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Reframing “Prevention with Positives”: Incorporating Counseling Techniques That Improve the Health of HIV-Positive Patients

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Abstract

Federal HIV prevention strategy seeks to increase efforts by health care providers to identify and reduce their HIV-positive patients' transmission-related behaviors. Implementation of these recommendations will be hindered if providers perceive these efforts have the potential to harm their relationships with patients. Because transmission-related behaviors (unsafe sex and sharing needles) and the related issues of drug and alcohol use also jeopardize the health of HIV-positive patients, providers can use patient-centered counseling when addressing those behaviors. We suggest efforts to increase provider-delivered transmission-prevention counseling be reframed so that “prevention with positives” includes the goal of protecting HIV-positive patients' health. We review the specific consequences of these risky behaviors on HIV-positive patients' health and review brief counseling strategies appropriate for HIV care providers.

INTRODUCTION

HEALTH CARE PROVIDERS have important opportunities to improve their patients' health by identifying risky health-related behaviors and providing information, counseling, and other support to help their patients change those behaviors. In the area of HIV care, these opportunities are particularly important because HIV-positive patients frequently have high rates of risky behaviors and because treatment advances have enabled HIV-positive patients to live longer, healthier lives. HIV-positive patients and their health care providers have historically enjoyed strong, enduring relationships. With HIV/AIDS having evolved into a chronic disease, HIV care providers are in a unique position to help their patients recognize the importance of various health-promoting behaviors and take steps toward making healthy choices.

We feel particularly close to these issues because of our 20 years' work studying health care providers' and patients' attitudes and behaviors regarding HIV risk factors and other sensitive areas such as domestic violence, substance use, and smoking. In the course of this research, we have conducted numerous surveys and interviews with HIV-positive patients and their

providers.^{1–6} We have learned that patients can be extremely open to having risk-reduction discussions with their providers, and that useful techniques exist to enable providers to assess and counsel their patients with increased confidence. The clinicians among us also wish to share the approaches we have used throughout the HIV epidemic to forge close working partnerships with our own patients. We view identifying risky behaviors and working to change those behaviors as a mutually acceptable challenge that providers and patients embrace together.

Our intent with this paper is twofold. First, we comment on recent controversies in HIV prevention strategies, particularly the efforts to have HIV care providers address their patients' risky behaviors with the aim of reducing HIV transmission. This commentary includes a reframing of "prevention with positives" that could enhance providers' successes in this area. Second, we offer providers concrete advice in delivering risk-reduction messages to HIV-positive patients within a harm-reduction framework.

TRANSMISSION PREVENTION IN THE PRIMARY CARE SETTING: RESISTANCE AND BARRIERS

During the first 20 years of the HIV epidemic, transmission prevention efforts were directed almost exclusively at HIV-negative individuals, with messages that emphasized these individuals' responsibility to protect themselves from exposure to the AIDS virus. As a result, public health messages rarely if ever addressed HIV-positive individuals' responsibility to avoid transmission of the virus to others,⁷ and attempts to deliver such messages were often labeled "blaming the victim."

Recently, however, evidence of rising rates of risky sexual behavior among HIV-positive people prompted the Centers for Disease Control and Prevention (CDC) to substantially revise their HIV prevention policy. In 2003, the CDC issued new recommendations advising health care providers to prioritize screening and brief interventions to reduce the transmission-related risk behaviors of their HIV-positive patients.⁸ The CDC prepared these recommendations in conjunction with the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association as one component of a new federal strategy for HIV prevention that emphasizes broader testing and early detection and treatment of HIV infection.⁹ Subsequently, professional societies published guidelines defining the providers' role in identifying and addressing transmission-related behaviors.¹⁰

This new strategy has proven to be both controversial and problematic. Emphasizing the risky behaviors of HIV-positive individuals caused an immediate outcry from HIV advocacy groups, including the National Association of People with AIDS (NAPWA).¹¹ Concerns were raised that increased scrutiny of HIV-positive individuals' behavior would increase HIV stigmatization and could result in invasions of privacy. The new strategy also threatened to shift resources away from "primary prevention" services—services that help uninfected persons avoid contracting HIV. Some agencies providing these prevention services expressed concern that the new strategy neglected the needs of the populations at greatest risk for new infections.^{11,12}

