HIV/AIDS Counseling Skills and Strategies: Can Testing and Counseling Curb the Epidemic?

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INTRODUCTION

The epidemic of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is in its third decade and has reached to alarming proportions worldwide. According to the Centers for Disease Control and Prevention, more than one million people are living with HIV with an estimated 56,300 infections happening each year in the United States. Diagnosis of HIV/AIDS via early testing along with pretest and post-test counseling is important for psychosocial stabilization and destigmatization. Risk reduction counseling as a preventive counseling method is equally important in high-risk individuals such as adolescents, substance abusers and in gay and bisexual population. The purpose of this review is to address a number of counseling strategies used for education and counseling of individuals at risk of getting HIV/AIDS and also among those who are HIV-infected.

ABSTRACT

Objectives: The human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic is in its third decade and has reached to alarming proportions worldwide. According to the Centers for Disease Control and Prevention, more than one million people are living with HIV with an estimated 56,300 infections happening each year in the United States. Diagnosis of HIV/AIDS via early testing along with pretest and post-test counseling is important for psychosocial stabilization and destigmatization. Risk reduction counseling as a preventive counseling method is equally important in high-risk individuals such as adolescents, substance abusers and in gay and bisexual population. The purpose of this review is to address a number of counseling strategies used for education and counseling of individuals at risk of getting HIV/AIDS and also among those who are HIV-infected.

Methods: In order to collect materials for this review, a detailed search of CINAHL, MEDLINE, ERIC, Academic Search Premier, Scopus, Web of Science and Social Sciences Citation Index databases was carried out for the time period 1995-2010.

Results: Some of the various dimensions of counseling are negative approach counseling, assessing readiness to change, and motivational enhancement therapy.

Conclusions: Multiple approaches are used by counselors in providing education and prevention counseling to ‘at risk’ individuals and also individuals who have been infected with the virus. No one method is superior to another and some gamut of techniques are practiced by HIV/AIDS counselors.

Keywords: Social testing; HIV education; Counseling.

