus, but some people living with HIV describe depression and fear of rejection as “reducing their sense of personal responsibility and making them less willing to disclose their HIV status and more willing to have unprotected sex.”11

Additional factors that may contribute to an HIV-positive individual’s inability to reduce his or her risky behavior are: avoidant coping (including behaviors such as distancing and avoidance rather than more active coping methods);10 substance use;4,9,11 the belief that condoms decrease pleasure;4,10,24 and the fear that risk reduction will result in a loss of intimacy with partner(s).4,25

Couples of Mixed HIV Status

Mixed HIV status couples face additional challenges that may undermine risk reduction. These “unique stressors” include heightened fear of HIV transmission, fears of anticipated illness and death of the HIV-positive partner, difficulty maintaining sexual intimacy and sexual satisfaction, disclosure of individual and couple HIV status to friends and family, feelings of isolation, and uncertainty about the future.25

A study of 75 mixed status couples identified factors that most related to levels of distress: relationship satisfaction, sexual satisfaction, coping style, and partner support.25 Researchers found that interventions that counsel the couple together and focus on improving “positive” communication, validating concerns and fears, strengthening support systems, and increasing relational and sexual intimacy may “reduce distress and increase individual feelings of well-being.”25

Some mixed status couples are gauging the need for unprotected sex based on an HIV-positive partner’s viral load and studies that suggest it may be less likely to transmit HIV when viral load is below the level of detection.22 However, current data suggest that these findings may not be reliable and that a person’s viral load is not necessarily an accurate guide to transmission risk.16 Viral load varies from hour to hour, and the viral load in the blood does not necessarily match the viral load in the rectum or semen. Further, the presence of an STD can increase a viral load once thought to be below the level of detection.16

Interventions for People with HIV

The goal of interventions with people with HIV is not only to encourage behaviors that reduce the risk of HIV transmission, but also to attend to other health and wellness goals. Risk reduction can be achieved through a variety of approaches, including barrier protection for sex, cleaning needles and works during needle sharing, reducing the number of sexual partners, and changing the types of sexual or drug use behaviors to ones that are less likely to transmit HIV. It has been assumed as a given that among people with HIV, disclosure of HIV status to sexual and needle-sharing partners is the first step to any risk reduction.

A recent review of the literature on disclosure, however, concluded that the relationship between disclosure and risk reduction is unclear: the 15 published studies that offered adequate data from which to draw
conclusions yielded inconsistent findings.° Eleven of the articles revealed a relationship between disclosure and an increased likelihood of protective behaviors, such as condom use or fewer sexual partners, however, four studies did not find a significant correlation between status disclosure and a reduction in behaviors that transmit HIV.

The review theorizes that disclosure may sometimes simply shift the responsibility to reduce risk from the disclosing HIV-positive partner to the other partner, who may be willing to accept this risk. Further, disclosure may lead to “adverse reactions” such as rejection, violence, and discrimination. The review observes that while there may be a relationship between disclosure and risk reduction, the research literature has not yet clarified this relationship. It concludes that the consensus is that risk reduction may result less from disclosure of serostatus and more from open communication and agreements about protection.

Interventions focused on increasing communication and negotiation skills, by improving self-efficacy and self-esteem, have been successful. One of the first studies looking at this process followed 332 HIV-positive men and women who received an intervention based on Social Cognitive Theory that included the following goals: developing skills to cope with HIV-related stressors and sexual risk-producing situations; enhancing decision-making skills for disclosing HIV serostatus to sexual partners; and facilitating the development and maintenance of safer sex practices by having participants identify barriers to communication with and disclosure to sex partners and then problem-solving these barriers and role-playing solutions. The intervention also included a discussion of the health risks of unprotected sex, for example, HIV transmission to others, STD co-infection, and HIV super-infection. Those who completed the intervention showed a significant decline in unprotected intercourse: the study found that increased self-efficacy and improved safer sex negotiation resulted in changes such as more frequent condom use.

Two 2003 studies—which used strategies such as teaching negotiation and communication skills, role playing, and problem solving—improved self-efficacy, increased positive outcome expectations, and enhanced knowledge of risk factors. Other techniques include teaching proper condom use, using motivational counseling to reinforce attempts to change behavior, and addressing substance abuse and relationship issues such as communication and intimacy. Nurturing “resiliency factors” can also help HIV-positive people develop effective coping mechanisms. Diaz suggests fostering the following factors: family acceptance; social and sexual satisfaction; social/political networking and activism to instill a feeling of belonging and community; and the existence of HIV-positive role models. Most importantly, counselors must tailor plans to individuals so clients can successfully transfer their new skills into their particular social settings. Learning strategies in the context of supportive counseling is very different from following through on harm reduction plans in the heat of the moment.