Regarding HIV-care providers' perspectives on the new strategy, we have identified three major concerns that may impede interventions in health care settings on transmission-related risk behaviors. Stigma is the first. Many providers will resist counseling approaches that might stigmatize their patients. In any health care setting, prevention activities that seek to identify and modify patient behaviors, especially behaviors considered private, have the potential to increase patients' perception of stigma. HIV providers have so tenaciously reinforced the traditional, self-protective model of HIV prevention that it has become their ethos. This

approach has not been without some positive consequences. By downplaying the patient's potential to transmit HIV to others, providers have avoided objectifying their HIV-positive patients (in a worst-case scenario, treating their patients as mere "fomites"—inanimate spreaders of disease). HIV, after all, remains a highly sensitive topic. People living with HIV frequently report that they are subjected to physical harm because of their HIV-positive status.¹³ Many HIV-positive individuals choose to limit disclosure of their HIV status because they fear violence, or the loss of a job or a relationship, or because they think disclosing their status will prevent them from finding a new job or relationship.^{14,15} Historically, even health care settings have been venues where HIV infection has been stigmatized;¹⁶ mistreatment of HIV-positive patients has included homophobia, sexism, and denial of treatment.¹⁷ The stigma of HIV also impacts providers; for example, research has found that encountering stigmatized behaviors may be a source of stress to HIV providers.¹⁸

A second concern is that attention to transmission risks could jeopardize the trust between patient and provider. The process of "negotiating trust" has been identified as central to the relationship between health care professionals and HIV-positive patients.¹⁹ Patients' trust in their provider may be jeopardized if they perceive that their provider is more concerned about risks to others than about their own health and well-being.

Conflict in ethical principles is the third concern that may hinder providers' implementation of the new CDC recommendations. The principle known as "duty to warn" has been extended to the case in which a physician learns that an HIV-infected patient refuses to notify sexual partners while continuing to place them at risk; in such a case, the physician is obliged to act to prevent harm to a third party.²⁰ This duty, however, can conflict with the ethical principle of beneficence: the duty to be of benefit to the patient.²¹ Providers may consider devoting time to transmission prevention counseling to be a lapse in their duty to serve their patient when it diverts time and attention from the numerous other priorities of a medical visit.

In light of these three factors, it is not surprising that one recent survey found overall low rates of transmission prevention counseling to both newly diagnosed and established HIV-positive patients.²² As efforts to educate HIV care physicians get underway, these rates may improve. Yet over the longer-term, unless stigma, trust, and ethics concerns are addressed, the CDC recommendations may be unlikely to change physician behavior and may in fact negatively impact providers' willingness to perform risk-reduction counseling.

EASING THE TRANSITION: EMPHASIZE THE PATIENT'S OWN HEALTH AND WELLNESS

The CDC's new recommendations are intended to help health care providers incorporate HIV transmission prevention into the medical care of all HIV-infected adolescents and adults. The recommendations briefly mention that providers may counsel their patients about the ways that changing risky behaviors can protect their own health.⁸ When providers discuss transmission-related risk behaviors with their patients, the discussion does not have to center on the patients' capacity to transmit HIV to others. Many HIV care providers have longstanding practices of engaging in risk-reduction efforts that emphasize their patient's own health. We believe that guidelines and educational efforts should also contain content that will help providers continue to emphasize protecting the patient's health as an essential complement to transmission prevention efforts. The same behaviors that increase the risk of HIV transmission—risky sexual practices, substance use leading to risky sex, and unsafe injection drug use practices—also have significant potential to harm the HIV-positive patient's own health. When addressing the potential for unsafe behaviors to adversely affect the patient's own health, providers have a greater chance of being perceived as supportive and nonstigmatizing than when they focus on the potential of the patient's personal behaviors to harm others. A genuine concern for the

patient's own health and wellness can alleviate fears that arise when providers focus on behaviors that are well-known to transmit HIV.

So what are the specific consequences of transmission-related risk behaviors on the health of HIV patients? And what are the strongest messages stressing personal wellness that providers can deliver? Compelling evidence exists to support messages that counsel HIV-positive patients to avoid or reduce risky sex, injection drug use, use of illicit drugs, and alcohol abuse. Each of these behaviors impacts the HIV-positive patient's health. A sampling of these consequences is provided below.

