Research Update

To understand behavior change, it can be useful to understand theories that explain the process of change. One of these, the Stages of Change continuum theory, is especially relevant to the work of HIV test counselors and is being used increasingly in test counseling sessions.

The Stages of Change continuum theory views change as part of a process that occurs incrementally over five stages. Applying this model, HIV counselors most often would deal with helping clients make small changes in knowledge, attitudes, and behaviors. The Stages of Change model is consistent with the behavior change concept of “harm reduction.” Harm reduction acknowledges that complete elimination of risks is unrealistic for many people. Therefore, it focuses on taking precautions to lessen the risks for infection and the frequency with which one engages in risky behaviors.

The Stages of Change theory is also useful because it recognizes that numerous factors influence behavior and affect a person’s motivation. This article explores these factors and personal motivation, then evaluates the role of various prevention efforts in leading to behavior change.

Factors Leading to Unsafe Behaviors

Researchers have cited the following factors as influencing a person’s decision to engage in risk behaviors for HIV infection:

Ignorance of Personal Risk. Sometimes, people do not have accurate knowledge of HIV infection risks, or they do not recognize that risks apply to them. People may engage in unsafe behaviors because they have received unclear information or they may not consider themselves to be part of a “high-risk group.” In addition, a person might understand the need to use a condom, but not be aware of the need to use a latex, instead of natural-membrane, condom, or water-based, instead of oil-based, lubricant.

Enjoyment. The desire to engage in risky behavior often stems from the pleasure a person derives from sex or drug use. Many people report that safer forms of sex are less enjoyable. For people who inject drugs, the complicated measures required to clean their needles—particularly when clean water and bleach may not be available—can inhibit their ability to use drugs.

Significance of Behaviors. Risk behaviors often carry a symbolic or personal meaning. Especially for young men who have only recently identified themselves as homosexual, changing behavior is often a difficult task. Changing HIV risk behaviors can be especially difficult. This issue of PERSPECTIVES reviews factors that contribute to risky behavior, the role of motivation in behavior change, and the effectiveness of various prevention efforts. The Implications for Counseling section looks at stages of behavior change and applies these to strategies that counselors can use to support clients in reducing their risks for HIV infection.
ual, unprotected sex can be a way to experience what some identify as a “basic and fundamental aspect of gay sexuality.” In addition, condoms have a negative association in some cultures that particularly value having children, and may communicate distrust of potential partners.

When the personal significance of an activity outweighs someone’s concerns of becoming infected, this person may see HIV infection as acceptable or inevitable.

Social Norms. Peer pressure and perceived attitudes toward high-risk activities help reinforce unsafe behavior and create a barrier to change. Young people who are strongly influenced by their peers and who are often unaware of their own mortality can be especially susceptible to messages from their friends that safe sex is not “cool” or that only older gay men get infected with HIV.

Lack of Skills. Many people feel unable to discuss and negotiate safer sex. A commitment to avoid a risk behavior may be undermined when someone is in a potentially risky situation and does not feel capable of insisting on safer behaviors.

Psychological Issues. People who are depressed or have low self-esteem may not have enough concern about their own health to take steps to avoid infection. They may also feel unable to assert themselves in a risky situation, because they may fear rejection. Conversely, people whose self-esteem appears overly inflated might see themselves as invulnerable to becoming infected or infecting others.

Habit. As with any habit, a pattern of sharing needles or having sex without a condom may be difficult to end, even if a person wishes to end it. Research of habit-forming behaviors consistently finds that the return to risk behavior is associated primarily with the intensity and frequency of the behavior in the past. By the time a person seeks HIV testing, he or she may have established a pattern of unsafe behavior. Habit formation can also have productive outcomes. Once a person establishes healthy behavior routines, for instance, these become easier to maintain.

Substance Use. Studies have found that people report engaging in high-risk behavior as a result of the disinhibiting effects of alcohol, nitrite inhalants, and other drugs.

