# Brief, Individual Behavioral Counseling for STD/HIV Risk Reduction

## Learning Objectives

Upon completion of this content the learner will be able to:

1. List four factors that influence the process of behavior change.
2. Discuss the differences between education and counseling.
3. Describe one behavioral counseling intervention that has been used successfully for STD/HIV risk-reduction counseling.
4. Describe the steps in performing a client-centered risk-reduction session:
   a. Risk assessment
   b. Identifying a safer goal behavior
   c. Assessing readiness for change
   d. Formulating an individualized plan.
5. Give an example of an open-ended question appropriate to each step listed in #4., above.
6. Recognize the importance of accessible referral sources for client support and further counseling.

This curricular outline was developed by the Curriculum Committee of the National Network of STD/HIV Prevention Training Centers. This project was funded through a grant by the US Centers for Disease Control and Prevention.
This curriculum was initiated and developed as a collaboration between the Behavioral and Clinical training sections of the NNPTC.

# Behavioral Counseling for STD/HIV Risk Reduction Curriculum Module Contributors

**Primary Editor 2007 and 2011 Revisions: Linda Creegan, MS, FNP**, Clinical Coordinator, California STD/HIV Prevention Training Center, Oakland, CA

**Contributing Editors 2002 Edition**

**Teri Anderson, MT,** Associate Clinical Training Coordinator, Denver STD/HIV Prevention Training Center, Denver Public Health Department, Denver, CO; **Helene Calvet, MD,** Medical Co-director, California STD/HIV Prevention Training Center, Long Beach, CA, Public Health Physician, Long Beach Department of Health and Human Services, Long Beach, CA; **Pat Coury-Doniger,** RN, FNPC, Director, Center for Health and Behavioral Training, Part II. of the New York State STD/HIV Prevention Training Center Infectious Diseases Unit, Department of Medicine University of Rochester, Rochester, New York; **Linda Creegan, MS, FNP,** Clinical Nurse Liaison, California STD/HIV Prevention Training Center, Berkeley, CA; **Anne C. Freeman,, MSPH**, Faculty Associate and Director, Dallas STD/HIV Behavioral intervention Training Center, Community Prevention and Intervention Unit, UT Southwestern Medical Center, Dallas, TX; **Alice Gandelman, MPH,** Chief, Community & Behavioral Intervention/Training Section, Director, STD/HIV Prevention Training Center, Berkeley, CA; **Jolie Pearl, RN, MPH,** Clinical Training Coordinator, STD/HIV Prevention Training Center, Berkeley, CA; **Kees Rietmeijer, MD, MSPH,** Director, HIV/AIDS Prevention, Denver Public Health, Denver, CO; **Bradley Stoner, MD, PhD**, Associate Professor, Washington University School of Medicine, St. Louis, Medical Director, St. Louis STD/HIV Prevention Training Center, St. Louis, MO; **Darrel Washington,** Behavioral Trainer/Consultant, California STD/HIV Prevention Training Center, Berkeley, CA

**Expert Reviewer 2001 Edition**

**Erica Monasterio, RN, MN, FNP**, Associate Clinical Professor, Division of Adolescent Medicine, Department of Pediatrics, Family Health Care Nursing, School of Nursing, University of California, San Francisco

# Brief, Individual Behavioral Counseling for STD/HIV Risk- Reduction

## I. Primary prevention of STDs is an important goal in STD/HIV control

A. STDs cause significant morbidity, especially in women.
B. STDs facilitate transmission and acquisition of HIV.
C. Viral STDs are often chronic rather than curable infections.
D. Secondary prevention stresses early detection and treatment of STDs.

## II. Primary prevention depends on effectively promoting behavior change

A. Behavioral change is affected by multiple factors (behavioral determinants and social determinants) including:

1. Perceived seriousness (or severity, consequences) of condition.
2. Perceived susceptibility to (or risk of) condition.
3. Knowledge, attitudes, and beliefs about condition.
4. Perceived and actual social norms related to the behavior (influence of peers, family, cultural and religious norms).
5. Self-efficacy (belief in one's ability to carry out a specific behavior).
6. Skills required to implement the behavioral change.
7. Barriers and facilitators to intended change.
8. Perceived and actual cost (financial or personal).
9. Access to services or support.
10. Power dynamics within relationships, including distribution of power between partners.