Consequences of risky sex

Given that approximately 3 of every 4 new cases of HIV infection are the result of unprotected vaginal or anal intercourse,²³ the transmission-related risks of unsafe sex are well known. Less emphasized is that unprotected intercourse puts HIV-positive people at risk of acquiring new sexually transmitted infections (STIs). STIs can cause discomfort, exacerbate social stigma, and—most pertinently—accelerate the progression of HIV disease.²⁴ HIV in turn can affect the natural history of STIs by changing their clinical presentation, reducing the accuracy of laboratory diagnostic tests, and causing variations in response to therapy.²⁴ Also, while research has found low levels of drug resistance among HIV-positive patients,²⁵ a report from New York City in 2005 generated concern about transmission of multidrug-resistant strains of HIV that caused rapid progression to AIDS.²⁶ Substantiation of such cases would increase the inducement for HIV-positive people to practice safer sex with other positives.

Among the various STIs seen in our patient populations, herpes and hepatitis have presented the gravest consequences. Herpes infection is highly prevalent among HIV-infected adults,²⁷ who may experience severe and prolonged herpes outbreaks.²⁸ HIV infection may worsen the course of hepatitis B, as coinfecting patients have higher rates of chronic HBV carriage, accelerated progression toward cirrhosis,²⁹ and increased risk of liver-related mortality.³⁰ It is estimated that 80% of HIV-positive adults have been exposed to hepatitis B, with chronic hepatitis affecting about 10%.³¹ To prevent new infections, hepatitis B vaccination is recommended for sexually active adults,³² but the vaccine has weaker efficacy among HIV-positive adults than among others,³³ and so providers may advise safer sex practices to reduce the risk of exposure even after vaccination.³⁴ Also, research findings presented at a recent conference indicate that hepatitis C can be transmitted during unprotected sex among HIV-positive men.³⁵ While sexual transmission may be rare, these findings challenge some experts' statements about HCV transmission and are relevant to providers helping their patients fully understand the risks of various sexual practices.

Consequences of injection drug use

Transmission of HIV by risky injection practices (sharing needles or injection paraphernalia) has accounted for more than one third (36%) of AIDS cases since the epidemic began and remains a significant transmission risk behavior.³⁶ Less attention has been paid to the ways that risky injection practices subsequent to HIV infection also pose grave risks to health. Risky practices such as repeated venepunctures, injection of insoluble substances, and sharing needles harm the skin and soft tissue and may result in cutaneous and subcutaneous abscesses,³⁷ necrotizing fasciitis,³⁸ and non-healing wounds.³⁹ Organisms involved in skin infections may spread to infect the underlying bones, resulting in osteomyelitis and septic arthritis.⁴⁰ Furthermore, long-term opiate use has been found to cause humoral and cellular immune suppression.⁴¹ Patients who inject drugs also have poorer adherence to HIV medications than do other groups.^{42,43} Injection drug users have benefited less from ART than others, as shown by an increasing ratio for AIDS-defining illnesses among injection drug users versus others.

⁴⁴ Similar to risky sex, continuing unsafe injection may put HIV-positive people at risk of acquiring a drug-resistant strain of HIV.

For HIV-positive patients, infection with hepatitis C (HCV) may be the gravest risk of sharing needles. HCV infection is associated with chronic liver disease, cirrhosis, and hepatocellular carcinoma, and patients with chronic HCV infection show substantial reductions in somatic and physical functioning.⁴⁵ HIV/HCV coinfecting patients have a greater risk of progressive liver disease than patients infected with HCV alone⁴⁶ and negatively affects survival from the time of diagnosis with HIV or AIDS.⁴⁷ The prevalence of HCV among HIV-infected adults in the United States is estimated at 16% by an analysis of a representative cohort.⁴⁸ With much higher prevalence among injection drug users (multiple studies estimate 50% to 95% are anti-HCV-seropositive⁴⁹), some providers may consider it too late for risk-reduction to prevent exposure. Yet HCV incidence rates in the United States have declined sharply, a change that may be related to safer injection practices,⁵⁰ and the needle exchange programs available since the late 1980s may have helped lower rates of HCV prevalence in younger people who have injected drugs.⁴⁹ Because patients over time may use new classes of drugs and may change from smoking, snorting, or sniffing drugs to injecting drugs, HIV care providers can provide relevant messages to their HCV-negative patients about the advantages of refraining from injection or adopting safer injection practices.