INTRODUCTION

The epidemic of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is in its third decade and has reached to alarming proportions worldwide. According to the Centers for Disease Control and Prevention, more than one million people are living with HIV with an estimated 56,300 infections happening each year in the United States. Men who have sex with men (MSM) population account for more than half (53%) of all the new HIV infections, and blacks represent almost half (46%) of people living with HIV in the United States.1 Most of the HIV-related research is targeted towards high-risk groups such as prostitutes, gays and substance abusers but there is evidence that it is increasing in college students and adolescents as well.2,3 In 33 states with confidential name-based HIV reporting, of the 17,824 persons 13-24 years of age, 62% were males and 38% were females.4 An early step in preventive HIV counseling is behavioral risk assessment especially among high risk individuals in resource-limited settings.4 Psychosocial stabilization as a means of coping among HIV infected individuals can not be overemphasized. Besides the trained HIV counselors, family physicians, who are trained in psychosocial and community medicine, are equally poised to meet this demand.5 Patient-provider relationships, when it comes to HIV positive patients, are ironically constrained as risk-reduction counseling falls woefully short of required percentage.6 Similarly, counseling for HIV positive individuals who are on treatment for maintaining treatment adherence is quite poor.7 Some of the barriers may be provider-centric, such as dealing with emotional issues surrounding HIV and doubt-
fulness of providing good care. These barriers faced by counselors need to be addressed by techniques such as interactive counseling, motivational interviewing and application of stages of change. The USA Preventive Services Task Force made a recommendation few years back of counseling all adolescents and adults about risk reduction after they have been advised about risk factors for HIV infection and sexually transmitted diseases, and sexual history taking. Some of the risk factors for engaging in unsafe sexual activities among the college students are use of alcohol, partner characteristics such as age, and substance abuse. The determinants of safer sex in adult population vary from whether they are HIV positive males, HIV positive females, gay or a bisexual population. The risk factors in a study which looked at HIV positive gays and bisexuals were mainly unprotected anal sex, which has a higher risk of HIV transmission. Some of the strategies tried in this population were problem solving exercises that attempt to increase perceived benefits of safer sex. Counselors also made the participants aware of alternative to regular use of male condoms. The reason for engaging in unsafe sexual practices especially in this gay population was pleasure seeking. Some of the barriers for attaining safer sex are inaccurate risk perception, and gender inequalities, like women being powerless to negotiate their sexual safety. Risk perception can be improved by using social interactions. Social network formation which includes spousal communication related to AIDS risk has been proven to improve diffusion of behavioral change through the society. Protection from getting HIV/AIDS consists of abstinence, consistent and correct condom usage and having just one sexual partner (monogamy). Several studies have found that pregnancy prevention rather than disease prevention was the impetus for condom use. Health education in the form of information about pregnancy prevention can unintentionally increase condom use. HIV/AIDS knowledge provided to individuals does not help in generating behavior change. It was found that Nigerian undergraduates, who had very good knowledge about HIV/AIDS, had low condom use to prevent its transmission. Further evidence of knowledge-behavior gap comes from a study, which used a random sample survey of students in which the level of student knowledge was very high but did not lead to protective condom behaviors. However, knowledge was found to be an enabling factor in maintaining a comfort level when asking partners about their sexual histories and in requesting their partners to take an AIDS test. In a pilot project, which looked at the effect of HIV/AIDS prevention related messages in improving protective behaviors among Indonesian participants, it was found that those exposed to the intervention were significantly more likely to use condoms to avoid AIDS. They also felt that these messages had a great impact on them to a point of wanting to change their lifestyle. This study did not show conclusively that there was actual behavior change on part of the participants. This helps to conclude that HIV/AIDS education related programs are not enough for generating a behavior change and can help in awareness of the disease to certain extent. Furthermore, from the point of view of clarifying risk perception, one needs to provide counseling which includes risk reduction or harm reduction as its integral part. The purpose of this review is to address a number of counseling strategies used for education and counseling of individuals at risk of getting HIV/AIDS. Moreover, later in this paper are discussed some of the counseling strategies used in individuals already diagnosed with HIV or AIDS and these strategies were used in preventing further transmission of the disease.

METHODS

In order to collect materials for this review, a detailed search of CINAHL, MEDLINE, ERIC, Academic Search Premier, Scopus, Web of Science, and Social Sciences Citation Index databases was carried out for the time period 1995-2010. A Boolean search strategy where the key words entered for search were “counseling” and “strategies” and “HIV/AIDS” and “HIV/AIDS Counseling” and “counseling” in differing orders was used to extract studies related to counseling skills and strategies for risk reduction as well as strategies in HIV positive people.

Counseling Skills and Strategies
counseling for risk reduction

HIV prevention counseling is a very important mode of behavioral intervention especially in the absence of an effective vaccine or a curative treatment. It consists of dealing with a variety of issues such as medical, psychological and social. Client-centered counseling changed the focus of counseling from a sole educative one to one focusing on client’s needs and circum-

International Journal of Preventive Medicine, Vol 2, No 1, Jan 2011 11
tances. The word ‘client-centered’ meant that counseling should be tailored to needs, circumstances and behaviors of a specific client which entailed active listening, to provide assistance and determining client’s specific prevention needs. Prevention counseling primarily consists of risk reduction counseling, pretest-counseling and post-test counseling. In terms of adolescent counseling, the risk reduction approach to HIV counseling can be divided into various phases such as, exploring clients feelings about sexual activity, using their existing HIV knowledge as an engaging tool, addressing the barriers they have for safer sex, focusing on perceptions that might affect risky behaviors, focus on safe sex planning and in the end, referral making. Risk reduction counseling is used as a harm reduction technique quite effectively. Other interesting approaches used were information-motivation-behavior change model. Results showed that men who received the full information motivation behavior (IMB) model showed greater risk reduction skills and relatively lower rates of unprotected intercourse and increased condom usage more than HIV-negative and untested participants. Similarly, a multi-clinic safer sex behavioral counseling intervention using loss-frame intervention by emphasis on negative consequences of safe sex reduced the number of sexual partners among HIV positive patients compared with the control arm.