B. Knowledge alone does not produce behavior change (education is not the same as counseling):

1. Education can increase knowledge, but is insufficient to effect sustained behavioral change.
2. Education is a cognitive intervention; counseling acknowledges feelings, attitudes, values and beliefs.
3. Education is usually one-directional information-giving; counseling is a dialog between client and provider.

4. Education helps clients understand a subject better; counseling helps clients understand themselves better.
5. Education gives the same facts to everyone; counseling is individualized.

## III. Behavioral and Clinical Research Support a Patient-driven (or Client-centered) Approach

A harm reduction approach provides the context for brief, individual behavioral counseling. Harm reduction is:

A. Client-Centered Counseling Model – Project Respect:

1. Study design:
   a) Multi-site research study conducted in Long Beach, CA; San Francisco, CA; Baltimore, MD; Newark, NJ; and Chicago, IL.

   b) Approximately 6000 participants followed over three-year period.

   c) Study participants randomized into four "arms".

      1) Arm 1 received five-minute "information" message by clinician on risk-reduction.

      2) Arm 2 received two 20-minute client-centered risk-reduction counseling sessions (pre/post counseling model).

      3) Arm 3 received four one-hour client-centered risk-reduction counseling sessions (enhanced counseling model).

      4) Arm 4: control groups with no counseling intervention.
         (a) Half the controls asked to return for periodic clinical follow-up and testing.
         (b) Other half were tested at any subsequent self-initiated visit during the study period.

2. Participants of Arms 1 and 2 were counseled by staff trained in client-centered counseling.

3. Results: a decrease in risk-taking behaviors and a decrease in STDs occurred in participants in Arms 2 and 3.

B. Stage-Based Behavioral Counseling – Stage of Change (SOC) Transtheoretical Model (TTM) Theory of Behavior Change:

1. SOC-based, individual-level counseling has been found to be effective when used by clinicians for counseling patients about a variety of health related behaviors (i.e., smoking cessation, contraceptive use, substance use, etc.)

2. Postulates that behavior change occurs along a continuum of five stages:
   a) Precontemplation (no intention to change)
   b) Contemplation (long-range intention to change)
   c) Preparation (short-term intention to change)
   d) Action (short-term, consistent behavior change)
   e) Maintenance (long-term, consistent behavior change).

3. Identifies target behavior and assesses patient's stage of readiness for change.

4. Uses an appropriate counseling strategy (process of change) that is needed to help patient (psychologically) move from one stage to another.

C. Motivational Interviewing Model:
Directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence.

**D.** A synthesis of these interventions has been used to prepare this module.

## IV. Common Elements – Principles of Client-centered Counseling

A. Individualized, client-centered approach:

1. Talk with, rather than to, the patient.

2. Individualize the session to meet the patient's needs by asking questions that
   a) Focus on issues and circumstances that the client identifies.
   b) Elicit, accept, and support the client's ideas about changing her/his own behavior.
   c) Acknowledge client's feelings as an important consideration.

B. Basic counseling skills:

1. Maintain a neutral, non-judgmental attitude.
2. Use open-ended questions.

C. Support positive risk-reduction changes that patient has already made.

D. Help patient recognize barriers to risk reduction; address contradictions or discrepancies regarding patient's stated desires or intentions and actual risky situations.

E. Aim for a realistic risk-reduction plan:

1. Risk reduction steps should be acceptable to the patient, appropriate to his/her situation, explicit and achievable.
2. Offer options, not directives.
3. Recognize the counselor's limited role.

## V. Implementing Behavioral Counseling in a Clinical Setting

A. Session is short (15-20 minutes) and efficient.
B. Session can be incorporated into existing clinic flow.
C. Session can integrate HIV and STD prevention messages.