Consequences of other drug use

Substance use and abuse contribute to HIV transmission by increasing the risk of unsafe sex among both HIV-positive and HIV-negative populations.^{51,52} This connection is particularly strong for use of stimulants (e.g., methamphetamine and cocaine).^{53–55} While this relationship is reason for HIV care providers to express concern about drug use, the effect of substance abuse on HIV-positive patients' health also merits attention. Illicit drug use occurs at high rates among HIV-positive individuals^{56,57} and has important health consequences for users. Regardless of HIV infection, long-term drug abuse can interfere with normal brain activity and metabolism and can become a chronic, relapsing condition.⁵⁸ Other drug-related consequences may include injury, illness, or disability, as well as crime and domestic violence.⁵⁹ The use of drugs by HIV-positive individuals decreases their likelihood of using ART,⁶⁰ adhering to ART,⁵⁶ and achieving effective viral suppression.⁶¹ As HIV-infected drug users' lives become more chaotic, they often have difficulty keeping appointments, filling prescriptions, and adhering to medications.^{62,63} HIV-positive individuals who do not receive treatment for their substance abuse have higher hospitalization rates⁶⁴ and are more likely to engage in risky sexual behavior than those receiving treatment,^{64,65} increasing their risk of contracting a new STI.

Consequences of alcohol use

Alcohol consumption is common among HIV-infected individuals and heavy drinking occurs at almost twice the rate found in the general population.⁶⁶ People whose alcohol consumption exceeds recommended limits suffer many more diseases, accidents, and family and work problems than do light drinkers or nondrinkers.⁶⁷ Problem drinking has been associated with decreased medication adherence among persons with HIV infection.⁶⁸ Research has found that reductions in alcohol use are associated with reductions in high-risk sexual behaviors,^{69,70} thus lessening patients' risk of contracting a new STI.⁷¹

RISK-REDUCTION TECHNIQUES FOR USE BY HIV CARE PROVIDERS

Table 1 provides nonstigmatizing risk-reduction recommendations that you might deliver to your HIV-positive patients regarding reducing risky sexual behaviors, risky injection practices, drug use, and alcohol abuse. Benefits to the patient of making a change are also described.

The concept of “harm reduction” lies at the heart of delivering risk-reduction messages within the clinical setting. Harm reduction interventions assess each individual’s “readiness to change”⁷² and then provide appropriate counseling to bring about a change or reduction in the behavior based on his or her readiness. Not every individual will be ready to eliminate risky behaviors, and bringing about incremental reductions in risky behaviors is preferable to achieving no reduction at all. A number of techniques are available that enable HIV care providers to work in collaboration with their patients to set practical, achievable goals. These goals should be revisited and strengthened during subsequent visits.

An intervention technique that some HIV care providers have found practical in clinical settings is known as “brief motivational intervention.” Such interventions use a flexible set of messages and approaches to enhance patients’ internal motivation to change specific health behaviors.⁷³ These interventions are based on the patient-centered counseling style known as “motivational interviewing,” in which the clinician does not try to persuade the patient, but takes into account the patient’s readiness to change and helps the patient explore and resolve his or her own ambivalence about behavior change.⁷⁴ Over the past decade, studies have shown that brief motivational interventions used in a variety of clinical settings have effectively decreased smoking rates^{75,76} and reduced drinking among problem drinkers.^{77,78} Brief motivational interventions by providers are particularly effective for primary care patients who are not actively seeking help for reducing their risky behaviors and who are in earlier stages of change.^{76,79} When providers wish to intervene directly, and no other counselor is immediately available, these techniques can be extremely useful.