**CONCLUSION**

There are several examples of one-on-one counseling methods used for risk reduction counseling among HIV positive individuals. The various dimensions touched upon were use of a negative approach, assessing readiness to change, and motivational enhancement therapy. Hence, we see multiple approaches used by counselors in providing education and prevention counseling to ‘at risk’ individuals and also individuals who have been infected with the virus. Internet-based counseling has gained some popularity over recent years but has to deal with issues such as lack of visual and verbal cues, confidentiality, accessibility problems by those in great need and increased client separation. Counseling related to using spiritual coping techniques have been well established in cancer literature but has limited evidence in HIV related counseling. It is mainly applicable as a psychosocial adaptation technique.

**Conflict of interest statement:** All authors declare that they have no conflict of interest.

**Source of funding:** None

**REFERENCES**

1. Centers for Disease Control and Prevention. HIV and AIDS in the United States [Online]. 2010 Jul 15: Available from: URL: http://www.cdc.gov/hiv/resources/factsheets/PDF/us.pdf.
2. Lewis JE, Malow RM, Ireland SJ. HIV/AIDS risk in heterosexual college students. A review of a decade of literature. J Am Coll Health 1997; 45(4): 147-58.
3. Stine JG. AIDS Update 2010: An Annual Overview of Acquired Immune. New York: McGraw-Hill Higher Education; 2010.
4. Chen Z, Branson B, Ballenger A, Peterman TA. Risk assessment to improve targeting of HIV counseling and testing services for STD clinic patients. Sex Transm Dis 1998; 25(10): 539-43.
5. Khalsa AM. Preventive counseling, screening, and therapy for the patient with newly diagnosed HIV infection. Am Fam Physician 2006; 73(2): 271-80.
6. Margolis AD, Wolitski RJ, Parsons JT, Gomez CA. Are healthcare providers talking to HIV-seropositive patients about safer sex? AIDS 2001; 15(17): 2335-7.
7. Golin CE, Smith SR, Reif S. Adherence counseling...
practices of generalist and specialist physicians caring for people living with HIV/AIDS in North Carolina. J Gen Intern Med 2004; 19(1): 16-27.

8. Obermeyer CM, Osborn M. The utilization of testing and counseling for HIV: a review of the social and behavioral evidence. Am J Public Health 2007; 97(10): 1762-74.

9. Metsch LR, Perrya M, del Rio C, Gardner L, Dufus WA, Dickinson G, et al. Delivery of HIV prevention counseling by physicians at HIV medical care settings in 4 US cities. Am J Public Health 2004; 94(7): 1186-92.

10. Counseling to prevent HIV infection and other sexually transmitted diseases. The U.S. Preventive Services Task Force. Am Fam Physician 1990; 41(4): 1179-87.

11. Haist SA, Griffith III CH, Hoellein AR, Talente G, Montgomery T, Wilson JF. Improving students’ sexual history inquiry and HIV counseling with an interactive workshop using standardized patients. J Gen Intern Med 2004; 19(5 Pt 2): 549-53.

12. Diclemente RJ. Looking forward: Future direction for HIV prevention research. In: Peterson JL, Diclemente RJ, Editors. Handbook of HIV prevention. New York: Kluwer/Plenum; 2000.

13. Miller KS, Clark LF, Moore JS. Sexual initiation with older male partners and subsequent HIV risk behavior among female adolescents. Fam Plann Perspect 1997; 29(5): 212-4.

14. Sly DF, Quadagno D, Harrison DF, Eberstein I, Riehman K. The association between substance use, condom use and sexual risk among low-income women. Fam Plann Perspect 1997; 29(3): 132-6.

15. Semple SJ, Patterson TL, Grant I. HIV-positive gay and bisexual men: Predictors of unsafe sex. AIDS Care 2003; 15(1): 3-15.