Motivation to Change Behavior

To respond to the forces that can lead to unsafe behaviors, a person must be motivated to avoid unsafe behaviors. Different psychological elements—or combinations of elements—can motivate people to change their behaviors. For instance, fear of becoming infected with HIV and self-efficacy—the perceived ability to take steps to protect oneself from HIV infection risks—may combine to motivate a person to start thinking positively about behavior change.

Fear. Often, people know about HIV transmission but have an “optimistic bias,” or a view that bad things always happen to someone else. They will not be motivated to change behavior until they experience significant fear that HIV infection is a personal threat to them. When a person recognizes such fear, this can mobilize him or her to take actions—such as avoiding unsafe behaviors—to eliminate or reduce the fear.

Fear can also be counterproductive. A person may become overwhelmed with fear of becoming infected. Instead of reducing risks, this person may become depressed and begin to see the idea of becoming infected as inevitable and the effort to change behavior as pointless. He or she may seek the pleasure of risk behavior to drown out negative feelings.

The process of recognizing and acknowledging fear is an internal one. It can be fostered, but not forced. Therefore, prevention efforts based solely on emphasizing risks in order to invoke fear are rarely useful.

Self-Efficacy. To be effective at making behavior change, a person’s perception of being at risk must be accompanied by a belief that he or she has a level of control over personal health. A person must have confidence that not only will behavior change lead to a desired outcome such as not con-
A person must have confidence that not only will behavior change lead to a desired outcome, but also that he or she is capable of making such a change.

Related Issue: Behavior Change for People with HIV

Behavior change interventions for clients with HIV infection most commonly focus on avoiding transmission of HIV to those who are uninfected. In addition, interventions deal with concerns of re-infection with HIV.

For some people, learning that they are infected with HIV leads them to immediately stop having sex, while others may have an opposite reaction. In one study, the disclosure of HIV infection had no effect on the sexual behavior of about 40 percent of tested clients. Another study found that 22 percent of those who tested HIV positive continued to have unprotected sex with partners of negative or unknown infection status, many of whom were not aware that their partners were infected. Researchers associate certain barriers to change specifically with a positive serostatus. For example, for some people, denial may permit them to engage in ongoing risk behavior after receiving a positive result. Conversely, continuing to engage in unsafe behaviors may assist them in denying that they are infected with HIV.

Further, difficulty discussing infection with partners may lead people to engage in unsafe sex. They might be dishonest about their serostatus, or not mention it, in order to have sex. Since condom use might be seen as an indication that a person has HIV, some people may not suggest using condoms.

Fear of transmission, the complexity of negotiating safer sex, the stigma associated with HIV, and changes in sexual desire that correspond to fluctuating health can emerge for people once they are HIV-infected. These issues can challenge someone seeking to return to healthy forms of sexual expression.
Avoiding unsafe behaviors entirely is a long-term ideal. In the short-term, counselors should focus on helping clients think about reasons they might want to change behaviors, or to develop the skills to make or maintain change.

A discussion of behavior change begins with an assessment of a client’s reasons for testing and risks for HIV infection. Be aware that people may be knowledgeable of only some of the behaviors that have put them at risk. For instance, a client may be concerned about the possibility of having been infected during a particular experience of unprotected oral sex with a new partner, but fail to consider risks from unprotected anal intercourse with a longstanding primary partner.

Ask clients to describe how they feel about the risks of their behaviors. For instance, ask whether a person feels comfortable with past injection drug-use behaviors and whether he or she is comfortable accepting such risks in the future. Keep in mind that some clients may be considering a return to unsafe behavior.

With this information, evaluate where the client fits on the Stages of Change continuum. These stages are: pre-contemplation, contemplation, ready for action, action, and maintenance. Someone may move through these stages in a linear fashion, however, most people move forward, then back, and forward again, along the continuum.

Pre-Contemplation

During the precontemplation stage of behavior change, clients are not changing behaviors or even thinking about doing so, and they may have no desire to start thinking about change. Clients in this stage may be uninformed about their risks, they may be comfortable with the risks they are taking—regardless of the level of risk involved in these behaviors—or they may be uncomfortable with their risks but express no interest in change. In addition, clients may experience denial about their risks and actively resist information about risks.