The techniques of brief motivational interventions include providing clear recommendations in a supportive, nonthreatening manner; providing a range of different behavioral options for the patient; demonstrating empathy and a nonjudgmental attitude; using a collaborative, partnership-based approach to communication and behavior change negotiation; and emphasizing the patient’s freedom of choice and responsibility for his or her own choices.⁸⁰ The use of these techniques helps to avoid patient resistance and is associated with positive behavior change.^{77,81,82} Through the intervention, a provider helps patients recognize their susceptibility to the risks posed by their behaviors and the discrepancies between their behaviors and their goals. Studies show that patients’ recognition of these factors helps facilitate behavior change.^{83,84}

We suggest the following specific counseling steps:

1. First, work with patients to obtain a full understanding of their recent risky behaviors by asking nonjudgmental questions. You may explore these personal behaviors in the context of a general conversation regarding lifestyle and health.
2. Second, when the patient reports recent risky behaviors, clearly state a recommendation that the patient make a change in order to protect their health. Place the recommendation in the context of concern for the patient’s well-being.
3. The next step is to assess the patient’s readiness to change. You could ask patients to place themselves on a continuum between 0 and 10, with 0 being “not at all ready” and 10 meaning “extremely ready” to make specific behavioral changes. Asking for a patients’ response on a scale gives patients permission to let you know when they have mixed feelings about making a change.^{76,85}
4. Next, you can offer a range of options that patients can follow to change their specific risky behavior(s). These options should be compatible with the patient’s specific level of readiness to change, and should take into consideration the specific realities of each patient’s life. Selecting among the options is the patient’s decision. A patient’s verbal commitment to a change—whether modifying a behavior or thinking things over—

increases the likelihood of making some progress, and leaves the door open for continuing discussions.

5. The fifth step is to promote or reinforce patients' self-efficacy—their belief that they have the ability to make positive changes. Offer feedback about the successes patients describe and observe the small successes they don't mention (such as keeping their appointments). This nurtures their self-efficacy and sends a message, "I believe you can do it!"⁸⁶

Table 2 provides samples of these steps in action. These messages can be tailored to suit your style and individual patients' needs. Repetition of these messages is helpful because consistency promotes your credibility and enhances patients' trust. Patients will remember your consistency and the concern you show for their well-being.⁸⁷ As their confidence in your credibility and reliability increases, so does their trust in you.⁸⁸

CONCLUSION

In a perfect world, HIV care providers would have the time and inclination to conduct comprehensive risk assessment and risk-reduction counseling at each medical visit. In the real world, this is not always possible. The brief assessment and counseling techniques we describe can be effectively implemented by busy providers in the real world to help patients modify risky behaviors.

Patients typically report that they are not embarrassed to discuss HIV/AIDS with their provider, and most patient-provider discussions about AIDS are initiated by patients.⁸⁹ Yet, prevention counseling for HIV-positive patients still has not become routine.^{22,90} In a recent survey of HIV-care experts, we found that 75% of experienced HIV-care physicians were highly confident in choosing the initial antiretroviral regimen for a treatment-naïve HIV-positive patient, but only 59% rated themselves highly confident in assessing patients' sexual risk behaviors, and only 47% were highly confident in assessing patients' substance use and abuse.⁵ We believe the time is right for the widespread adoption of the risk assessment and counseling techniques we recommend here.

In a previous qualitative study of experienced HIV care physicians, we identified a spectrum of counseling behavior, marked at the extremes by two distinct styles of risk prevention. Some physicians, whom we labeled "consultants," viewed themselves primarily as sources of information about risky behaviors, leaving it up to the patients to use that information as they wished. Other physicians, whom we labeled "collaborators," tended to view themselves both as sources of information and as partners in their patients' lives, responsible for helping patients use the information to reduce risky behaviors and for working with patients on a broad range of psychosocial factors. "Collaborators" also tended to revisit prevention and counseling more often at patients' follow-up visits.²

HIV care providers whose style more closely resembles that of "consultants" might find the messages in Table 1 to be useful and sufficient. Providers who wish to assume a larger counseling role could utilize those messages and some or all of the techniques presented in Table 2. In either case, a provider's protocol can involve as small a number of elements as asking a few risk assessment questions and giving a direct risk-reduction message, such as, "For your overall health, I recommend that you cut down on your use of these drugs." A small investment of time during each patient encounter can return a big payoff for the patient. The authority of the provider—"the power of the white coat"—infuses significant weight to the discussion of even the most sensitive topics.⁹¹

For many people living with HIV, the physiologic benefits of antiretroviral therapy have become an opportunity for a “second life.”⁹² For some, this may mean taking their lives in new, positive directions and making sustained changes in health-promoting behaviors. The more these individuals trust their HIV care provider, the more the provider can serve a vital role in the patient’s support system.¹⁹ We believe providers have a great opportunity to help HIV-positive patients change risky behaviors. By engaging in the prevention techniques that we have summarized here, and without overburdening themselves or stigmatizing their patients, providers can have a significant impact on the health of their patients.