Counseling People with HIV

HIV counselors may face challenges when counseling HIV-positive clients, particularly since counselors are accustomed to undertaking prevention interventions with HIV-negative clients. Basing its work on the research literature—in particular, on the finding that possessing a positive, satisfied feeling from sexual relationships, without shame, guilt, or discrimination, can result in a decrease in behaviors that transmit HIV—the UCSF AIDS Health Project developed a training course on positive sexual health and prevention.

According to the World Health Organization (WHO), positive sexual health views “sex as a restorative act that can foster self-esteem and increase the ability to control sexual situations.” How can counselors empower people so they feel able to negotiate healthy, protective behaviors? First, counselors need to be comfortable in order for their clients to be comfortable. To foster their own comfort, counselors should educate themselves about the value of prevention with people with HIV and recognize their own prevention-related feelings and values particularly regarding prevention with people with HIV. Self-awareness enables counselors to understand and reduce their own barriers; this allows them to embrace a client-centered and non-judgmental position.

Likewise, counselors should seek to increase their comfort in bringing up sexual issues with clients. Research shows that some counselors are uncomfortable talking about sexual practices, and they may have an even greater level of discomfort when speaking with people with HIV who are sexually active.

Counselors are well-advised to develop an open, honest, and supportive rapport with all clients, and especially with HIV-positive clients given the understandable reluctance of some of these individuals to disclose information. Likewise, counselors can seek to appreciate the powerful environmental forces that can influence poor decision-making, rather than seeing behavior as related simply to their clients’ “personal deficiencies.”

According to WHO, “Sex is a restorative act that can foster self-esteem and increase the ability to control sexual situations.”
**Implications for Counseling**

The primary goal of counseling sessions with clients who receive an HIV-positive test result is to focus on emotional responses to the result, clarify immediate steps a client might take, and help clients integrate the knowledge of their serostatus. This focus may make it difficult for counselors to broach prevention-related issues. It is helpful, if possible, to introduce the practical prevention concerns that will be part of a client’s long-term experience of living with HIV. At the very least, counselors should seek to provide referrals to services that can help clients sustain their sexual health and injection safety.

Testing HIV-positive changes a person’s relationship to behaviors that can transmit HIV. Concerns usually shift from avoiding HIV infection to confronting other sexual or injection-related health issues, including: the consequences of infection with other STDs or injection-related infections, the possible risks from HIV superinfection, and the possibility of infecting a sexual or injection partner. In response, counselors should be prepared to help HIV-positive clients articulate their self-defined sexual health and injection safety goals and options.

**Co-Infection and Superinfection**

While some clients may see other STDs as insignificant compared to their HIV infection, STD co-infection represents a key health risk to people with HIV because these infections can complicate HIV-related treatment and exacerbate HIV disease. Similarly, superinfection—the acquisition of a second strain of HIV—while much rarer than STD co-infection, has potential health consequences including increased HIV viral load and HIV progression, reduced CD4+ cell count, and disrupted HIV treatment.

Help clients understand basic information about these risks to their health. Refer clients with more complex concerns about these issues to an HIV-knowledgeable medical provider.

Clients who wish to prevent STD co-infection or HIV superinfection can employ strategies that are similar to those recommended for people seeking to avoid HIV infection. For example, they should use condoms for some sexual activities and needle exchange or cleaning during injection drug use.

**Reducing Harm to Others**

For some HIV-positive clients, quality of life issues—including the freedom to engage in sex or substance use that is satisfying—may take precedence over concerns about either STD co-infection or HIV superinfection. These clients may still wish to protect HIV-negative partners from HIV transmission. A key tool for discussing such harm reduction options is the hierarchy of risk, both in terms of behavior and partner type. The hierarchy of risk is different for HIV-positive people compared to HIV-negative people.

For instance, a man who has sex with men who tests HIV-positive may consider engaging more often in receptive anal sex, because this activity poses less risk of HIV transmission to a partner than insertive anal sex would—although it is important to keep in mind that for many people what they enjoy sexually is not as flexible as the variety of available options. Similarly, an individual may reduce harm by limiting partner type, that is engaging in behaviors that are more likely to transmit HIV only with partners who are already HIV-positive.