If clients have engaged in unsafe behaviors, ask them more about how they view their behaviors and risks. For instance, learn whether they see their risks as being insignificant or serious, and learn whether they have at any point been interested in making changes. If clients are misinformed about their risks, clarify the information they have; then learn how they feel about this new knowledge and reassess whether they are still in a precontemplation stage. If clients deny their risks to themselves, counselors can assess reasons for this. For instance, clients may find the possibility of change too overwhelming to consider and, as a result, defend their behavior by seeing it as not harmful. It may be more palatable for them to think about changing some smaller part of their behavior rather than an entire activity.

At a given point, clients may not...
be thinking about change regardless of whether they have had previous success at stopping unsafe behaviors. A client may have relapsed to unsafe sex after successfully avoiding it, or may, at an earlier time, have known that a behavior was risky but has since heard otherwise from friends. Being asked why they chose one belief over another may help them gain clarity about their motivations.

**Contemplation**

Clients are at the contemplation stage of change when they say they are seriously considering change, but are not committed to it; when they express openness to feedback or education; or when they are actively seeking information about risks or evaluating their behaviors.

When clients say that they have considered change, ask more about these thoughts. Learn what experience, education, or insight led them to consider change and what doing so has been like. For instance, have their desires for change been consistent or only occasional? Have they most often entertained or disregarded these thoughts?

A person might appear to have reached a stage of action by saying, “Yes, I want to change,” but further discussion may reveal this readiness is conditional. For instance, the person might say, “This isn’t a good time.” In such a case, the person remains at the contemplation stage.

When clients are at pre-contemplation or contemplation stages, counselors can help them move to the next step using several types of interventions. For instance, ask clients if their current behaviors are acceptable to them, and, if not, how are they not. Does it feel that life is unmanageable or out of control as a result of risky behaviors? Learn what choices clients believe they have and what challenges they think they might face.

Often, people are not aware of the reasons they are uncomfortable with certain behaviors. Clients may experience anxiety when they engage in unsafe behaviors, but not recognize the source of their anxiety—or perhaps not wish to recognize its source. Brainstorm with clients on possible reasons for their discomfort and on the drawbacks to changing behaviors. Focus on and validate clients’ intuitive feelings that might lead them to desire change. These may be revealed when a client discusses having a “gut feeling” or a feeling of being anxious about engaging in certain behaviors.

A person’s views of the benefits and drawbacks of unsafe behaviors can change frequently and quickly. For instance, a client may believe that he will always use condoms for vaginal intercourse, but, after meeting a partner he feels is “special,” this belief may change, either spontaneously in a sexual encounter or as a relationship develops. Feelings related to the desire or need to please partners—or to conform to the beliefs of peers—can lead a person to discard previously held beliefs related to protecting oneself.

The effects of alcohol and other drugs can also lead a person’s evaluation of the benefits and drawbacks of safer sex to shift, both suddenly as a result of being intoxicated, and over time as substance use takes on increasing importance and other things, such as avoiding unsafe sex, become less important.

**Ready for Action**

A person is at a stage of being ready to change behavior when he or she expresses a serious commitment to do so. A counselor can explore if there is anything more that a person needs to do to implement change and anything that may lead the person to hesitate to proceed with changes. Respond to these concerns. For instance, if a client is ready to change and says he or she needs help negotiating safer sex, perform role-plays and reverse role-plays that focus on words or actions the client may use.

Evaluate a person’s degree of social support for making changes in behavior. Explore ways of increasing support. In addition, provide self-affirmations—such as the statements “I can do this” or “I will try to do this”—that clients can use to support themselves.