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Table 1
Risk-Reduction Messages That Benefit HIV-Positive Patients

Behavior recommendations for HIV-positive patients	Benefit for the HIV-positive patient's health
Sexual behaviors	
If you choose to have anal or vaginal intercourse, I recommend that you use a condom and lubricant every time.	Using condoms helps to protect you from getting infected with a new STI that could weaken your immune system or require you to take additional medications.
If you are having intercourse without a condom, I recommend regular examinations to check whether you acquire new STIs.	Regular examination will help you to start treatment for the STI early to prevent harm to your immune system.
Injection of drugs	
If you choose to use drugs, I recommend that you consider a method other than injection, like snorting or smoking.	By not injecting, you reduce the risk of skin and soft tissue infections that may be difficult to treat.
If you choose to inject drugs, I recommend that you use a brand new sterile syringe for each injection and not share needles or works with another person.	By not sharing needles, you can avoid getting infected with Hepatitis C.
Drug use	
I recommend that you consider quitting your use of drugs in the near future.	This will improve your overall health and reduce your chance of having a serious accident or a problem with your family or your work. It also will help you stick to your HIV medication schedule.
If you continue to use drugs, consider using them less often, using fewer kinds of drugs, or taking steps to make your drug use safer.	This will protect you from harmful interactions between street drugs and your HIV medications. This will help you become more aware of your surroundings and actions.
Alcohol use	
[For women] I recommend you limit your drinking to no more than one drink a day, and never as many as four or more drinks on any one occasion.	This will improve your overall health. By helping you stay in control, this may protect you from accidents or family and work problems. This will help you stick to your HIV medication schedule, and will help reduce nausea and stomach problems caused by HIV medicines.
[For men] I recommend you limit your drinking to no more than two drinks a day, and never as many as five or more drinks on any one occasion.	This may help you get better, deeper sleep to keep you well.
	Cutting back on drinking could reduce feelings of depression.
STI, sexually transmitted infection.	

Table 2
Suggested Language for Brief Motivational Interviewing Steps by HIV Care Providers

Step 1: Assess risk
Example: excessive drinking
Think back over the past 3 months. How many days in a typical week did you have at least one drink of any alcoholic beverage? And, on a typical day, how many drinks did you drink?
Example: binge drinking
How many times over the past 3 months did you have five or more drinks on one occasion? (For women: four or more drinks)
Step 2: Give clear recommendations
Specifically for women ...
I recommend you limit your drinking to no more than one drink per day, and never as many as four or more drinks on any one occasion.
Specifically for men ...
I recommend you limit your drinking to no more than two drinks per day, and never as many as five or more drinks on any one occasion.
Step 3: Assess patient's readiness to change
On a scale of 0 to 10, where 0 means not at all ready and 10 means extremely ready, how ready would you say you are to consider cutting back on the amount of alcohol you generally drink?
Follow-up to their answer:
I'm assuming you picked that number because you're ready to make this change (or unsure about making a change, or not ready to change). Am I understanding you?
Step 4: Provide options
Here are some options. Which ones might you try?
Ready to change: Cut back on your alcohol use
Quit all alcohol use
Contact an agency or program for support
Unsure: Plan to stay safer when drinking
Contact an agency or program for support
Write a list of what making a change in your drinking would mean to you
Not ready to change: Plan to stay safer when drinking
Think about what you like and don't like about using alcohol
Discuss your alcohol use with someone you trust
Step 5: Support self-efficacy
The first step in making a change in one's drinking is to make a firm decision and commitment to do so. Only you can make the decision for yourself.
I'm confident that if you stay committed to your decision, you'll find a way to do it.