D. Who should receive counseling?
1. Any client whose behavior puts him/her at risk for acquisition of STD/HIV.
2. Persons with HIV who are putting partners at risk for acquiring HIV.

E. Who can provide counseling?
Any staff member responsible for and trained in basic risk-assessment/risk-reduction client-centered counseling methods (clinicians, nurses, medical assistants, health educators, social workers, other clinic or community staff).

## VI. Process of Client-Centered Counseling

A. Use information gathered during history and physical exam to begin discussion pertaining to risk reduction:
1. Number of sexual partners during past three months, including new partners
2. Gender of partners
3. Sexual practices (anal, oral, vaginal intercourse)
4. Patterns of condom use
5. History of unintended pregnancy

6. Alcohol and/or drug use affecting sexual activity
7. Prior STDs
8. Past STD/HIV testing history
9. Injection drug use (IDU) and needle-sharing practices

10. Exchange of sex for money or drugs
11. Assumptions about partners' risk behaviors

B. Ask patient to identify risky behavior they would like to change; correct misinformation.

C. Assess client's readiness to change.

1. Precontemplative (client sees no need to change behavior).
2. Contemplative (client sees need to change behavior, but barriers outweigh benefits, so is not ready to take action).
3. Ready for action (client is ready to change behavior and may have already taken some steps).
4. Action (client is in process of behavior change for a short period of time, <6 months).
5. Maintenance (client has been acting on new behavior for at least 6 months).
6. Relapse frequently occurs and is seen as a normal part of the change process.

D. Assist client to identify a safer goal behavior that s/he believes can be taken to reduce risk.

1. Definition: a safer goal behavior is a behavior that will prevent or reduce the risk of STD/HIV transmission and that the patient is willing to adopt.

2. Discuss risk-reduction efforts already made, or planned, such as
   a) Increasing condom use with main and/or non-main partners.
   b) Intent to reduce number of sexual partners.
   c) Enhancing partner communication and sexual negotiation.
   d) Monogamy.
   e) Abstinence.
   f) Sexual activities that don't involve exchange of blood, semen or vaginal secretions.
   g) Discussion with partner(s) to negotiate risk-reducing activities.
   h) Partner testing.
   i) Reducing use of alcohol and/or drugs.
   j) Consideration of any of the above factors.
   k) Other client-relevant behaviors.

E. Assist the client to identify circumstances that may help or hinder his/her risk-reduction efforts:
   1. Perception of personal risk for STD/HIV.
   2. Confidence in ability to negotiate condom use.

3. Power and control dynamics in relationships.
4. Cultural issues.
5. Access to appropriate health care.
6. Encouragement/support from others to reduce risky behaviors.
7. Other information relevant to client that may help or hinder risk-reducing behaviors.

F. Client identifies action step(s) to take in a realistic risk-reduction plan, based on patient willingness, readiness and ability. An "Action step" is a specific incremental step a client can take to help him/her adopt a safer goal behavior.

G. Follow up or refer to other specialized services as needed.

## VII. References


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## Appendix to Behavioral Counseling Module

The three main steps in client-centered counseling are:

1. A personal risk assessment
2. Patient identifies safer behavioral goals
3. Patient and counselor together develop a personalized action plan.

Examples of open-ended questions to address risk assessment:

1. “How at-risk do you think you are for STDs?”
2. "What are the situations in which you are most likely to put yourself at risk for STDs?"
3. "What's working for you regarding safer sex, and what isn't?"
4. "Tell me about the times when safer sex is most difficult for you."
5. “What do you know about your partner’s risk behaviors?”

Examples of open-ended questions to address identifying safer behavioral goals:

1. "What would you like to do to reduce your risk for STDs/HIV?"
2. "What's the best (or the next or the most important) thing you could do to decrease your risk for STDs?"
3. "What one thing do you think you could start doing that would reduce your risk?"

Examples of open-ended questions to address a personalized action plan:

1. "How would you go about that?"
2. "Tell me how you'll do that."
3. "What specifically will you do to accomplish that?"
4. "How difficult do you think that's going to be?"
5. "What’s standing in the way of that?"
6. "What would help or make it easier?"