Plan for obstacles or setbacks that could lead a person to give up. Reframe the concept of failure so that clients who are unable, in a given situation, to make desired changes will not view themselves as failures. Acknowledge successes, no matter how small, in any area of a client’s life, and differentiate the idea of “failing” or not succeeding at something from being a “failure.” This is important because when a person views him or herself as being a failure, he or she is less likely to change behaviors or to feel it is worthwhile to do so.

**Action**

A person in the action stage has successfully begun to alter behavior. This person has also consciously made changes in his or her experiences, environment, or beliefs to support changes. For instance, someone may have formed new friendships with people who will support his or her changes in
behavior. A person may avoid seeing a former partner with whom he or she is afraid of engaging in unsafe sex. The action stage, in particular, can demand considerable time and energy from a person. Acknowledge these demands to a client at this stage and provide support for actions he or she is taking.

**Maintaining Change**

A person is at the maintenance stage of change when he or she is able to resist urges to return to previous unsafe behaviors. This person may have no desire to continue old behaviors or may consistently display an ability to minimize the intensity of urges to engage in old behaviors.

While some people reach a point at which they no longer desire unsafe sex, relapse into unsafe behavior can remain a significant possibility. Be open to this possibility. For instance, a client who says that behavior change has been difficult for him or her in the past may make absolute statements that he or she has no desire to return to old behaviors. Validate this client’s success and current experience, but recognize that, in some cases, clients may be trying to avoid acknowledging current difficulties in maintaining change. Clients may have gained confidence as a result of being able to make changes and may fear they will lose confidence by acknowledging that this state is fragile. By recognizing that a return to unsafe behaviors can occur, counselors can establish an environment that supports clients in disclosing any concerns they may have.

While clients who are maintaining change may feel they are caring for themselves in a positive way, they may also experience a variety of losses as a result of giving up certain behaviors. Such loss may accelerate the struggle to maintain their resolve. Counselors can learn more about this possibility by asking clients what life is like as a result of not having unsafe sex.

**Remaining Stable, Moving Forward**

Regardless of a person’s stage of change, the counselor’s goal is to help clients either remain at their current stage, consider progressing to the next stage, or take steps to progress to the next stage.

Interventions for people at the precontemplation and contemplation stages typically deal with gaining education and insight, which occurs most often through verbal interaction. Encourage clients to respond to questions or to share their thoughts on topics such as changing behaviors, the history of their behaviors, or their relationships with various behaviors. For instance, ask a client who is thinking about change how it might feel to engage in safer behaviors and what it has felt like to have done so in the past. Or, ask how the client feels about the risks he or she is currently facing.

At the action stage and at subsequent stages, verbal interaction remains valuable, but behavioral interventions become increasingly important. These may include such things as changing environments, creating stronger support systems, changing patterns of alcohol use, or slowing down the pace of an overly stressful life. Successful changes also involve a restructuring of thoughts about oneself and one’s actions.

Often, it is useful to combine behavioral and verbal interventions. A person seeking to maintain change, for instance, may be frustrated or angry at having been rejected by a former or prospective sexual partner as a result of refusing to engage in unsafe sex. This person may benefit from discussing his or her feelings. But he or she may also want increased support from friends or family who can encourage him or her to make choices to engage in healthier behaviors.

Throughout a counseling session, support and affirm clients’ changes and movements toward change. Offer feedback when clients discuss challenges or problems related to changes, and neither blame nor excuse a person’s unsafe behaviors. Focus on problem-solving, being careful not to chasise. Remember that counselor judgments may diminish clients’ trust in the counseling process.

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**A Counselor’s Perspective**

“I can get frustrated and angry when clients don’t want to change behavior. I ask myself, ‘Why don’t they get how dangerous this is?’ But, I have to keep that anger out of the session. Instead, I can begin to appreciate that changing behaviors is hard, and that there are stages clients move through incrementally.”
Case Study

Melody is 35 years old and has been engaging in sex with her boyfriend for the past three months. They used condoms during vaginal sex for the first month in which they were sexual, but since then they have used condoms for vaginal sex only occasionally. She says that because they both have sex outside the relationship, she sometimes feels uncomfortable when they do not use condoms with each other. She says they are more likely to use condoms when she feels more concern about risks. In further discussion, she says she is uncertain whether she wants to use condoms more often.