16. Donovan B, Ross MW. Preventing HIV: determinants of sexual behavior. Lancet 2000; 355(9218): 1897-901.

17. Kohler HP, Behrman JR, Watkins SC. Social networks and HIV/AIDS risk perceptions. Demography 2007; 44(1): 1-33.

18. Thato S, Charron-Prochnow D, Dorn LD, Albrecht SA, Stone CA. Predictors of condom use among adolescent Thai vocational students. J Nurs Scholarsh 2003; 35(2): 157-63.

19. Arowojolu AO, Ilesanmi AO, Roberts OA, Okunola MA. Sexuality, contraceptive choice and AIDS awareness among Nigerian undergraduates. Afr J Reprod Health 2002; 6(2): 60-70.

20. Shapiro J, Radecki S, Charchian AS, Josephson V. Sexual behavior and AIDS-related knowledge among community college students in Orange County, California. J Community Health 1999; 24(1): 29-43.

21. Turk T, Ewing M, Newton FJ. Using ambient media to promote HIV/AIDS protective behavior change. International Journal of Advertising 2006; 25(3): 333-59.

22. Technical guidance on HIV counseling. Center for Disease Control and Prevention. MMWR Recomm Rep 1993; 42(RR-2): 11-7.

23. Pinto RM. HIV prevention for adolescent groups: A six-step approach. Social Work with Groups 2000; 23(3): 81-99.

24. Kamb ML, Fishbein M, Douglas JM Jr, Rhodes F, Rogers J, Bolan G, et al. Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. Project RESPECT Study Group. IAMA 1998; 280(13): 1161-7.

25. Kalichman SC, Cain D, Weinhardt L, Benotsch E, Presser K, Zweben A, et al. Experimental components analysis of brief theory-based HIV/AIDS risk-reduction counseling for sexually transmitted infection patients. Health Psychol 2005; 24(2): 198-208.

26. Gollub EL, French P, Latka M, Rogers C, Stein Z. Achieving safer sex with choice: Studying a women's sexual risk reduction hierarchy in an STD clinic. Journal of Women's Health and Gender-based Medicine 2001; 10(8):771-83.

27. Fisher WA, Black A. Contraception in Canada: a review of method choices, characteristics, adherence and approaches to counselling. CMAJ 2007; 176(7):953-61.

28. Gerbert B, Danley DW, Herzig K, Clanon K, Ciccareone D, Gilbert P, et al. Reframing "prevention with positives": incorporating counseling techniques that improve the health of HIV-positive patients. AIDS Patient Care STDS 2006; 20(1): 19-29.

29. Rutledge SE. Single-session motivational enhancement counseling to support change toward reduction of HIV transmission by HIV positive persons. Arch Sex Behav 2007; 36(2): 313-9.

30. Weinhardt LS, Carey MP, Johnson BT, Bickham NL. Effects of HIV counseling and testing on sexual risk behavior: a meta-analytic review of published research, 1985-1997. Am J Public Health 1999; 89(9): 1397-405.

31. Richardson JL, Milam J, McCutchan A, Stoyanoff S, Bolan R, Weiss J, et al. Effect of brief safer-sex counseling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment. AIDS 2004; 18(8): 1179-86.

32. Zúñiga ML, Baldwin H, Uhler D, Brennan J, Olshesky AM, Oliver E, et al. Supporting Positive Living and Sexual Health (SPLASH): a clinician and behavioral counselor risk-reduction intervention in a university-based HIV clinic. AIDS Behav 2007; 11(5 Suppl): S58-S71.

33. Picciano JF, Roffman RA, Kalichman SC, Walker DD. Lowering obstacles to HIV prevention services: effects of a brief, telephone-based intervention using motivational enhancement therapy. Ann Behav Med 2007; 34(2): 177-87.

34. DeGuzman MA, Ross MW. Assessing the application of HIV and AIDS related education and counselling on the Internet. Patient Educ Couns 1999; 36(3): 209-28.

35. Simoni JM, Martone MG, Kerwin JF. Spirituality and Psychological adaptation among women with HIV/AIDS: Implications for counseling. Journal of Counseling Psychology 2002; 49(2): 139-47.
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