In both of these instances, a client may be willing to accept other risks. For example, when changing sexual activity, a client may risk STD co-infection, which may accompany unprotected receptive sex with partners of any serostatus. When changing partner type, a client may risk superinfection, which may accompany unprotected sex with HIV-positive partners.

Clients who envision beginning HIV antiviral treatment may imagine that a resulting drop in viral load to below the level of detection may enable them to reduce harm to their partners without significantly altering behavior. Some research supports this belief, but the approach may be a less reliable prevention strategy than it seems. Viral load changes from hour to hour, it is different in the blood (which is the source of viral load readings) and the semen, and it can increase should a person contract another STD. Again, counselors should consider referring clients who are thinking about using reduced viral load as a preventative measure to an HIV-knowledgeable medical provider.

**Disclosure and Negotiation**

Disclosing HIV infection to partners can be useful in HIV prevention. Recent research, however, suggests that other factors may relate more to successful risk reduction and that disclosure of HIV status, alone, may not change the behaviors in which partners engage.

Disclosing HIV-positive status—whether to partners, or to family, friends, or colleagues—may occur over time as a person adjusts to his or her status and assesses how safe it might be to reveal it. For someone with HIV, particularly someone newly diagnosed, the prospect of immediate disclosure to partners can be overwhelming and may be complicated by stigma, shame, and fear of rejection. Normalize these responses by explaining that such concerns are common among HIV-positive people.

The disclosure process also relies on sound communication and negotiation skills. Upon testing HIV-positive, this communication process may become even more difficult.
client’s past experience discussing sexual behavior and HIV risk with partners may be a guide to a client’s comfort and skill in this area.

Some clients may believe that it is not necessary for them to disclose their HIV status to partners, especially if they are engaging in safer sex. Others may turn to counselors for universal rules or guidelines for disclosure. Still others may want the flexibility of being able to evaluate whether or not to disclose on a case-by-case basis with partners. Encourage clients to consider what it might be like to disclose, including identifying the benefits and drawbacks that may come with each type of disclosure. Explain that clients may not need to disclose their HIV status in every sexual situation, and help clients develop criteria for determining when to disclose, based on their beliefs and the science of transmission.

Some clients may be anxious about having transmitted HIV to partners before these clients became aware of their status. Counselors can offer these clients referral to testing services for their partners in the areas where these partners live. Counselors can also refer clients who are uncomfortable disclosing to these partners to partner notification and referral services. These services contact and disclose to a client’s former sex or injection partners, without identifying the client.

**Concerns for Clients in Couples**

Clients in primary relationships may face many challenges after one partner tests HIV-positive—whether or not the other client is HIV-negative. These concerns may range from guilt for bringing HIV into the relationship and fear of having infected an HIV-negative partner to anger towards HIV-positive partners, who may have been the source of the infection. Conversely, a client may feel greater intimacy or identity with a partner who is HIV-positive.

Unlike the decision about whether to disclose serostatus to facilitate risk reduction, there may be many other reasons for clients to decide to disclose seroconversion to primary partners. Not disclosing may risk the couple’s emotional intimacy and the relationship’s foundation of honesty. On the other hand, counselors should never assume that disclosure is always necessary for them to disclose their HIV status. Counselors can offer these clients referral to testing services for their partners in the areas where these partners live. Counselors can also refer clients who are uncomfortable disclosing to these partners to partner notification and referral services. These services contact and disclose to a client’s former sex or injection partners, without identifying the client.

**References**


Case Study

Joe is a 28-year-old gay man who has just tested HIV-positive. During the disclosure session, he tells his counselor, Nora, that he is sad but not surprised. “I’ve prepared myself for this,” he adds. Although Joe’s immediate concern is for obtaining medical help, he says he is open to discussing HIV prevention. Joe also has a history of combining alcohol use with sex.

Counseling Intervention

After providing Joe with referrals to a couple of medical providers who are knowledgeable about HIV, Nora asks him to talk about his prevention concerns. Joe sighs and says he is worried about infecting his partner, Jason.

Nora validates Joe’s concern and asks him what he currently does to reduce his risk. Joe says he and Jason use condoms occasionally. Nora asks Joe if he thinks he’ll want to continue to use condoms now. “Definitely!” he says, “I don’t want this to happen to Jason.”

She continues, “Are there times when you and Jason have found it easier to use condoms?” “I don’t know,” Joe replies. “Actually, we do use them more when I am the top. I’m kind of . . . rough, and it makes sense. The problem is that if we’ve been drinking, I forget to use them, and it’s when we’ve been drinking that he usually wants to be the bottom.”