Counseling

By expressing concern about risks, Melody appears to be at a stage of contemplating change. It may be most useful to work with Melody in helping her continue to think about change.

Learn more about the risks she and her boyfriend face outside the relationship. Find out to what extent she and her partner discuss these risks. Make sure Melody is aware of her risks from sex with her boyfriend and with others. Ask more about the context of occasions when she and her boyfriend or other partners use condoms. Ask Melody what she feels it would be like to use condoms more regularly during sex. Does she feel, for instance, that it would be useful, or possible, to discuss condom use with her boyfriend? If she does not always use condoms during sex outside the relationship, would she consider this? Learn what Melody views are the drawbacks of consistent condom use.

Return to discussing reasons she might want to use condoms. Try to help Melody remain focused on these reasons. For instance, if she expresses concern about her risks but backs away from this discussion, refocus on the concern, and point out her conflicting feelings. If Melody seems interested, develop a list of reasons she thinks she might want to change and review these with her. She may have never considered them in such a way. To assess the possibility of moving forward, ask Melody what changes she feels are possible for her. If she does not express interest in this, reemphasize the value for her to continue to think about change.

Explain the value of support. Learn whether she wants to talk with friends or family about condom use and her sexual risks. If it appears she has little support or wants more, present the option of formal support from a counselor, for instance at a women’s health clinic, and provide referrals.

References

Test Yourself

**Review Questions**

1. True or False: A person who displays what appears to be an exceptionally high level of self-esteem will always avoid risk behaviors.

2. Relapse means that a person a) has returned to unsafe behavior; b) has tried to change behavior at some point; c) has not necessarily failed in changing behavior; d) all of the above.

3. When celebrities disclose that they are infected with HIV, this a) can be an example of how popular people can influence social norms; b) can have impact on the way people perceive HIV infection; c) can lead to an increase in the number of people seeking HIV test counseling; d) all of the above.

4. True or False: A person with HIV infection will nearly always avoid unprotected sex with partners who are negative or whose infection status is not known.

5. True or False: HIV prevention campaigns on television tend to have their greatest effect long after a person has been exposed to them.

6. The term “harm reduction” refers to prevention efforts that a) have an immediate goal of achieving total abstinence; b) work on the principle that people can only change their behavior by quitting “cold turkey”; c) attempt to help people lessen their risk by engaging less frequently in risk behaviors.

7. The test counseling session is an important part of prevention efforts because a) its one-on-one format allows for assessment and education; b) it provides the opportunity for referrals; c) it can help people move from one stage of change to another; d) all of the above.

8. True or False: A person’s beliefs of being able to avoid unsafe sex can affect his or her motivation.

**Discussion Questions**

1. How can a counselor respond when dealing with a client who places him or herself at great risk for infection, and says he or she has no interest in changing behaviors?

2. Why might some studies indicate that test counseling has limited value in helping clients bring about behavior change? Can counseling be made more effective in response to such findings? If so, in what ways can this be done?

3. Are there occasions when use of the Stages of Change continuum will be ineffective with clients?

4. Can the idea of viewing behavior change as occurring in stages work across cultures or does it relate only to certain cultures or certain clients in each culture?

**Answers**

1. False. A person who displays what appears to be an exceptionally high level of self-esteem may develop feelings of invulnerability, and believe he or she will not be infected even when engaging in risk behavior.

2. D. All of the above.

3. D. All of the above.

4. False. A study found that 22 percent of those with HIV infection had unprotected sex with partners of negative or unknown infection status.

5. False. Mass media messages generally have their greatest effect immediately after exposure, with their effects declining precipitously thereafter.

6. C. Harm reduction is the idea that abstinence is an unrealistic goal for many people and they can instead be encouraged to lessen risk.

7. D. All of the above.

8. True. A person’s motivation to change behavior may decline if that person lacks a sense of being able to change.
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