Nora observes, “I think I get it, Joe. It sounds like you are saying that when you’ve been drinking, you are more likely to top and more likely to forget to use condoms. Is that accurate?” Joe responds, “Yeah, I guess it is.” Nora then talks about Joe’s drinking and its relationship to his behavior. She offers a counseling referral, which Joe takes, expressing some hopefulness.

Nora asks Joe whether he is interested in topping less often or not at all as a way of protecting Jason. Joe says “Yes.” He adds, “But I am not sure about Jason. He’s not as flexible as I am about it.”

Nora reminds Joe that Jason is still at risk if they don’t use condoms and if Joe is the bottom, but that Jason’s risk is lower in this case than it would be if Joe were the insertive partner. She also points out that Joe might be at risk of contracting an STD infection if Jason tops without using a condom and if Jason has sex outside the relationship. Joe responds, “I guess we could try to use condoms more, but at least I know I’m protecting Jason if I’m the bottom. That’s more important than protecting me.”

Nora then says, “Okay, it sounds like you are really committed to protecting Jason and that one way to start to do this is to make sure that you are the bottom.” Nora asks, “What step might you take after you leave here that will help you carry out this commitment?”

Joe responds that he is thinking about doing three things: talking with Jason, bottoming more, and using a condom when he tops. Nora asks if Joe thinks Jason will support him in this commitment, or if this will be a problem if Jason wants to drink. Joe responds, “I guess I have to tell him about turning positive . . .”

Nora picks up on this and says, “Do you want to tell Jason?” Joe says, “Yes, I do. But it’s going to be hard.”

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Nora picks up on this and says, “Do you want to tell Jason?” Joe says, “Yes, I do. But it’s going to be hard.”

Nora assesses the possibility that Jason will react in harmful ways to Joe’s disclosure. After Joe states that Jason has never reacted harmfully or abusively, Nora asks, “Would it help if we tried out the discussion. I could pretend I am Jason.” Joe agrees, and the pair role-play several responses Jason might have, including the possibility that Jason will be concerned that Joe has infected him.

Nora provides Joe with a referral to a counselor for more support for Joe and for the couple. Finally, Nora confirms that Joe has a source of immediate support.
Test Yourself

Review Questions

1. True or False: The majority of HIV-positive people feel a responsibility to protect themselves and others.

2. If an HIV-positive person engages in behaviors that can transmit HIV, he or she could: a) become co-infected with an STD or hepatitis C; b) become superinfected with a second strain of HIV; c) transmit HIV to a partner of any serostatus; d) all of the above.

3. True or False: If an HIV-positive person becomes co-infected with an STD, his or her health is permanently affected.

4. A common consequence of the stigmatization, violence, and rejection some people with HIV face is: a) increased number of sexual partners; b) decreased self-esteem and self-efficacy; c) suicide; d) abstinence.

5. True or False: Individuals in mixed HIV status relationships should avoid counseling in order to ensure the HIV-positive partner’s confidentiality and should stop being intimate in order to ensure the HIV-negative partner’s safety.

6. True or False: Disclosure is the best way to reduce behaviors that can transmit HIV.

7. Resiliency factors that can help an HIV-positive person face challenges and obstacles include all of the following except: a) finding an HIV-positive role model; b) being a part of his or her community, for example, through political or social activities; c) increasing social and sexual satisfaction; d) removing him or herself from social interactions.

8. True or False: Problem solving and role-playing can help clients reduce their fears and increase their self-esteem.

9. True or False: Sex can be a “restorative act” that can increase self-esteem.

Discussion Questions

1. Should prevention efforts continue to focus on HIV-positive people? In what ways might prevention interventions evolve to be more effective with people with HIV?

2. Does responsibility for harm reduction rest on the shoulders of the HIV-positive person, the HIV-negative person, or both?

3. Can couples of mixed status maintain sexual intimacy? How?

4. How might a counselor respond to a client’s concerns about HIV superinfection if the counselor is not up to date on the latest research?

Answers to Review Questions

1. True.
2. d.
3. False. Successful STD treatment can eliminate the effect of an STD on HIV viral load and infectiosity.
4. b
5. False. Couples counseling can help partners figure out ways to support each other and partners can improve their relationships by focusing on increasing communication, intimacy, and support.
6. False. Studies are inconsistent in their findings, and there is reason to believe that disclosure alone does not lead to risk reduction, even though disclosure may be a component of risk reduction.
7. d.
8. True.
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